STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 000	INITIAL COMMENTS The survey team entered the facility on 09/10/19 to conduct a complaint investigation survey and exited on 09/12/19. Additional information were obtained on 09/16/19 and 09/27/19. Therefore, the exit date was changed to 09/27/19. Event ID# 7EPS11. 8 of the 31 complaint allegations were substantiated resulting in deficiencies F584 and F677.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		11/8/19

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

Electronically Signed | 10/18/2019

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to (1) maintain clean walls, floors, baseboards, light switches, bath tubs, windows and window sills for 17 of 63 rooms (rooms 101, 104, 109, 113, 114, 201, 203, 204, 207, 210, 213, 301, 302, 313, 317 and 325), (2) repair/replace lighting in resident rooms for 4 of 63 rooms (rooms 110, 117, 201 and 214), (3) repair walls, doors and ceilings from chipped paint exposing wood and plaster throughout the 200 hallway and 300 hallway and for 4 of 63 resident rooms (rooms 201, 202, 204 and 331), (4) maintain toilets, furnishings, faucets, vents, floors and window treatments in good repair for 10 of 63 rooms (rooms 204, 206, 213, 214, 302, 304, 309, 315, 325 and 327). Findings included: 1.Observations of resident rooms and bathrooms and common areas revealed the facility failed to maintain a clean environment in the following	F 584	483.10 Safe/Clean/Comfortable/Homelike Environment Criteria One: 1. Maintain a clean environment Failure to Maintain Clean Environment a. The area of concern noted in room 104 observed at 8:40a.m. on 9/11/2019 having a 6 foot by 6 foot dried red substance was cleaned and sanitized prior to survey exit, shortly after discovery. Upon investigation, the soiled area was caused by a resident having a significant nose bleed earlier in the day. Facility staff was educated on proper cleanup and sanitation of blood spills prior to survey exit, at time of incident correction. b. The Ceiling in the hallway on the 300 unit had a brown water stain caused by a recent water leak. The leak was repaired prior to complaint survey, yet the stained	

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F 584	Continued From page 2 rooms and areas: a. Room 104 was observed at 8:40am on 9-11-19. The floor of the resident's room was noted to have a 6 foot by 6-foot dried red substance. An interview with the unit manager for hall 100 occurred on 9-11-19 at 8:41am. The manager stated the dried red substance was blood and that she was waiting for housekeeping to clean the floor. The nurse confirmed the blood had been on the floor since 4:20am the morning of 9-11-19. A second observation of room 104 occurred on 9-11-19 at 9:30am and was noted to still have blood around the bed frame, a spot of blood measuring approximately 2 centimeters round in the middle of the resident's room, a spot of blood measuring approximately 4 centimeters round by the bathroom door and blood smears on the bathroom floor. A third observation was made with the housekeeping manager at 11:55am on 9-11-19 and revealed the blood found during the second observation at 9:30am was still present in the room. The housekeeping manager stated it was the responsibility of the nursing assistant to clean up bodily fluids and the responsibility of housekeeping to come in and sanitize once the fluid was cleaned up however, the housekeeping manager stated she had cleaned up the blood herself and that she was unaware there was still blood present in the residents room. The manager stated she would have someone go back and re-clean the floors.	F 584	area was pending repair. The area was sanded, primed and painted prior to survey exit. The doors, handrails and baseboards that were noted as dusty during survey was cleaned at time of discovery. Touch up painting was completed immediately post survey to correct the black streaked areas noted on wall surfaces due to normal wear and tear caused by bumping and equipment striking walls and surfaces during use. c. The brown substance that was observed in the restroom of room 113 was noted to be feces from resident self toileting. Deep cleaning and sanitation of the restroom was completed after the time of discovery and prior to survey exit. Housekeeping staff was educated regarding the process of restroom cleaning and sanitation of surfaces. Nursing staff was also instructed on the process and procedure of completion, as this should be completed at the time of discovery. d. Housekeeping cleaned and sanitized the bathroom wall and light in resident room 101 and removed the brown substance prior to survey exit. e. Upon discovery of brown/black streak marks on the walls in resident room 109, housekeeping cleaned and sanitized areas and maintenance completed touch up painting as black marks were caused by apparent equipment scuffs. f. The wall guard observed in 114 to have	

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F 584	Continued From page 3	F 584		

b. The 200 and 300 hallways were observed on 9-11-19 at 2:00pm and revealed (a) the ceiling of the hallway had areas of brown discoloration and (b) the doors, hand rails and baseboards were dusty and had black streaks and/or smudges.

c. Room 113 was observed on 9-11-19 at 8:32am. The observation revealed a dried brown substance on the walls in the bathroom by the commode and there were noted to have 2 small round brown substances on the floor next to the commode.

Another observation was made of room 113's bathroom on 9-11-19 at 11:48am and revealed a dried brown substance on the walls in the bathroom by the commode and 2 small round brown substances on the floor next to the commode.

During an interview with housekeeper #1 on 9-12-19 at 8:20am, the housekeeper stated she had cleaned room 113 prior to 12:00pm on 9-11-19 and that she had seen the 2 small round brown substances on the floor "I believe that was poop and we are not allowed to clean bodily fluids or feces. The nursing assistants are to clean up the feces than housekeeping will go in and sanitize the area." She denied informing staff there was "poop" on the floor in 113's bathroom.

d. Room 101 was observed on 9-11-19 at 8:27am and revealed the resident's bathroom wall and light switch had a brown substance on them.

A second observation was made of room 101 on 9-11-19 at 11:45am and revealed the resident's bathroom wall and light switch had a brown substance on them.

a brown "splattered" substance was cleaned and sanitized after the time of discovery prior to survey exit.

g. The brown dried substance on the baseboards in resident room number 201 was removed, cleaned and sanitized by housekeeping staff members upon discovery and survey exit.

h. The cob webs in the window sills and black streaks noted in resident room 203 on the floor was cleaned and sanitized after the time of discovery prior to survey exit.

i. The dried smeared brown substance smeared on side of bathtub noted in resident room 204 was cleaned and sanitized after discovery and prior to survey exit.

j. A resident spilling juice had caused the dried orange/red substance noted behind the door in room 207. The dried orange/red substance has since been cleaned and sanitized. No staining persist.

k. The black streaks and smears noted on the main door in room 210 was caused by equipment scuffs and has since been cleaned and as much of the scuff removed as possible as there are no noted penetrations with scuffs.

l. Resident room number 213 that was noted to have yellow/brown stained ceiling approximately 1.5 feet long and 2cm wide

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F 584	Continued From page 4 e. An observation of room 109 occurred on 9-11-19 at 8:29am. Room 109's bathroom was noted to have brown and black streak marks on the walls. Room 109 was observed again on 9-11-19 at 11:46am and was noted to have brown and black streak marks on the walls. f. The walls in room 114 was observed on 9-11-19 at 8:35am and the corner wall guard was noted to have a dried brown substance splattered on the guard. A second observation of room 114 was made on 9-11-19 at 11:50am and the corner wall guard was noted to have a dried brown substance splattered on the guard. g. Room 201 was observed on 9-11-19 at 2:20pm. The room was noted to have a dried brown substance on the baseboards. A second observation of room 201 occurred on 9-11-19 at 3:50pm and was noted to have a dried brown substance on the baseboards. h. Room 203 was observed on 9-11-19 at 2:45pm and was noted to have cob webs in the window and black streaks on the bathroom floor. A second observation of room 203 occurred on 9-11-19 at 4:10pm and was noted to have cob webs in the window and black streaks on the bathroom floor. i. The resident's bathtub in room 204 was observed on 9-11-19 at 2:24pm and was noted to	F 584	has been primed, sanded and painted. The stain resulted from a leak that has been recently repaired. m. The dried brown substance noted to door, as well as brown/black streaks on baseboards and black spots in the vent were removed, cleaned, sanitized since survey exit. n. Room 302 floor surface has been deep cleaned including stripping, surface scrubbing and waxing. The tile stains are from old damages from equipment and rust marks. All room vents have been cleaned and dusted since survey exit. o. The stain noted in the window sill in resident room 313, caused by liquid spill has been cleaned and sanitized resulting in the removal of the stain. This was completed upon survey exit. p. External window in room number 317 has been cleaned, therefore removing the dust and soil allegedly obstructing view of outside. This task was completed upon survey exit. q. Room 325 was observed to have a 2.5ft by 6 inch dried yellow stain that was caused by a soda spill. This surface was cleaned and sanitized prior to survey exit, thus removing the yellow dried stain. 2.Missing light Fixtures and bulbs a. The cover to the over bed light in room 110 has been replaced. b. The missing bulb noted in 117 causing	

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F 584	Continued From page 5	F 584		

have a dried brown substance smeared down the inside of the tub.

A second observation of the resident's bathtub in room 204 was made on 9-11-19 at 3:54pm and was noted to have a dried brown substance smeared down the inside of the tub.

j. Room 207 was observed on 9-11-19 at 2:30pm. The floor behind the main door had a dried red/orange substance.

Room 207 was observed again on 9-11-19 at 4:00pm and was noted the floor behind the main door had a dried red/orange substance.

k. The main door in room 210 was observed on 9-11-19 at 2:34pm to have black streaks and smears from the middle of the door to the bottom of the door.

Room 210's main door was observed again on 9-11-19 at 4:05pm and was noted to have black streaks and smears from the middle of the door to the bottom of the door.

l. Room 213 was observed on 9-11-19 at 2:50pm. The resident's ceiling was noted to have a dried yellow/brown substance approximately 1.5 feet long and 2 centimeters wide.

Room 213 was observed again on 9-11-19 at 4:15pm and was noted the resident's ceiling was noted to have a dried yellow/brown substance approximately 1.5 feet long and 2 centimeters wide.

m. Room 301 was observed at 5:45pm on 9-11-19. The door leading into the resident's

the dimly lit bathroom was replaced upon discovery.
c. The missing light bulb shade in room 201 has been replaced since survey exit.
d. The switch to the bathroom light in room 214 was repaired upon discovery.

3. Chipped Paint
a. Hallways on 200/300 had patching and painting completed to areas of chipped door frames, doors and baseboards exposing wood. The popcorn ceiling was patched, sanded and painted. These tasks were completed upon survey exit.
b. The areas of chipped paint noted in room 201 on the baseboard and under the light above the head of the bed was patched and painted upon survey exit.
c. The door on room 202 having chipped paint and the door frame into resident room and closet was patched, painted, and repaired upon survey exit.
d. The chipped paint observed in room on the resident bathroom door was patched and painted upon survey exit.
e The areas identified in room 301 and 322 having chipped paint have been addressed and patching and painting completed.
f. Supplies to include tile and cement was ordered to repair cracked tile noted in room 331 post survey.
4. Furnishings in Good Repair
a. The facuet that was observed as leaking in room 204 was repaired post survey. The ceiling screws securing the vent was repaired and replaced prior to survey exit.
b. Supplies to repair the noted holes in

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F 584	Continued From page 6 room was noted to have a dried brown substance, the baseboards had black streaks and there were small black spots in the wall heat/air vent. Room 301 was observed again at 1:45pm on 9-12-19 and was noted the door leading into the resident's room was noted to have a dried brown substance, the baseboards had black streaks and there were small black spots in the wall heat/air vent. n. An observation of room 302 occurred on 9-11-19 at 5:47pm. The floor was noted to have brown stains throughout the room and the ceiling vent in the bathroom was covered in dust. A second observation of room 302 was completed on 9-12-19 at 1:47pm. The floor was noted to have brown stains throughout the room and the ceiling vent in the bathroom was covered in dust. o. An observation of room 313 occurred on 9-11-19 at 6:12pm. The resident's window sill was noted to contain a dried brown and orange substance. A second observation of room 313 occurred on 9-12-19 at 1:55pm. The resident's window sill was noted to contain a dried brown and orange substance. p. Room 317 was observed on 9-11-19 at 6:45pm and the resident's window was noted to obtain dust and dirt obscuring the view to outside. Another observation of room 317 occurred on 9-12-19 at 2:00pm and the resident's window was	F 584	the tile in room 206 to include tile and cement were ordered. Contractor was contacted to provide service agreement for the replacement of the broken glass. Tasks were complete upon survey exit. c. Missing screws in the "door stopper" noted in Room 213 were replaced upon survey exit. A contractor to repair the sink that has pulled away from the wall was contacted to set up service agreement. Internal repairs were made to secure the sink until full repair could be completed upon survey exit. d. The flush valve on the toiled in room 214 was replaced therefore stopping the continual water flow. Repairs were completed prior to survey exit. e. The mini blinds in room 302 were replaced upon survey exit. f. The handle on the dresser in room 304 was replaced upon survey exit. Resident stated that the drawer was much easier to manage with repair. g. The loose wood on the dresser in room 309 was repaired upon survey exit and no further issues noted. h. A plumber was dispatched to make repairs to clogged toilet in room 315 as attempts by internal staff were unsuccessful. The broken trashcan was replaced. Mentioned tasks were completed prior to survey exit. i. Door handle in room 325 was replaced upon survey exit. j. The window sill in room 327 was repaired and replaced upon survey exit. Criteria Two: Comprehensive reviews of resident rooms	

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F 584	Continued From page 7 noted to obtain dust and dirt obscuring the view to outside. q. Room 325 was observed on 9-12-19 at 8:17am. The floor was noted to have a 2.5 foot by 6-inch dried yellow substance covering the tile. Another observation of room 325 occurred on 9-12-19 at 2:10pm. The floor was noted to have a 2.5 foot by 6-inch dried yellow substance covering the tile. During an interview with the housekeeping manager on 9-11-19 at 11:51am, the manager stated the marks on the walls, light switches and floor were to be cleaned by the nursing assistant and then housekeeping would come behind the nursing assistant and sanitize the area. The housekeeping manager also stated the 2 small round substances in room 113 was feces and it was the responsibility of the nursing assistant to clean feces off the floor. 2. Observations of resident rooms and bathrooms revealed missing light fixtures and light bulbs in the following rooms: a. Room 110 was observed on 9-11-19 at 8:31am. The light fixture above the resident's bed was noted not to have a cover over the florescent bulbs. A second observation was made of room 110 at 11:47 on 9-11-19 and revealed the light fixture above the resident's bed was noted not to have a cover over the florescent bulbs. b. During an observation of room 117 on 9-11-19 at 8:42am, the room was noted to have a light out	F 584	and bathrooms and common areas were conducted upon survey exit to ensure a clean environment. Areas of focus were as follows: Floor surfaces - Surfaces in Residents rooms were reviewed to ensure the absence of stains, cracks and general soil. Wall Surface - wall surfaces in general areas and resident rooms were observed and any scuff marks, dried soil, chipped paint, spots, and splatters of soil were noted and marked for correction. Bed Frames and Resident furnishings - Furnishings were reviewed to ensure clean and free from unsanitary debris or stains. Lightening and Fixtures - A comprehensive review of facility fixtures and lightening was conducted by Administrator and Maintenance Director to ensure functioning equipment, adequate lightening, and removal of broken and damaged fixtures. Upon discovery of additional areas of concerns, the Maintenance Director and Assistant repaired damaged areas, and housekeeping staff removed soil and stains. Upon completion of review of above mentioned areas, 6 additional areas required deep clean and 2 areas needed repair of tile surface. 12 Light bulbs were replaced, 1 door knob, and 3 fixtures were replaced These items were corrected at time of discovery. Above Mentioned Tasks were completed by the Maintenance Director, Housekeeping Staff, Administrator, and Maintenance Assistant. Criteria Three: The Administrator, Maintenance	

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F 584	Continued From page 8 in the bathroom causing the bathroom to be dimly lit. A second observation of room 117 was made on 9-11-19 at 12:01pm and was noted to have a light out in the bathroom. c. Room 201 was observed on 9-11-19 at 2:20pm. The light fixture in the resident's bathroom was noted not to have any shades over the light bulbs. A second observation of room 201 occurred on 9-11-19 at 3:50pm and was noted the light fixture in the resident's bathroom was noted not to have any shades over the light bulbs. d. Room 214 was observed on 9-11-19 at 2:36pm. The resident's bathroom did not have a working light switch. A second observation of room 214 occurred on 9-11-19 at 4:07pm and was noted the resident's bathroom did not have a working light switch. The maintenance worker was interviewed on 9-11-19 at 4:07pm and stated the light switch was a sensor switch but was not working in room 214 and would need to be replaced. During an interview with the maintenance director on 9-11-19 at 4:20pm, the director stated he was not made aware of the repairs and replacements of light bulbs needed in the resident rooms. 3.Observations in resident rooms and common areas revealed chipped paint in the following rooms and areas:	F 584	Director/Assistant and Housekeeping Manager are conducting rounds twice weekly to evaluate general cleanliness within the facility, condition and cleanliness of furnishings, fixtures, wall surfaces, flooring, window treatments, and other equipment, and appropriate lighting. Audits will be initiated on October 1 and completed twice weekly for two months. Upon completion of rounds work order punch lists are being devised outlining area of needed correction, person/department responsible for correction, and due date of correction. Correction date should not exceed reasonable time period with consideration of materials and priority of need. The Administrator will review and approve the due date and upon completion of listed tasks will verify completion. Facility staff will receive education related to the submission of facility online maintenance request program. The NHA and Maintenance Director will complete educational components. Classroom education is scheduled for October 30 and 31, but 1:1 education was initiated October 1. New staff will receive training at General Orientation upon Hire. The Maintenance Director or designee will conduct daily reviews (M-F) of submitted work orders and ensure timely completion. The Administrator will conduct audits monthly to ensure work orders are completed timely. The above mentioned reviews and Audits will be conducted for 2 months and the results of the reviews will be submitted to the facility QAPI committee for review.	

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F 584	Continued From page 9 a. The 200 and 300 hallways were observed on 9-11-19 at 2:00pm and revealed (a) there was paint chipped off door frames, doors, and baseboards leading into storage rooms and the lobby exposing the wood underneath and (b) the popcorn ceiling was noted to be chipping off. b. Room 201 was observed on 9-11-19 at 2:20pm. The room was noted to have chipped paint on the baseboards and paint chipping off the wall under the light above the head of the bed. A second observation of room 201 occurred on 9-11-19 at 3:50pm and was noted to have chipped paint on the baseboards and paint chipping off the wall under the light above the head of the bed. c. An observation of room 202 was made on 9-11-19 at 2:22pm and revealed the door frame leading into the resident's room had paint chipped off exposing the wood underneath and the closet door in the resident's room had paint chipped off covering the width of the door exposing the wood underneath. Room 202 was observed again on 9-11-19 at 3:52pm and revealed the door frame leading into the resident's room had paint chipped off exposing the wood underneath and the closet door in the resident's room had paint chipped off covering the width of the door exposing the wood underneath. d. Room 204 was observed on 9-11-19 at 2:24pm and was noted the resident's bathroom door frame had paint chipped off exposing the wood underneath which was also noted to be chipped.	F 584	Criteria Four: Comprehensive review of above mentioned citation as well as resulting audits, reviews, repairs, and maintenance, and results of educational sessions and general outcomes will be conducted by the facility QAPI committee to determine the need for further intervention, recommendation, continual monitoring, and/or closure of issue due to compliance and issue being non-persistent. Reviews will be conducted for 2 months unless deemed necessary for continuation at that time.	

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A second observation of the resident's bathroom door frame in room 204 was made on 9-11-19 at 3:54pm and was noted to have paint chipped off exposing the wood underneath which was also noted to be chipped.

e. Rooms 301 to 322 were observed on 9-11-19 from 5:45pm to 7:15pm. The rooms were noted to have paint chipped from the main door frame and doors, walls and baseboards had chipped paint and the bathroom door frames and doors also had chipped paint exposing wood and/or plaster.

A second observation of rooms 301 to 322 occurred on 9-12-19 from 1:45pm to 2:05pm. The rooms were noted to have paint chipped from the main door frame and doors, walls and baseboards had chipped paint and the bathroom door frames and doors also had chipped paint exposing wood and/or plaster.

f. An observation of room 331 occurred on 9-12-19 at 8:25am. The resident's tile floor was also noted to have an approximately 1.5-foot crack by the wall air/heat vent.

A second observation of room 331 was conducted on 9-12-19 at 2:17pm and revealed the resident's tile floor was also noted to have an approximately 1.5-foot crack by the wall air/heat vent.

During an interview with the maintenance director on 9-11-19 at 4:07pm, the maintenance director stated, "painting and touch ups are never ending" and that he was unaware of the severity of the chipped paint in the halls and resident rooms.

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4. Observations of the resident rooms and bathrooms revealed the facility failed to maintain toilets, furnishings, faucets, vents, floors and window treatments in good repair in the following rooms:

a. The resident's bathtub in room 204 was observed on 9-11-19 at 2:24pm and was noted to have a leaking faucet and the air vent in the bathroom ceiling was noted to be missing 3 screws allowing the vent to hang from the ceiling.

A second observation of the resident's bathtub in room 204 was made on 9-11-19 at 3:54pm and was noted to have a leaking faucet and the air vent in the bathroom ceiling was noted to be missing 3 screws allowing the vent to hang from the ceiling.

b. Room 206 was observed on 9-11-19 at 2:28pm. The resident's bathroom floor was noted to have holes in the tile and the glass in the bathroom window was noted to be broken.

A second observation of room 206 occurred on 9-11-19 at 3:58pm. The resident's bathroom floor was noted to have holes in the tile and the glass in the bathroom window was noted to be broken.

c. Room 213 was observed on 9-11-19 at 2:50pm. The door stopper attached to the top of the main door was noted to be missing 2 screws allowing the stopper to hang from the door and the sink in the bathroom was noted to be loose and pulled away from the wall.

Room 213 was observed again on 9-11-19 at 4:15pm. The door stopper attached to the top of

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the main door was noted to be missing 2 screws allowing the stopper to hang from the door and the sink in the bathroom was noted to be loose and pulled away from the wall.

d. Room 214 was observed on 9-11-19 at 2:36pm. The resident's commode was noted to be constantly running.

A second observation of room 214 occurred on 9-11-19 at 4:07pm and was noted the resident's commode was noted to be constantly running.

The maintenance worker was interviewed on 9-11-19 at 4:07pm and stated the stopper inside the commode was not working and would need to be replaced.

e. An observation of room 302 occurred on 9-11-19 at 5:47pm. The resident's mini blinds were noted to have the slats bent away from the window not allowing full privacy in the room.

A second observation of room 302 was completed on 9-12-19 at 1:47pm. The resident's mini blinds were noted to have the slats bent away from the window not allowing full privacy in the room.

f. Room 304 was observed on 9-11-19 at 5:50pm and revealed the handle on the resident's dresser was broken. The resident stated she had a difficult time trying to open the drawer because of the broken handle.

Room 304 was observed again on 9-12-19 at 1:49pm and revealed the handle on the resident's dresser was broken.

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g. Room 309 was observed on 9-11-19 at 5:56pm and revealed the wood piece on the bottom of the resident's dresser was broken. The resident stated, "every time I try to open that last drawer, that wood piece falls down." The resident also stated she had informed staff and "they said they would tell maintenance, but no one has come yet."

Room 309 was observed again on 9-12-19 at 1:51pm and revealed the wood piece on the bottom of the resident's dresser was broken.

h. An observation of room 315 occurred on 9-11-19 at 6:30pm. The resident's trash can was noted to be missing a large section of one side of the can and the resident's commode was noted to be clogged with a foul odor emanating from the bathroom. The resident in room 315 stated it had been clogged since 12:00pm on 9-11-19. The resident denied smelling any foul odors but stated the bathroom door had been closed. The also stated she did not use the commode but did use a bed pan "so now staff has to carry my bed pan to another room to clean it out."

A second observation of room 315 occurred on 9-12-19 at 1:58pm. The resident's trash can was noted to be missing a large section of one side of the can and the resident's commode was noted to be clogged with a foul odor emanating from the bathroom.

The maintenance director was interviewed on 9-12-19 at 1:58pm and stated he was able to unclog the commode around 6:00am on 9-12-19. He stated he could not fix the issue on 9-11-19 because the main pipe was clogged, and it took him until 9-12-19 to clean out the pipe.

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i. Room 325 was observed on 9-12-19 at 8:17am. The bathroom door handle was noted to not be attached to the door preventing the door to be opened so the resident was unable to close the bathroom door.

Another observation of room 325 occurred on 9-12-19 at 2:10pm. The bathroom door handle was noted to not be attached to the door preventing the door to be opened.

j. Room 327 was observed on 9-12-19 at 8:20am and was noted that the window sill was cracked and loose from the wall.

A second observation was made of room 327 0n 9-12-19 at 2:12pm and was noted that the window sill was cracked and loose from the wall.

During an interview with the maintenance director on 9-12-19 at 2:25pm, the maintenance director stated he had not received any work orders for the issues found during the observations. The director explained staff could put in a work order request through the computer or hand write a request but there was nowhere for staff to place hand written requests so maintenance could receive them. He also stated he would work on the issues found but did not have a time frame. The maintenance director stated he and an assistant were the only 2 maintenance personal for the facility.

The Administrator was interviewed on 9-12-19 at 5:37pm. The Administrator stated he was going to be changing housekeeping staff and that he had received bids from outside contractors to complete some of the other issues. He also

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F 584	Continued From page 15 stated he expected staff to use the computer system to report maintenance issues as they occur.	F 584		
F 600 SS=G	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 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with facility staff, Emergency Medical Service (EMS) transporter, physician, radiologist, and x-ray company representative, the facility failed to protect 1 of 3 residents (Resident # 2) from an injury of unknown origin, failed to provide comprehensive assessments, and delayed to initiate medical treatment when x-ray results were positive for a hip fracture. Findings included: Resident #2 was admitted to the facility on 1/10/18 with diagnoses that included dementia, abnormal gait and mobility, anxiety disorder and	F 600	Resident #2 was noted to have a large bruise to Left Thigh. The Physician Service was notified and order for x-ray was obtained. On Monday 9/2/2019 (Labor Day) the x ray was obtained and scheduled with contracted provider. The service provider arrived to the facility at approx. 2pm and performed the x-ray per order. The results were not called to the facility as a critical value and the x-ray result was not received by the nursing department until the following morning. Upon receipt, the nurse notified the MD and an order for CT scan was obtained. Emergency services was contacted by	11/8/19

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F 600	Continued From page 16 major depression disorder. The fall risk assessment dated 4/26/19 revealed Resident #2 was assessed as high risk for falls. Review of the Quarterly Minimum Data Set (MDS) dated 7/12/19 revealed Resident #2 was assessed as having adequate hearing, clear speech and highly impaired vision. The resident was coded as cognitively impaired and being totally dependent with one-person physical assistance with dressing, toileting and personal hygiene and needing extensive one-person assistance with bed mobility, transfer and bathing. The resident was always incontinent of bowel and bladder and had no falls during the look back period. Care plan review for Resident #2 dated 7/9/19 revealed a focus area of at risk for falls related to needing one-person assistance for all safe transfers and mobility. The goal was that the resident would have no falls with major injury. The interventions included to encourage nonskid footwear or socks when out of bed, remind resident that when rising from a lying position, to sit on the side of the bed for a few minutes before transferring /standing. Interventions also included to remind resident to ask for assistance with transfers prior to transferring and to report falls to physician and responsible party. Review of the incident report dated 8/18/19 revealed Resident # 2 had an unwitnessed fall on 8/18/19. The resident was observed on the floor beside his bed. Report also indicated the bed was at the lowest position. No injuries were observed upon assessment. Floor mat was placed as an intervention. Physician and resident guardian	F 600	facility , but due to the absence of pain or ongoing discomfort/complaints, Emergency Services stated that the resident was medically stable and therefore would not provide an emergency transport. Private transportation company was contacted, and responded to the center to assist the resident to the ER of the hospital. After evaluation at the hospital the facility was notified of the presence of the fracture and planned surgery. Further calls from the hospital informed the facility that the resident would not be returning to the facility. Residents with bruising was reviewed to ensure proper assessment and intervention was completed at time of discovery. Residents having pain were reviewed to ensure assessment and intervention. Reviews were completed by the DON and ADON prior to survey exit and no further issues were identified. The ADON, DON and Administrator will conduct comprehensive Education related to Abuse, Neglect, Reporting of Incidents and Accidents, Injuries of unknown origin, clinical assessment and documentation requirements and protocol. Audits of future injuries of unknown origins, bruising and new onset pain will be reviewed to ensure appropriate documentation, assessment and intervention by the DON, ADON and Unit Mangers daily with clinical meeting (M-F). The results as well as corrective measures will be documented and summarized for 2 months for presentation to the facility QAPI	

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F 600	Continued From page 17 were notified. Interview with Nurse aide (NA) #5 on 9/11/19 at 2:11 PM, revealed nursing assistant (NA) # 5 was working on 9/1/19 from 7 AM - 3 PM. NA # 5 stated, around 7:00 AM, when walking down the hallway, she observed Resident # 2 in his room sitting on the bed which was closer to the resident's room door. NA #5 indicated the resident was assisted with dressing. NA # 5 stated while assisting the resident with his pants, he pointed to his left knee and indicated pain in his left knee area. The resident was able to stand up and allowed the NA # 5 to finish dressing him. NA #5 stated, she had informed Nurse #3, about Resident #2's left knee pain. NA # 5 stated NA #4 (who was assigned to the resident on 9/1/19) went into Resident #2's room approximately 30 minutes later and found the resident without his pants. NA # 4 proceeded to redress the resident, when he complained to her of his left knee pain. NA # 4 approached NA # 5 to enquire about Resident # 2's pain and if the Nurse was informed. NA #5 stated NA # 4 also notified Nurse # 3 about Resident# 2's pain. Interview with NA # 4 via phone on 9/11/19 at 3:00 PM revealed NA # 4 was assigned to Resident #2's care on 9/1/19 from 7 AM to 7 PM. NA # 4 stated at around 7:45 AM, the resident was observed sitting in his wheelchair, with no pants and looking at his leg. Resident #2 flinched when his left leg was touched by NA # 4. NA #4 indicated the resident was assisted with the aid of another NA (does not recollect the NA's name). Resident # 2 was later taken in his wheelchair to the nurse's station. NA # 4 notified Nurse # 3 about Resident #2's pain. NA # 4 stated Resident #2 was in his wheelchair most of the day near the	F 600	Committee. The QAPI committee will review the audits and review as well as the educational outcomes and determine if additional intervention, recommendation, or additional process alteration is necessary.	

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nursing station. NA # 4 stated the resident did not appear to be in any pain and no bruising was observed when taken to the bathroom in the afternoon (after lunch - unsure of the time). NA #4 stated Resident #2 was assessed by the Unit Manager (Nurse # 6) and Director of Nursing (DON) later that afternoon. NA # 4 stated she did not receive any report of resident's fall earlier that morning during shift change.

Interview with Nurse # 3 via phone on 9/11/19 at 2:00 PM, revealed Nurse # 3 was working on 9/1/19 from 7AM to 7PM. Nurse # 3 stated a NA (unsure of the name) had reported to him in the morning (unsure of the time) that Resident #2 had reported knee pain. The resident was in his wheelchair near the nursing station most of the day and Nurse # 3 indicated he had not observed the resident in pain. Nurse # 3 indicated around lunch he was sitting at the nurse's station and had observed the resident being assessed by the Unit Manager (Nurse # 6) and DON near the nurse's station. Nurse # 3 stated he overheard the DON and Nurse # 6 talking about a bruise and possible X-ray. The resident was not observed in pain when assessed by DON and the Unit Manager. Nurse #3 indicated no orders were given after their assessment. Nurse # 3 stated he thought the DON and Unit Manager were taking care of the issue and he did not assess the resident.

Review of nursing notes dated 9/1/19 at 10:33 AM written by Nurse #6, read in part "Resident sitting at nurses' station in wheelchair. CNA (Nurse aide) reported to writer and Director of nursing (DON) that resident was complaining of foot hurting. Writer and DON assessed resident's legs bilaterally, resident had no face grimacing, s/s (signs and symptoms) of pain, or bruises at

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time of observation. Will continue to monitor."

During an interview on 9/11/19 at 2:30 PM, Nurse # 6 indicated she was notified about Resident #2 's leg pain on 9/1/19 (unsure of the time). Nurse #6 stated on 9/1/19 (unsure of the time) she and the DON went to assess Resident #2. The resident was assessed at the nurse's station. No pain or bruising were noted during the assessment. Nurse # 6 stated the DON looked at the legs, pressed leg for pain and the resident was moving the legs fine. There were no issues with the resident's range of motion. No falls were reported.

During an interview on 9/12/19 at 3:35 PM, the DON stated on 9/1/19, Resident #2 was assessed by him and Nurse #6. The resident was sitting at the nurse's station during the assessment. The resident was assessed physically (by touching his leg, pressing it and moving his leg for range of motion). The DON stated the resident had no bruises, no pain or grimacing. No facial expression of pain was noted. The DON stated no one had reported the resident having a fall. The DON further stated the resident's last fall was on 8/18/19, which was an unwitnessed fall with no injuries. The DON indicated no falls were reported since 8/18/19.

Interview with Nurse # 5 was conducted via phone on 9/11/19 at 2:50 PM. Nurse # 5 stated she had worked on 9/1/19 from 7 pm- 7 am and was assigned to Resident# 2. The Nurse indicated she did not recollect much about the resident but stated no report regarding resident's pain or fall was given to her by Nurse # 3 during shift report. Nurse # 5 stated the resident was in bed the entire shift and had not observed the

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resident to be in any pain.

During an interview on 9/11/19 at 5:40 PM, NA# 6 indicated she was assigned to Resident #2 on 9/1/19 from 7 PM to 7 AM. NA # 6 stated Resident # 2 was in bed the entire shift and did not complain of any pain. NA #6 further stated she did not observe any bruising during incontinent care.

The pain assessment scale for 9/1/19 at 1:02 AM, at 9:01 AM and at 8:00 PM, was coded as zero (0). No Skin assessment was documented on 9/1/19. Review of the ADL care tracker revealed ADL care on 9/1/19 for bed mobility, transferring, toilet use, personal hygiene and dressing was marked as provided at 2:44 AM and at 2:30 PM.

During an interview on 9/11/19 at 9:53 AM, NA # 1 indicated on 9/2/19 prior to breakfast she went into Resident's #2's room to set the bed table for his breakfast. NA #1 stated she observed Resident # 2 was holding his knee, and he stated "ouch it hurts". Resident #2 was not touched or moved. NA #1 indicated, when she removed the sheets to see what the issue was, she noticed a big bruise on his inner left thigh. NA #1 stated Nurse #1 was immediately notified.

During an interview on 9/11/19 at 2:11 PM, NA # 5 stated on 9/2/19 at around 8:00 AM when she entered Resident# 2's room to feed him breakfast, NA #5 observed Resident #2 was in a fetal position, was screaming when touched, and noticed the bruising on the resident's inner thigh. NA # 5 stated the resident was in pain on 9/2/19 during the entire shift (until 3 PM) and would only allow NA to do incontinent care very slowly. NA # 5 stated the resident's pain had worsened since

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9/1/19. NA #5 stated the bruising was large on the inner leg and could not have been missed by any staff. NA #5 indicated she notified Nurse #2 immediately.

During an interview on 9/10/19 at 2:44 PM, Nurse # 1 stated on 9/2/19, she was notified about the resident's bruising by NA # 1 around mid-morning after breakfast (unsure of the time). Nurse #1 stated Resident #2 was provided ADL care when NA # 1 noticed the bruises and notified her. Nurse # 1 stated she assessed Resident # 2's bruise, and the on- call physician and resident's guardian were notified of the bruising. The On-call physician ordered X-rays around lunch (time unsure). Nurse # 1 indicated the incoming nurse (around 6 PM) was notified about the bruising and pending X-ray. She further stated Resident #2 was assessed to be in pain and a standing order for Tylenol 650 milligrams was administered. Nurse # 1 indicated the resident was reassessed for pain a few minutes after Tylenol was administered. Nurse stated Resident# 2 's pain was stable, and the physician was not notified. When asked what she meant by "pain being stable", Nurse #1 stated it was similar to any person having a fracture, there should be pain when a person has a fracture. When asked did Resident #2 have pain, she stated any patient with fracture will have pain. The pain was stable, and the physician was not informed as it was stable.

Interview with Nurse # 2 was conducted via phone on 9/11/19 at 1:18 PM. Nurse # 2 indicated he was working on 9/2/19 from 7 AM to 7 PM. Nurse # 2 stated Resident # 2's bruises were reported to him by a NA (unsure of the name). Nurse # 2 indicated Resident #2 had a

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large purplish area on his inner thigh, and it appeared bad. Nurse # 2 further indicated the Unit Manager (Nurse #1) was notified about the bruising and he wanted the Unit Manager to reassess the resident. He stated he did not do a complete skin assessment but indicated the details of the bruise in his notes on 9/2/19. Nurse #2 stated Resident #2 was very guarded and did not allow the staff to touch him and was in bed the entire shift. Nurse #2 stated the resident was administered an as needed (PRN) pain medication of Tylenol which was ineffective. Nurse # 2 indicated Nurse #1 was notified about the ineffectiveness of the pain medication and no other pain medication was administered. Nurse #2 stated he was an agency nurse and hence he notified the Unit Manager (Nurse #1). Nurse #2 indicated he was unsure of the pain scale, but recollected Resident #2 being in bed, and calm until touched. Nurse # 2 stated they did receive an order from the on-call physician for an X-ray. The X-ray was completed on 9/2/19 later that afternoon. Results were pending at the end of the shift.
Review of the physician order dated 9/2/19 (no time indicated) read in part "STAT (immediately) x-ray of left hip, left pelvis and left knee with 2 views".

Review of the Medication administration record (MAR) for September 2019 revealed an order for Acetaminophen tablet 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed (PRN) for temperature 100F or above. The MAR revealed on 9/2/19 at 1:37 PM Acetaminophen 325 mg 2 tabs was administered and a temperature of 98.9 was recorded.

Review of the pain assessment scale for 9/2/19

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revealed at 1:48 AM Nurse #5 had indicated the pain scale as zero (0). No other pain assessment was noted on 9/2/19. No Skin assessment was documented on 9/2/19.

Electronic Medication Administration Note (eMAR) review dated 9/2/19 at 2:32 PM, read in part "PRN (pain medication) Administration was: Ineffective".

Review of nursing note dated 9/2/19 at 3:21 PM written by Nurse # 2, read in part "follow up large bruise from previous day. Large dark purplish discoloration to inner left thigh, resident appeared in pain, guarding area. As needed (PRN) pain medication was ineffective. Unit coordinator (Nurse #1) notified and new order for X-RAY to rule out fracture. Resting in bed, total care provided. Vital signs (VS) (temperature) 98.6 (heart beat) 76 (respiration) 18 (blood pressure) 145/62. Oxygen (O2) sat 94% on Room air (RA)".

Interview with Nurse # 4 was conducted via phone on 9/12/19 at 9:28 AM. Nurse # 4 indicated she was working on 9/2/19 from 7 PM to 7 AM and was assigned to the resident. Nurse # 4 stated during the shift report, she was informed that something happened over the weekend. The nurse stated Nurse #2 informed her that the resident had pain over the weekend per NA who reported to him and something must have happened to the resident to have pain and Resident #2 was screaming in pain on the morning of 9/2/19. An X-ray was ordered and completed on 9/2/19 prior to shift change. The results were pending. Nurse #4 further stated, she checked the back-station Fax machine on unit 1 later that evening for any X-ray results and

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had not received any results. Resident #2 was already in bed during medication administration and did not show any sign of pain during medication administration.

During a telephone interview on 9/12/19 at 3:12 PM, NA # 9 stated he was working on 9/2/19 from 3PM to 7AM and was assigned to Resident #2. NA # 9 indicated prior to his shift and during the shift, he was not made aware about Resident# 2's pain, bruising and the resident being due for an X-ray. No falls were reported to him. NA # 9 stated Resident #2 was in bed the entire shift and he did not observe bruising or pain when incontinent care was provided to the resident.

Review of the radiology report that was electronically signed by the radiologist on 9/2/19 at 5:36 PM revealed 1) Hip unilateral -There was a displaced left basitrochanteric fracture (hip fracture) assumed acute. Consider computed tomography (CT) to further assess extent of fracture and further evaluate the pelvis. 2) Left Knee - Osteophyte, loose body or fracture fragments of unknown age at the anterior tibial articular surface. Consider CT if there is further suspicion. Mild degenerative changes.

During an interview on 9/10/19 at 3:00 PM, NA # 2 stated Resident# 2 was assigned to her care on 9/3/19. Resident had a large bruise and was in pain when incontinent care was provided. He was guarded and care had to be provided slowly. The resident indicated pain by pointing to the leg that hurt. Resident # 2 was in bed and did not move much. NA# 2 indicated Resident #2 was able to communicate pain by facial expression and able to answer simple questions. Resident #2 was dependent and needed assistance with

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ADL care and transfers.

Review of nursing note dated 9/3/19 at 10:50 AM written by Nurse # 3, read in part "X- RAY results received this AM for left hip and left knee. Conclusion indicates left basitrochanteric fracture assumed acute. (Unit manager Nurse #1) notified. Physician on call was notified and orders received to send resident to Emergency room (ER) for further evaluation. Family notified and requested resident be sent to (name) hospital. Arranging transport to hospital at present".

During a telephone interview on 9/11/19 at 2:00 PM, Nurse # 3 stated on 9/3/19, someone (unsure name and time) gave him the resident's X-rays results. Nurse # 3 indicated he did review the results and notified the on-call physician about the X-rays results. He further indicated orders were received to send the resident to the hospital. Nurse # 3 stated on 9/3/19, Resident # 2 was in bed and did not complain of any pain. No pain medication was administered. Nurse # 3 also stated he did not recall if resident's bruising and X-ray results were discussed during the shift change and was not aware of the resident's bruising until he read the X-ray results.

Review of nursing note dated 9/3/19 at 1:15 PM written by Nurse # 3, revealed the emergency transport service (EMS) transported the resident to the hospital via stretcher. The resident left the facility in a stable condition.

Review of the hospital record revealed on 9/3/19, in the Emergency Department, the resident was presented with complaints of left hip pain, received CT scan, which revealed acute left hip intertrochanteric fracture. Trochanteric fracture is

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a typical bone fracture of the femur (big/long bone of the leg). Comminuted fracture is when the bone breaks into many pieces - could be the result of bone structure issue, like osteopenia or from the high-impact trauma (car accident). Other X-rays findings showed osteopenia (poor bone structure) and multiple moderate degenerative changes of hip, pelvis and knee (most likely severe arthritis). Assessment in the hospital included: significant bruising over the left inner thigh with anterior and lateral hip. Tender to palpation (touch) diffusely. An orthopedic specialist was consulted and recommended operative management. The resident received IM (intramedullary) nailing (type of surgery) on 9/3/19 without complications. Patient was evaluated by physical therapy and the resident was weight bearing as tolerated.

During a telephone interview on 9/11/19 at 11:08 AM, the physician stated it was the expectation that the nursing staff notify the on-call doctors about any pain that was not controlled or managed with PRN pain medication. The physician also stated that the nurse should notify the physician immediately when the X-ray results were received, so appropriate decision can be made at the right time.

During a telephone interview on 9/11/19 at 3:15 PM, the X-ray company district sales manager indicated their company received orders for Resident # 2's X-ray on 9/2/19 at 12:57 PM. On 9/2/19 at 4:31 PM, the technician had completed the X-rays. On 9/2/19 at 5:40 PM the results were faxed to the facility at 2 Fax numbers indicated in their file as "Station 1" and "All routes". The sales manager also stated as the resident's results were positive, an email and a

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text alert were sent to the email id and phone number that the facility had provided and was on their file.

During an interview on 9/12/19 at 1:50 PM and on 9/12/19 at 3:35 PM, DON stated that Station 1 Fax was not in working order. DON indicated, he was responsible for notifying X- ray company when a Fax number was not working. DON stated it was the expectations that the nursing staff also check the main fax in the administrative suite copy room, when any results were pending. He stated if a report was given to the Nurse that the X-ray results were pending then the receiving nurse should be on the lookout for the results. DON added if the nurse does not receive the results, then he should be notified. The DON indicated it was the expectation that the staff notify the physician when pain was not managed by PRN medication. A pain scale should be included to verify the effectiveness of pain and a follow up pain evaluation should be completed. The DON stated Resident #2 was severely cognitively impaired and it was hard to assess the resident's pain. The DON further stated staff should be using a pain scale when the pain medication was documented as ineffective. The DON indicated he had not observed the resident 9/2/19 and was not notified about the pain. Upon follow up around 3- 4 PM on 9/2/19 he was notified by the Unit Manager (Nurse #1) that the X-rays were completed, and results were pending. On 9/3/19 between 9 AM and 10 AM, Unit Manager (Nurse #1) had notified him of the X-rays results, which indicated the resident had a fracture and that the on-call physician was notified about the X-ray results.

During an interview on 9/11/19 at 5:30 PM and a

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telephone interview on 9/13/19 at 10: 30 AM, the Administrator stated the physician was notified about the bruises and X-ray was ordered. Resident #2 had a history of falls and was able to get up by himself after a fall. The Administrator indicated on 9/3/19, staff observed the resident in his wheelchair, able to wheel himself to the nurse's station and was not observed to be in any pain. He indicated the pain assessment on 9/1/19, 9/2/19 and 9/3/19 indicated a pain score of zero (0). He stated the resident did not have any pain based on the pain scale. The administrator further stated there was only one progress note that stated the pain medication was ineffective. The administrator indicated that the facility did not receive any phone calls from the X-ray company for any alerts indicated on the report. He added an alert was emailed to the DON, however the DON did not receive the alert or the reports as his email was spelled incorrectly.

During a telephone interview on 9/16/19 at 12:26 PM, the EMS Transporter stated when the EMS transporters entered Resident #2 's room on 9/3/19 at around 13:02 PM, the resident was observed lying on the floor on a mattress with no sheets on it. EMS transporters attempted to get the resident up, but he had no abdominal strength to stand up. The EMS transporters stated they did not want to pull the resident up by his arms, so they used a sheet to pull him to the stretcher. Resident did not show any pain during the process. Resident was then pulled from the stretcher to the hospital bed using a sheet.

An interview with the Radiology medical director via phone was conducted on 9/27/19 at 11:52 AM. The medical director indicated it was hard to

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F 600	Continued From page 29 predict the exact date of the fracture. He further indicted it could be recent, possibly the date of exam or the day when the resident had a fall and had pain. He stated based on the radiology report there was no specific reason how the fracture could have occurred. But this kind of fracture was generally related to a fall.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		11/8/19

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F 609	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report a left inner thigh bruise of unknown origin within 24 hours to State agency for 1 of 3 residents (Resident #2) reviewed for accidents. Resident #2 ' s bruised left inner thigh area was X-rayed and showed the resident had a left basitrochanteric fracture (hip fracture) assumed acute. Findings included: Resident was admitted to the facility on 1/10/18 with diagnosis that includes dementia, abnormal gait and mobility, anxiety disorder and major depression disorder. On 4/26/19 Resident #2 was assessed as high risk for falls. Review of the Quarterly Minimum Data Set (MDS) dated 7/12/19 revealed the resident was assessed as having adequate hearing, clear speech and highly impaired vision. The resident was coded as cognitively impaired and being totally dependent with one-person physical assistance with dressing, toileting and personal hygiene and needing extensive one-person assistance with bed mobility, transfer and bathing. No falls were coded on the MDS. Review of health status notes dated 9/1/19 at 10: 33 AM written by Nurse #6, read in part "Resident sitting at nurses' station in wheelchair. CNA (Nurse aide) reported to writer and Director of nursing (DON) that resident was complaining of foot hurting. Writer and DON assessed resident's legs bilaterally, resident had no face grimacing, s/s of pain, or bruises at time of observation. Will continue to monitor."	F 609	The bruise of unknown origin in question on Resident #2 was reported to the state on 9/5. Initially the resident was in no pain, with no bruising, then later there was no pain noted, however there was significant bruising. The resident's history of confusion, BIMS of 0, unsteady gait, inability to follow safety instructions, and being observed falling and assisting self from the floor provided significant rationale as to the nature of the bruise, therefore the bruise was not felt to be unknown. The Administrator and DON determined as the initial investigation progressed to submit the report to state agency as the incident was not unknown, but unusual, and was submitted in good faith. Incidents that have occurred within the facility related to bruising, falls with fractures and injuries of unknown origins were reviewed by the facility administrator to ensure appropriate and timely reporting upon survey exit. The Administrator and Director of Nursing will complete comprehensive education related to reporting guidelines and time requirements. Incidents and accidents resulting in bruising or falls with fractures, or any injury of unknown origin will be reviewed by the DON and ADON daily at clinical meeting (M-F) to insure appropriate reporting and timeliness of submission. The administrator will conduct monthly for 2 months, reviews of	

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F 609	Continued From page 31 During an interview on 9/11/19 at 2:30 PM, Nurse # 6 (unit manager on unit 3) indicated on 9/1/19 she was notified about Resident #2 's leg pain. The Nurse and the DON completed an assessment. There was no pain or bruising noted during the assessment. Nurse #6 was unsure if the resident was administered any pain medication. Nurse # 6 stated the DON looked at the legs, pressed Resident# 2's leg for pain. There were no issues with the resident's range of motion and the resident was moving his legs fine. Review of nursing note dated 9/2/19 written by Nurse # 2, read in part "follow up large bruise from previous day. Large dark purplish discoloration to inner left thigh, resident appeared in pain, guarding area. As needed (PRN) pain medication was ineffective. Unit coordinator notified and new order for XRAY to rule out fracture.". An interview with Nurse # 2 was conducted via phone on 9/11/19 at 1:18 PM. Nurse # 2 stated Resident # 2's left inner thigh bruises were reported to her on 9/2/19 by the NA #5 who was assigned to the resident. Resident #2 's bruise was assessed, and it appeared very bad, like big purplish area. Nurse # 2 indicated the unit manager (Nurse #1) was notified about the bruising and had requested Nurse #2 to assess the resident as well. Nurse # 2 indicated no incident report was started as the NA indicated to him that the resident had bruising since past 2 days. Nurse #2 stated he documented the details in his nursing note. During an interview on 9/11/19 at 2:11PM, NA # 5 indicated on 9/2/19 was assigned to Resident #2.	F 609	incidents to ensure DON/ADON monitoring is effective and any reportable incident is completed and timely. Results of the DON/ADON review as well as the Administrator oversight report will be presented as part of the facility QAPI process for further intervention and recommendation if deemed necessary.	

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NA # 5 stated at around 8:00 AM when she entered resident's room to assist with breakfast, observed Resident #2 was in a fetal position, was screaming when touched, and noticed the bruising. NA stated the bruising was large on inner leg and could not have been missed by any staff. NA indicated the nurse (Nurse # 2) was immediately notified.

During an interview on 9/11/19 at 9: 53AM, Nurse aide (NA) # 1 indicated on 9/2/19 when she went into the resident's room to set up Resident# 2 for breakfast. Resident # 2 was holding his knee, was in pain, and stated "ouch it hurts". The resident was not touched or moved. NA stated, when she removed the sheets to see what the issue was, noticed a big bruising in the inner left thigh, NA #1 further stated Nurse # 1 was immediately notified.

During an interview on 9/10/19 at 2:44 PM, Nurse # 1 (unit manager) stated on 9/2/19 was notified about the resident's bruising by NA # 1 around mid-morning after breakfast. Nurse #1 stated Resident #2 was provided ADL care when NA # 1 noticed the bruises. Nurse # 1 indicated Resident # 2 was assessed, on- call physician and resident's guardian were notified. The On- call physician ordered X-rays. Nurse # 1 indicated the incoming nurse (Nurse #2) and Director of nursing (DON) were notified about the bruising and pending X-ray. Nurse #1 stated no incident report was completed for injury of unknown origin.

Review of the physician order dated 9/2/19 read in part "STAT x-ray of left hip, left pelvis and left knee with 2 views".

Review of the radiology report dated 9/2/19

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revealed 1) Hip unilateral -There was a displaced left basitrochanteric fracture (hip fracture) assumed acute. 2) Left Knee - Osteophyte, loose body or fracture fragments of unknown age at the anterior tibial articular surface.

Review of the facility's initial allegation 24-hour report dated 9/5/19 revealed an initial report conducted for an injury of unknown origin. On 9/1/19 Resident #2 complained of leg pain, assessment revealed no change in range of motion, redness, bruising or tenderness to palpitation. On 9/2/19 a bruise to the area of pain was noted. Orders received for x-ray evaluation. X -ray revealed left trochanteric fracture assumed to be acute. MD ordered the resident to be sent to the hospital for follow up.

During an interview on 9/11/19 at 5:30 PM, the administrator stated the DON and the unit manager who were initially involved could have started the investigation. Administrator added that based resident history, he did not think it was an incident of unknown origin as treatment for bruising and fracture was in process and resident had a history of falling and getting up. Administrator added the initial 24-hour report was sent to the state agency on 9/5/19 as a good faith report and not as injury of unknown origin.

During an interview on 9/12/19 at 3:35 PM, the DON stated both Administrator and DON could initiate the initial investigation. The initial investigation of the resident's bruise was started on 9/4/19. The investigation process began with staff interviews and were waiting on the X-rays results to assure it was injury of unknown origin. DON stated on 9/1/19, he was notified of Resident #2's leg pain by the NA. The resident

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F 609	Continued From page 34 was assessed by Unit manager and DON. There was no bruising, no pain or grimacing. On 9/2/19 Nurse #1 notified the DON about the large bruising on Resident #2's left inner thigh, the Physician was contacted and X- ray order was obtained. On 9/3/19 the Nurse #1 notified DON about the X-ray results that indicated the resident had fracture. The resident was transferred to the hospital. DON further stated, based on the written statements from staff, it was decided that this was an injury of unknow origin and an initial 24 hour report began on 9/4/19 and Faxed to State on 9/5/19.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and family interview the facility failed to provide incontinence care for 1 of 4 dependent residents (Resident #6) reviewed for activities of daily living. Findings included: Resident #6 was admitted to the facility on 9-3-19 with multiple diagnosis that included hemiplegia and hemiparesis following a cerebral infarction affecting the left side, dysphagia, aphasia, congestive heart failure and diabetes. The care plan for Resident #6 dated 9-10-19 revealed a goal that he will improve his activities	F 677	Resident was observed to have had urinary incontinence and wet bedding. Upon discovery, the Unit Manager instructed the Nursing Assistant to provide incontinence care to include bed change. The Unit Manager assisted the CNA in completion of task. This occurred upon discovery of alleged deficient practice. Comprehensive rounds were completed within the facility by nursing assistant staff on residents who have urinary incontinence and any noted incontinent episode was addressed prior to survey exit. These rounds were completed immediately at the time the initial incident	11/8/19

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F 677	Continued From page 35	F 677		

of daily living (ADL). The interventions listed for that goal included in part; resident needed assistance with bed baths, resident needed assistance with personal hygiene and oral care and the resident needed assistance with toileting.

An observation of Resident #6's incontinence care occurred on 9-12-19 at 9:40am with nursing assistant (NA) #10. NA #10 was noted to explain each step of the ADL care to Resident #6 and continually checked with the resident to make sure he was not in pain or having any other difficulties. When NA #10 removed Resident #6's brief it was noted to have a large dark dried yellow ring and when she turned Resident #6, the drawl sheet under the resident was also noted to have a 3 inch by 3-inch diameter circle that was dry and yellow. Resident #6's skin was noted to be intact with no redness or sores.

During an interview with NA #10 on 9-12-19 at 9:45am, the NA stated she had not observed Resident #6 for incontinence care the morning of 9-12-19 until 9:40am. The NA stated she began her shift at 7:00am and that she had observed the resident to make sure his tube feeding was running; the head of the bed was elevated and that he was comfortable. The NA stated she and the other NA on the hall were trying to get the other residents' ready for the cook out the facility was having on 9-12-19, so she did not provide morning care or check Resident #6 for incontinence until 9:40am. She also stated she had not worked hall 100 before and was not familiar with Resident #6.

Resident #6's family member was interviewed on 9-12-19 at 11:20am. The family member stated there were "many" mornings she had come to

was noted. Unit Managers and ADON conducted rounds following nursing assistant rounds to ensure compliance with rounds and that all residents had received care as needed.

Facility clinical staff members will receive education by the NHA and DON related to provision of incontinence care and policy related to practice. Education is scheduled for October 30 and 31. Unit based 1:1 education was initiated on October 1. All education will be conducted by the NHA and/or DON Unit Managers and Charge Nurses will conduct rounds post nursing assistant rounds to ensure that residents receive care and services as needed rounds will be conducted every shift for three weeks. The Administrator met with Resident Council to assess any new or continual issues related to care provision. Rounding and Quality of Care Reviews will be conducted daily and PRN for 4 weeks and corrective measures will be addressed at time of identification. Results of the Rounding and Quality of Care Reviews will be documented to include corrective measures for QAPI purpose.

The results of the above mentioned audits, documented rounds, and educational outcomes will be presented by the DON to the QAPI committee for review, recommendations, and interventions as deemed necessary,

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F 677	Continued From page 36 visit and found Resident #6 had a brief on that was soiled with urine and feces that was dried. The family member stated her last observation was 9-11-19 around 9:00am. She also stated she tried to come at different times but came mostly in the mornings to visit with Resident #6. The family member stated when she found the resident wet and/or soiled she provided the resident with incontinence care and after providing the care she informed staff of finding the resident soiled and in need of care. The Administrator was interviewed on 9-12-19 at 5:37pm. The Administrator stated there was "no excuse for residents not to be clean" and that he would "take care of the issue." He also stated he expected staff to provide proper care to the residents.	F 677		
F 732 SS=C	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 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.	F 732		11/8/19

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F 732	Continued From page 37 (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 interviews the facility failed to post the daily nursing staff information to include resident census, number of licensed and non-licensed staff working each shift, staff hours, and total number of hours for 3 of 3 days of the survey (09/10/19, 09/11/19 and 09/12/19). The findings included: On 9/10/19 at 9:45 AM and at 4:30 PM, the following facility areas were observed for the posted daily nursing staff information; the front lobby/reception area, nursing stations on 100, 200 and 300 halls, back door reception area/bulletin boards and center hall of facility where staff time clocks and public information were located. There was no daily nurse staff	F 732	The Staffing Coordinator had completed the staffing information form used by the facility to ensure compliance with posting information. During the survey, the Administrator failed to post the form in public view. Upon discovery and verbal notice from the surveyor, the Administrator immediately posted the staffing data in public view. The Administrator reviewed the daily staffing postings dating back to 6/2019 noting any omitted sheets. There was one missing sheet noted for hour retention. The Administrator and/or staffing coordinator will post daily staffing data	

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F 732	Continued From page 38 information posted during these observations. Also, there were no signs or information available to indicated where the posted daily staffing information could be located in the facility. Observation on 9/11/19 at 7:30 AM and at 7:00 PM, of all areas where the daily nurse staff information could be posted, which were easily accessible to residents and family members, revealed there was no nursing staff information was posted in the facility. An observation on 9/12/19 at 7:30 AM, in the facility for the daily nurse staff information reveled there was no daily nursing staff information posted in the facility. During an interview on 9/12/19 at 8:30 AM, the Director of Nursing stated the administrator was responsible for ensuring the staff posting was done daily and posted for residents and family review. During an interview on 9/12/19 at 11:27 AM, the Administration stated he was responsible for ensuring the nursing staff information was posted daily. The staffing information should include resident census, numbers licensed and non-licensed staff for each shift, the hours worked and the total number of hours per shift. The Administrator stated, "I dropped the ball ensuring the information was posted." He explained the nursing staff information should be posted at the center of the building where the staff time clock was located and signs should be posted to direct residents and family members where the information could be located. The Administrator indicated that he and the director of nursing would ensure the staffing information	F 732	and ensure continual access to the public. Daily audits of postings will be completed by Administrator or designee to verify posting. Audits were initiated October 1 and will be completed monthly for two months. At the conclusion of each month the administrator will conduct an audit to verify completion and appropriate filing for retention. Audits will be completed for 2 months and results will be presented to QAPI committee. The results of the audits will be presented to the facilty QAPI committee for further intervention, recommendation, or further change in process.	

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F 732	Continued From page 39 would be posted each day.	F 732		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		11/8/19

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F 880	Continued From page 40 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of the facility policy and procedure entitled "cleaning spills or splashes of blood or body fluids," the facility failed to clean and disinfect blood off a resident's room floor, bathroom floor, bed frame, bathroom door and toilet for 1 of 63 resident rooms (Room 104) that was observed for environment.	F 880	Upon the surveyor discussion with the Administrator, the facility Administrator met with Housekeeping Manager and accompanied her to the room to clean the blood spill appropriately. Surfaces cleaned and sanitized included flooring, bathroom surfaces, bed frame, bathroom door and toilet.	

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F 880	Continued From page 41 Findings included: The policy entitled "cleaning spills or splashes of blood or body fluids" dated 1-2012 was reviewed and revealed in part; Spills and splashes of blood and bodily fluids must be cleaned, and the area decontaminated as soon as "practical". The person who spilled or witnessed the spill or splash of blood would notify environmental services and a trained and authorized person would clean and disinfect any surface and/or equipment as soon as practical. During an environmental round on 9-11-19 at 8:40am room 104 was noted to have approximately a 6-foot by 6-foot dried red substance on the floor. The unit manager was interviewed on 9-11-19 at 8:41am. The manager stated the dried red substance in room 104 was blood and she was waiting for housekeeping to come and clean the floor. She also stated the blood had been on the floor since 4:20am the morning of 9-11-19. A second observation of room 104 occurred on 9-11-19 at 9:30am and was noted to still have blood around the bed frame, a spot of blood measuring approximately 2 centimeters round in the middle of the resident's room, a spot of blood measuring approximately 4 centimeters round by the bathroom door and blood smears on the bathroom floor. A third observation of room 104 was made on 9-11-19 at 11:55am with the housekeeping manager. During the observation, blood was still present around the bed frame, there was still an	F 880	Sanitation rounds were completed by the Administrator to ensure no resident rooms had residual blood and body fluids present. There were no further occurrences noted. These rounds were completed multiple times prior to survey exit. The Administrator and DON will conduct Blood Borne Pathogen training with clinical and environmental services staff to include Bodily Fluid Spills. Training will be conducted on October 30 and 31. 1:1 Unit based Education was initiated on October 1, 2019. Infection Control Practices to include the cleaning of spills, equipment, and sanitation of surfaces by NHA, DON and Unit Managers 5xs weekly for 2 months. Unit Managers or designee will round in resident rooms daily to ensure the absence of blood and body fluid spills. Monitoring and rounding results will be documented as well as the corrective measures made at the time of discovery. Housekeeping Manager will review and observe staff performing surface sanitation to ensure proper technique. Observations will be documented and reviewed by Administrator. Results of reviews and audits will be documented and presented to facility QAPI committee. Results of Audits, Reviews and Observations will be reviewed by the facility QAPI committee for further intervention, recommendation, or further process change if deemed necessary.	

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F 880	Continued From page 42	F 880		

approximately 2-centimeter blood spot in the middle of the floor, a blood spot approximately measuring 4 centimeters by the bathroom door and blood smears on the bathroom floor and toilet. The housekeeping manager stated she had the housekeeper assigned to hall 100 mop the floor, but it was the responsibility of the nursing assistants to clean any bodily fluids off the floor and for housekeeping to sanitize the area afterwards.

During an interview with housekeeper #1 on 9-12-19 at 8:20am, the housekeeper stated she had "mopped" the blood off the floor in Room 104, "I'm really not allowed to clean up blood or bodily fluids, but I was told to do it, so I did." She also denied using any disinfectants "I just used the same mop pads we use for everyday cleaning." The housekeeper also denied being trained on cleaning or disinfecting an area after blood or bodily fluids had been spilt.

The Administrator was interviewed on 9-12-19 at 5:37pm. The Administrator stated he was in the process of changing housekeeping staff and there were "no excuses for that blood to be left there and not cleaned up appropriately."