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	345215	A. BUILDING _____ B. WING _____	C 08/01/2019

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E 000	Initial Comments An unannounced Recertification survey was conducted on 07/29/19 through 08/01/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QISF11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 7/29/19 through 8/1/19 at event ID# QISF11. 2 out of 10 alligations were substantiated. A recertification survey and complaint survey was conducted from 7/29/19 through 8/1/19. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
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	F 550		8/30/19

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

Electronically Signed | 08/21/2019

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F 550	Continued From page 1 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 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews the facility failed to treat a resident with dignity and respect by labeling residents who required assistance with meals as "feeders." This was evidenced in one resident observed for dining. (Resident #129) Findings included:	F 550	F550 Nurse Aide #2 (NA) and Nurse Aide #3 were immediately educated, on 7/29/19, on dignity and respect with emphasis on not referring to residents who require assistance with feeding as “feeders” to include Resident #129.	

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F 550	Continued From page 2 Resident #129 was admitted to the facility on 12/10/08. Her active diagnoses included quadriplegia, multiple sclerosis, and depression. A review of Resident #129 ' s minimum data set assessment dated 7/2/19 revealed she was assessed as cognitively intact. She had no behaviors and was totally dependent on staff for eating. Resident #129 was assessed to have impairment on both sides of her upper and lower extremities. A review of Resident #129 ' s care plan dated 4/4/19 revealed she was care planned to require assistance with eating related to multiple sclerosis and dysphagia. The interventions included to provide total assistance with eating. During breakfast observation on 7/29/19 at 7:55 AM Nurse Aide #2 was getting a tray out of the dining cart on the 200 hall. She turned to Nurse Aide #3 who was in room 208 setting up the resident in that room for breakfast. The resident in room 208 was awake. Nurse Aide #2 stated to Nurse Aide #3 that she needed help in another room because the resident was a "feeder." During an interview on 7/29/19 at 7:59 AM Nurse Aide #2 stated staff in the facility referred to residents who needed assistance with meals as "feeders." She continued to state while walking down the hall with the surveyor that the 200 hall had a lot of "feeders" and that was the term they used to describe those resident ' s including Resident #129. During an interview on 7/29/19 at 8:09 AM Nurse Aide #3 stated the staff used the term "feeder" to indicate residents who needed assistance with	F 550	On 8/20/19, the Social Worker initiated a 100% resident questionnaire with all alert and oriented residents to include resident #129 utilizing the Resident Rights Questionnaire in regards to dignity and respect with emphasis on dignity with meal assistance. The Director of Nursing (DON) will address all concerns identified during the audit. The questionnaires will be completed by 8/30/19. A 100% in-service for all nurses, geriatric care assistants, and nursing assistants to include NA #2 and NA #3 was initiated on 7-29-19 by the Staff Facilitator in regards to Dignity and Respect with emphasis on dignity with meal assistance and not referring to residents as “feeders”. In-service will be completed by 8/30/19. All newly hired staff will be in-serviced by the Staff Facilitator during orientation in regards to Dignity and Respect. 10% of all staff members to include NA#2 and NA#3 will be monitored utilizing the Resident Care Audit-Dignity during Meals by the Treatment Nurse, Assistance Director of Nursing, Quality Assurance Nurse, Staff Development Coordinator Nurse and Nurse Supervisor to ensure staff are treating residents with dignity and respect with emphasis on dignity with meal assistance. Audit will be completed weekly x 8 weeks then monthly x 1 month. The Treatment Nurse, Assistance Director of Nursing, Quality Assurance Nurse, Staff Development Coordinator Nurse and Nurse Supervisor will address all concerns identified during the audit to	

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F 550	Continued From page 3 meals. She further stated the nurse aides would communicate to each other on the hall by stating the room number of a dependent resident and say they were a "feeder." She again reiterated "feeder" was the term used by staff. She concluded she was not aware of any concern with the term "feeder." During an interview on 7/29/19 at 1:01 PM an alert and oriented resident who did not need staff assistance with meals stated staff referred to residents who could not eat by themselves as "feeders." She further stated she did not like the term. The resident stated she felt it was disrespectful to the other residents who needed assistance because they were people too. During an interview on 7/29/19 at 2:25 PM Resident #129 stated she was unable to feed herself. She stated, even though she could not feed herself or move her arms, she was still someone who she felt could be respected. Resident #129 stated she had heard staff call her a "feeder." She continued to state she was called a "feeder" all the time by staff and it made her feel bad because she was a person, not someone to be considered a task. She concluded she would prefer staff get her food tray and say she needed assistance with her meals and not call her a "feeder." During an interview on 7/31/19 at 9:10 AM the Director of Nursing stated staff had been educated to say the residents needed feeding assistance and not use the term "feeder" for dignity concerns.	F 550	include re-education of staff. The Director of Nursing (DON) will initial the Resident Care Audit-Dignity during Meals for completion and to assure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The DON will forward the results of the Resident Care Audit-Dignity during Meals to the Executive Quality Assurance Committee monthly x 3 months. The Executive Quality Assurance Committee will meet monthly x 3 months and review the Resident Care Audit-Dignity during Meals to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		8/30/19

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F 561	Continued From page 4 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review the facility failed to get a resident up and out of bed according to their preferred time for 1 of 2 residents reviewed for choices. (Resident #45) Findings included:	F 561	F561 Resident #45 was interviewed by the Director of Nursing (DON) on 7-30-19 in reference to resident #45 preference for waking hours.	

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F 561	Continued From page 5 Resident #45 was admitted to the facility on 4/1/15. His active diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A review of Resident #45's minimum data set assessment dated 5/24/19 revealed he was assessed as cognitively intact. He was also documented to be totally dependent on staff for bed mobility, transfers, and locomotion on and off unit. A review of Resident #45's care plan dated 5/2/19 revealed he was care planned to require assistance with activities of daily living related to impaired mobility. The interventions included Resident #45 was to be bathed and out of bed in chair on 11-7 shift and was to be put back to bed at 1 PM or before the end of 7-3 shift. This intervention was not populated to the digital care guide used by the nurse aides. During observation on 7/29/19 at 8:00 AM Resident #45 was observed still in bed. During observation on 7/29/19 at 10:00 AM Resident #45 was observed still in bed. During an interview on 7/29/19 at 10:09 AM Resident #45 stated he used to get up and out of bed on third shift and he really liked that schedule. He further stated recently they had not been getting him out of bed on third shift for the morning and he did not know why. He concluded he had not told anyone he wanted to wait until first shift to get out of bed in the mornings, they just stopped getting him up on the third shift. During an interview on 7/30/19 at 3:13 PM Nurse	F 561	On 8/20/19, The Minimum Data Set (MDS) Coordinator updated the care plan/care guide for resident #45 preference for waking hours. A 100% Resident Preference Questionnaires was initiated on 8/20/19 with all alert and oriented residents to include resident #45 by the Social Worker (SW) with emphasis on wake/sleep times. All care plans/care guides will be updated by the MDS Coordinator for all changes in resident preferences. Audit will be completed by 8/30/19 A 100% in-service for all nurses and Certified Nursing Assistants (NA) to include NA #1 was initiated on 8/5/19 by the Staff Facilitator in regards to Resident Preferences with emphasis on honoring preference of wake/sleep times. In-service will be completed by 8/30/19. All newly hired nurses or nursing assistants will be in-serviced by the Staff Facilitator during orientation regarding Resident Preferences. 10% of all alert and oriented residents to include resident #45 will be interviewed utilizing the Resident Preference Questionnaires by the SW weekly x 8 weeks then monthly x 1 month. This audit is to ensure resident preferences are identified and resident choices honored to include but not limited to wake/sleep times. The Social Worker, Assistant Director of Nursing, Nurse Supervisor and the MDS nurse will address all areas of concern identified during the audit to	

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F 561	Continued From page 6 Aide #1 stated she did not get Resident #45 up and out of bed the morning of 7/29/19 on her 11 PM to 7AM shift because to her knowledge he was not supposed to get up regularly on third shift. She further stated she would look at the care guide for information related to when residents would like to get up. During an interview on 7/30/19 at 3:59 PM the Director of Nursing stated care should be given to residents according to their plan of care. She further stated Resident #45 preference was to be out of bed on 11 to 7 shift and should have been reflected in the care guide for the nurse aides to use.	F 561	include updating care plan for all newly identified resident preferences and staff education. The Director of Nursing (DON) will initial the Resident Preference Questionnaires for completion and to assure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The DON will forward the results of the Resident Preference Questionnaires to the Executive Quality Assurance Committee monthly x 3 months. The Executive Quality Assurance Committee will meet monthly x 3 months and review the Resident Preference Questionnaires to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to accurately code the functional status of a resident's upper and lower extremities on the Minimum Data Set (MDS) for 1 of 2 residents (Resident #10) reviewed for range of motion. The findings included: Resident # 10 was admitted to the facility on	F 641	F641 On 8-5-19, the MDS Coordinator completed a correction to the 7/12/19 assessment for Resident #10 to reflect accurate coding of section “G”. On 8/20/19, a 100% audit all residents most recent MDS assessment section “G”	8/30/19

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F 641	Continued From page 7 10/24/2018 with the diagnoses which included contracture of the left wrist, and unspecified hemiplegia affecting unspecified side. The Quarterly Minimum Data Set (MDS) dated 7/12/2019 indicated the resident required total assistance with all activities of daily living (ADL). The MDS functional status revealed Resident #10 had no impairment to his upper or lower extremities and indicated the resident was severely cognitively impaired. A current care plan revised on 5/1/2019 revealed a plan which focused on Resident #10 was at further risk for left wrist contracture. An observation on 7/29/2019 at 11:00 am revealed Resident # 10 resting on his bed with his eyes open. When he was spoken to, he would look toward the wall. The resident left arm was stretched out on the bed with his wrist bent at an angle. His right hand had repetitious movements from his groin area to his head. Resident # 10 legs were stretched out on the bed under a sheet with no lower extremity movement observed. During an interview on 7/31/2019 at 10:00 am with Nursing Assistant # 4, she revealed Resident # 10 required total assistance with all ADLs. The nursing assistant also stated she had never noticed Resident #10 try to use his hands to assist with his ADLs. On 8/1/2019 at 10:30 am an interview with a Medication Aide (MA) was conducted, she revealed Resident # 10 was not an active participant in his daily care. She also stated the resident left wrist was contracted and she had never seen the resident move his left hand or left	F 641	to include Resident # 10 was initiated by the Director of Nursing to ensure all MDS assessments section “G” were completed accurately for range of motion and contractures. The MDS Coordinator will address all identified concerns during the audit to include retraining of the MDS nurse, or completing necessary modification to the MDS assessment. Audit will be completed by 8/30/19. On 8/20/19, the assigned hall nurses initiated an 100% audit of all residents to include resident #10 to identify any resident with contractures utilizing a resident census to ensure all residents with contractures are care planned appropriately and coded correctly on MDS assessment section “G”. The MDS nurse will address all areas of concern identified during the audit to updating care plan and completing necessary modification to the MDS assessment. The audit will be completed by 8/30/19. On 8-19-19, the Administrator completed an in-service with the MDS Coordinator in regards to MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. On 8-19-19, the MDS Coordinator completed an in-service with the MDS Nurses in regards to MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator, MDS	

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F 641	Continued From page 8 arm unassisted. An interview was conducted on 7/30/2019 at 9:30 am with the MDS Coordinator, she revealed the Resident #10's 7/12/19 Quarterly MDS was incorrect and needed to be corrected. The coordinator also stated that she did not complete the 7/12/19 MDS assessment, but all the other MDS assessments had Resident # 10 as having a limitation in his range of motion. She further stated the MDS would be modified to correctly reflect the resident had impairments to his upper and lower extremities. The interview with the Administrator on 8/1/2019 at 2:30 pm revealed the MDS coordinator and nurses were responsible for making sure the MDS assessments were accurate. He also indicated the facility should have policies and procedures in place to make sure the MDS assessments reflected the residents and their needs.	F 641	nurse will be in-serviced by the Staff Facilitator during orientation in regards to MDS Assessments and Coding 10% audit of all resident recent MDS assessments section “G”, to include resident #10 will be completed by the Treatment Nurse, Assistance Director of Nursing, Quality Assurance Nurse, Staff Development Coordinator Nurse and/or Nurse Supervisor utilizing the MDS Accuracy Tool. This audit will be completed weekly x 8 weeks then monthly x 1 month to ensure accurate and complete coding of the MDS assessment section “G”. All identified areas of concern will be addressed immediately by the MDS Coordinator to include retraining of the MDS nurse, or completing necessary modification to the MDS assessment. The Director of Nursing (DON) will review and initial the MDS Accuracy Tool weekly x 8 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The DON will forward the results of MDS Accuracy Tool to the Executive QA Committee monthly x 3 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		8/21/19

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F 689	Continued From page 9 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff and physician interviews and review of manufacturer's instructions the facility failed to secure a resident in the transportation van using the van's lap belt strap and shoulder strap during a van transport for 1 of 1 sampled resident reviewed for supervision to prevent accidents (Resident #74). During a facility van transport Resident #74 was not strapped in the van properly by the van driver which resulted in the resident falling from his wheelchair and landing on his knees onto the van's floor. The Van Driver also failed to have the resident evaluated by a licensed medical professional before he assisted Resident #74 back into his wheel chair and transported the resident back to the facility. After Resident #74 returned to the facility he complained of right knee pain and received medication to relieve his pain. Resident #74 had x-rays taken of both of his knees which showed no injuries. Findings included: On 7/31/19 the contracted van company's manufacturer's instructional videos for the proper use of the van's safety restraints during transportation were watched and a written guide of manufacturer's instructions was reviewed. The videos and written instructions specified after the wheelchair was secured in the van, the van's lap	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 10	F 689		

belt strap was to be placed between the wheelchair arm and the resident to secure the resident to the wheelchair. The manufacturer's instructions further specified to make sure the van's shoulder strap was in place once the lap belt was properly placed on the resident.

Resident #74 was admitted to the facility on 1/11/16 with diagnoses including end stage renal (kidney) disease, muscle weakness, difficulty walking and polyneuropathy (nerve damage) among others.

Review of Resident #74's minimum data set dated 3/18/19 and coded as a quarterly assessment revealed he was cognitively intact. He was documented as having no behaviors or rejection of care. He was assessed as needing the supervision assistance of one person for transfers and walking in his room and the extensive assistance of one person for movement off the unit. He was further assessed for balance as being steady at all times, as having no functional limitation for range of motion and as using a walker and a wheelchair assistive device.

Review of Resident #74's care plan revised on 3/18/19 revealed he was at risk for falls related to generalized weakness, end stage renal disease, pain, dizziness and syncope (fainting) episodes. The goal was for him to remain free from falls or accidents. The interventions included encourage resident to take rest periods as needed, encourage resident to use hand rails or assistive devices properly, keep assistive ambulation device (walker) within reach of resident and wheel chair for transport.

Review of a progress note dated 3/30/19 at 5:00

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PM written by Nurse #2 revealed Resident #74 returned to the facility from dialysis accompanied by Van Driver #1 at 2:50 PM. It further indicated Van Driver #1 reported Resident #74 had come out of his wheelchair onto his knees when he had to stop the van suddenly in the road. It went on to say Van Driver #1 indicated the wheelchair stayed secure, but the lap belt did not hold Resident #74 in the wheelchair. It further indicated Nurse #2 assessed Resident #74 for injury, noted none, and notified the facility's Administrator, the on-call Physician Assistant, Resident #74's Representative and the contracted van transportation company. It went on to say the Physician Assistant ordered x-rays of Resident #74's knees.

On 7/31/19 at 9:22 AM interview with Resident #74 revealed he recalled the van incident on 3/30/19. He stated Van Driver #1 put the lap belt on him while he was in his wheelchair in the van. He indicated he did not remove the belt, it came unbuckled when the van stopped quickly, and he fell forward onto his knees on the floor of the van. He went on to say Van Driver #1 did not have anyone assess him after the fall, helped him back up into his wheelchair and transported him back to the facility. He further indicated he was assessed by staff at the facility upon his return. He indicated he did not feel he had any lasting effects from the incident and felt safe being transported to dialysis.

In an interview on 7/31/19 at 10:28 AM the facility Administrator indicated a written statement taken from Van Driver #1 after the incident and an investigation of the incident revealed Van Driver #1 had not applied the shoulder strap in addition to the lap belt onto Resident #74 as

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recommended by the manufacturer's guidelines during transport.

On 7/31/19 at 12:00 PM a telephone interview with Van Driver #1 indicated he secured Resident #74's wheelchair into the van and had used the safety lap belt on 3/30/19. He further indicated he did not recall whether the van "WC-1" had a shoulder belt but stated he had been trained to use the lap belt as well as the shoulder belt if a van was equipped with them. He went on to say he stopped the van quickly the day of the incident because the car in front of him suddenly stopped. He indicated he heard a noise, looked back and saw Resident #74 on the floor of the van on his knees. He further indicated he should have called 911 but Resident #74 said he was okay, and it was only a couple of miles back to the facility. He stated he helped Resident #74 back up into his wheelchair and returned to the facility. He further indicated he had been retrained, now checks to make sure all latches are secure and was trained to call 911 immediately if there is an accident involving a resident.

On 7/31/19 at 9:53 AM interview with Nurse #2 indicated she would have expected Van Driver #1 to immediately pull over and call 911 if there was an incident involving a resident, have the resident assessed for injury and notify the facility. She further indicated when Resident #74 returned to the facility 3/30/19 she assessed him, made the required notifications and immediately called the contracted van company's dispatch to notify them and tell them not to send Van Driver #1 to the facility anymore.

On 7/31/19 at 11:18 AM in an interview, the contracted van transport company Chief

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Executive Officer (CEO) stated on 3/30/19 Van Driver #1 did not use the safety equipment when transporting Resident #74 on van "WC-1" as he had been trained to do. The CEO further indicated Van Driver #1 had not applied the shoulder belt in addition to the lap belt on Resident #74 that day. He went on to say Van Driver #1 did not call 911 after the incident to have Resident #74 assessed by a medical professional as Van Driver #1 felt Resident #74 was okay and it was only a couple of miles back to the facility. The CEO further indicated all company van drivers were trained to check the safety equipment on all company vans at the beginning of each day and the equipment was also checked weekly. He stated the safety equipment on van "WC-1" was inspected on 3/30/19 after the incident, was found to be functioning correctly, and it was determined safety equipment malfunction was not the cause of the incident.

In a second interview on 8/1/19 at 8:10 AM the contracted transportation company's CEO stated Van Driver #1 had not used the shoulder belt on 3/30/19 during the transportation of Resident #74 as he had been trained to do. He further indicated "WC-1" was an older van and the only van in the company's fleet with the lap belt and the shoulder belt separate. He stated all other vans have the lap belt and the shoulder belt as one piece. He further indicated Van Driver #1 had not followed proper procedure, had been placed on probation, had received remedial training and was no longer allowed to provide transportation for the facility.

Review of a progress note dated 3/30/19 at 6:30 PM written by Nurse #3 indicated Resident #74 had x-rays done of both knees.

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Review of a progress note dated 3/30/19 at 6:45 PM written by Nurse #3 indicated Resident #74 was complaining of pain to his right knee with bending.

Review of a progress note dated 3/30/19 at 9:15 PM written by Nurse #3 indicated Resident #74's x-ray results indicated only arthritis.

Review of a progress note dated 3/30/19 at 9:45 PM written by Nurse #3 indicated Resident #74 was notified of the results of his x-rays, was complaining of pain to his right knee, and was given pain medication as he requested.

Review of Resident #74's knee x-ray report dated 3/30/19 indicated Resident #74 had normal alignment of the bones with arthritic joints. It further indicated no acute pathology or foreign bodies were identified.

Review of a Physician's note dated 4/1/19 written by Physician #1 indicated Resident #74 stated he fell from his wheelchair during transport and hurt his right knee. It further indicated Resident #74's x-rays were negative, and his knee exam was normal. It went on to indicate a second Physician opinion would be obtained for Resident #74.

Review of a progress note dated 4/1/19 at 11:59 PM written by Nurse #4 indicated Resident #74 denied any pain or discomfort at that time and refused the offer of pain medication.
On 8/1/19 at 11:05 AM telephone interview with Nurse #4 indicated she provided care to Resident #74 both before and after the accident on 3/30/19 and was familiar with him. She stated she did not recall Resident #74 complaining of knee pain

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prior to the accident but he began to complain of knee pain after the accident. She further indicated she had provided pain medication to Resident #74 when he complained, the pain medication had been effective, and Resident #74's knee pain resolved completely a short time after the incident.

Review of a Physician consult report dated 4/10/19 indicated Resident #74 had bone infarcts in his distal femur which likely related to his chronic past medical history, and Resident #74 complained only of stiffness. It further indicated Resident #74 was not a surgical candidate, not a corticosteroid candidate and he would refer Resident #74's pain control to Physician #1.

On 7/31/19 at 5:44 PM in a telephone interview Physician #1 stated he had been notified by the facility of the accident involving Resident #74 and had examined the resident. He further indicated the exam had been unimpressive. He stated he ordered x-rays and an orthopedic consult. He went on to say in his opinion Resident #74 had not sustained any injury as the result of the accident.

On 8/1/19 at 8:05 AM an interview and observation was conducted with Van Driver #2 demonstrating the securement of a wheelchair resident into van "WC-1". Van Driver #2 stated she worked for the company for 18 months. She indicated she received training on proper procedures for van operation and patient transport on her hire and again about 3 months prior. Van Driver #2 was observed to place the wheelchair onto the van, lock the wheelchair brakes, secure the wheelchair to the van using the tie downs as indicated in the instructional

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videos, secure the lap belt as indicated in the instructional videos, secure the shoulder belt as indicated in the instructional videos, tighten all safety equipment securely and test the integrity of all connections. She then indicated she was done. She stated the use of the shoulder belt was not optional and was to be used for all wheelchair transports.

In an interview on 7/31/19 at 11:41 AM the facility Administrator stated it had not been his understanding it was a judgement call for van drivers to determine if residents were evaluated by a medical professional after an accident and he expected 911 to be called immediately at the time of the accident with Resident #74.

In an interview on 8/1/19 at 9:12 AM the facility Administrator stated Van Driver #1 had not followed proper procedure when transporting Resident #74 which resulted in Resident #74 experiencing a fall accident on van "WC-1". He further indicated it was unacceptable to him that any company employee not follow policies and procedures thereby putting a resident at risk.

On 8/1/19 at 5:27 PM the facility provided the corrective actions taken by the facility for tag F689 as follows:

"How the facility will identify other residents having the potential to be affected by the deficient practice

On 3/30/19 as a precautionary measure, the Administrator made the decision that the identified transport driver will no longer transport residents at the facility. On 4/1/2019, 100% interviews of all current alert and oriented

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residents were completed by the Social Worker with questions in regards to: Do you have positioning problems when up in the chair, to include while being transported in the van, Are seat belts used and secured appropriately when you are being transported? No areas of concerns were voiced during the interviews. On 4/1/19, a 100% audit of last 30 days of incident reports was conducted by the Director of Nursing to ensure that no incident was related to a fall in a transport vehicle. No areas of concern were identified during the audit. Return demonstrations were initiated on 4/1/19 by the transportation company and was completed on 4/3/19 with 100% of the transport company drivers to validate knowledge and skills of properly securing a resident in the wheel chair to include buckling the lap belt, utilization of shoulder strap, and calling 911 post van transport incidents. After 4/3/19, any transport company driver that has not completed the return demonstration will not be allowed to transport facility residents until successful completion of the return demonstration. On 4/1/2019 an in-service was completed by the Administrator with the transport company owner and Chief Executive Officer (CEO) in regards to: Ensure resident is appropriately secured with seat belt prior to any transport. Seat belt should be secured around resident not the arm rests. Be sure to properly secure residents with the shoulder strap. If a fall occurs with resident during transportation, to include slipping from the chair to the floor, immediately call 911. Then notify the administrator and/or the DON of the situation. Never move the resident, to include body parts and/or attempt to transfer resident back to the chair. On 4/1/2019 the owner and CEO of Transport Company initiated an in-service, with education based on manufacturer's instructions,

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with all transport company drivers in regards to: Ensure resident is appropriately secured with seat belt prior to any transport. Seat belt should be secured around resident not the arm rests. Be sure to properly secure residents with the shoulder strap. If a fall occurs with resident during transportation, to include slipping from the chair to the floor, immediately call 911. Then notify the administrator and/or the DON of the situation. Never move the resident, to include body parts and/or attempt to transfer resident back to the chair. To be completed on 4/3/2019. After 4/3/2019 any transport driver that has not received the in-service will not be allowed to transport facility residents until completion of the in-service.

Plan to monitor performance and to make sure that solutions are sustained

The decision to monitor van transportations was made by the Administrator on 4/1/2019. The Director of Nursing (DON), Treatment Nurse, Staff Facilitator Nurse or Nurse Supervisor will observe the transport company drivers secure 10% of residents to include resident # 1 in the wheelchair van prior to being taken to an scheduled appointment utilizing the Resident Transportation Audit Tool 3x a week for 4 weeks then monthly x 1 month. This audit is to ensure that resident is properly secured in the wheel chair van, to include proper usage of the lap belt and proper usage of the shoulder strap prior to going to an appointment. The Administrator will review and initial the Resident Transportation Audit Tool weekly x 4 weeks then monthly x 1 month to ensure completion and that all areas of concern were addressed appropriately.

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F 689	Continued From page 19 The initial Quality Assurance (QA) meeting to review the plan of correction was held on 4/1/2019. The Administrator will forward the Resident Transportation Audit Tool to the Executive QA Committee monthly x 2 month. The Executive QA Committee will review the Resident Transportation Audit Tool monthly x 2 month to determine trends and / or issues that may need further interventions put into place and the need for further and / or frequency of monitoring. The title of person responsible for implementing the plan of correction The Administrator and DON were responsible for the implementation of corrective actions to include all 100% audits, in-service and monitoring related to the plan of correction. Date of corrective action completion Final Compliance date was 4/3/2019." The plan of correction was verified through review of the 100% interviews with current alert and oriented residents, review of the 100% audit if the last 30 days of incident reports, review of the return demonstration of 100% of transport company drivers to validate knowledge and skills, review of the in-service trainings of transport company owner, CEO and all transport company drivers, and review of audit of transport drivers performance. The facility's date of compliance of 4/3/2019 was verified.	F 689		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility	F 732		8/30/19

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F 732	Continued From page 20 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to post staffing information in an area of the facility visible to residents and visitors	F 732	F732 On 7/29/19, The Console Operator	

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F 732	Continued From page 21 for 2 of 7 days. The findings included: On 07/29/19 at 5:00 AM an initial tour was conducted in the facility. Posted staffing information was observed on the bulletin board at the nurse's station. The staffing information sheet posted was dated 7/26/19. No staffing sheets were found for 07/27/19 or 07/28/19. On 07/29/19 at 6:46 AM the facility's Director of Nursing (DON) confirmed the absence of staffing sheets for 07/27/19 and 07/28/19. She stated staffing sheets should be posted daily. She went on to indicate the ward clerk on the weekend was responsible for posting staffing information on those days. On 07/29/19 at 9:31 AM in an interview geriatric care attendant #1 stated she was assigned by the weekend supervisor to answer phones and help at the desk on 07/27/19 and 07/28/19. She indicated she did not normally work at the desk, but the weekend ward clerk had been absent. She went on to say she was not aware staffing sheets needed to be posted and no one had asked her to do that. On 07/29/19 at 9:58 AM telephone interview with the weekend nurse #5 indicated she worked every weekend as the weekend supervisor. She stated she asked geriatric care attendant #1 to answer the phones because the weekend ward clerk had been absent. She further indicated she was aware of the requirement to post staffing sheets daily but had gotten busy. She went on to say she did not ask geriatric care attendant #1 to post staffing sheets for 07/27/19 or 07/28/19 and	F 732	immediately posted the Daily Nursing Staff Sheet in the hallway near the lobby with complete staffing information and resident census. On 8/20/19, 100% audit of the Daily Staffing Sheets for the past 30 days was initiated by the Director of Nursing to ensure all sheets were completed accurately to include resident census and that the current day was posted per facility protocol. The Administrator will address all concerns identified during the audit to include education of staff. Audit will be completed by 8/30/19. On 8/20/19 the Administrator initiated an in-service with the Director of Nursing (DON), Clinic Coordinators, Scheduler, Console Operator, Geriatric Care Assistant (GCA) to include GCA #1 and Nurse Supervisor in regards to Posting of Daily Staffing Sheet with complete information to include the census at the beginning of the shift. In-service will be completed by 8/30/19. All newly hired Administrator, DON, Clinic Coordinators, Scheduler, Receptionist, GCA and Nurse Supervisors will be in-serviced by the Staff Facilitator during orientation in regards to Posting of Daily Staffing Sheet. The Nurse Supervisors will audit the Daily Staffing sheets to include weekends weekly x 8 weeks and monthly x 1 month to ensure daily posting includes complete information prior to the beginning of the shift utilizing the Daily Staffing Audit Tool. Retraining will be immediately conducted	

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F 732	Continued From page 22 had not posted them herself. On 8/1/19 at 9:58 AM in an interview the DON stated staffing should to be visibly posted daily in the facility. She indicated not only was this a requirement, but it was important for residents and visitors to know how many staff the facility had available.	F 732	by the Director of Nursing and Nurse Supervisor for any identified areas of concern. The Administrator will review and initial the Daily Staffing Audit Tool weekly x eight weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Daily Staffing Audit Tool to the Executive QA Committee monthly x 3 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		8/30/19

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F 761	Continued From page 23 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 interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 5 medication carts observed. (400 Hall Medication Cart) Findings included: During observation on 7/29/19 at 4:54 AM the 400 hall medication cart was observed to be unlocked and unattended on the 400 hall. The cart ' s lock was observed not to be engaged. At 4:56 AM Nurse #1 returned to her medication cart. Nurse #1 was observed to open the medication cart, which contained medications and confirmed it was left unlocked while unattended on the hallway. During an interview on 7/29/19 at 4:56 AM Nurse #1 stated medication carts were to be locked when unattended. She further stated she left her medication cart to check the front door and forgot to lock the cart when she left the hall. The nurse concluded she should have locked the cart prior to checking the front door. During an interview on 7/31/19 at 9:05 AM the Director of Nursing stated medications carts should always be locked when left unattended by the staff.	F 761	F761 On 7/29/19, Nurse #1 locked the 400 Hall Medication Cart. The Administrator verified cart was secured appropriately. On 8/19/19, 100% audit of medication carts, to include the 400 hall medication cart, was completed by the Director of Nursing (DON) to ensure that all medication carts were locked when unattended. All identified areas of concern were addressed by the DON during the audit, to include locking the medication cart. On 8/20/19 an in-service was initiated by the Staff Facilitator with all nurses and medication aides, to include Nurse #1, in regards to Medication Storage with emphasis on locking medication cart when not directly supervised by assigned nurse. In-service will be completed by 8/30/19. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation in regards to Medication Storage. 10% Audit of all medication carts to include 400 hall medication and nurse #1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 24	F 761	will be monitored by the Treatment Nurse, Assistance Director of Nursing, Quality Assurance Nurse, Staff Development Coordinator Nurse and Nurse Supervisor weekly x 8 weeks then monthly x 1 month utilizing the Medication Security Audit Tool. This audit is to ensure that all carts were locked when not supervised by assigned nurse. All areas of concern found during the audits will be addressed immediately by the Treatment Nurse, Assistance Director of Nursing, Quality Assurance Nurse, Staff Development Coordinator Nurse and Nurse Supervisor. The DON will review and initial the Medication Security Audit Tool for completion and to ensure all areas of concerns were addressed weekly X 8 weeks then monthly X 1 month. The Administrator will forward the results of the Medication Security Audit Tools to the Executive Committee monthly X 3 months to review, address any issues, concerns and/or trends to make changes as needed, to include continued frequency of monitoring.	