STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 9/30/19 through 10/3/19. The facility was found in compliance with the requirement CFR 483.73, Energency Preparedness. Event ID#IJHK11.	E 000		
F 000	INITIAL COMMENTS A receritification with complaint investigation survey was conducted 9/30/19 through 10/3/19. 1 of the 7 complaint allegations were substantiated resulting in deficiencies (F690).	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 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.	F 550		10/31/19

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

Electronically Signed | 10/28/2019

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F 550	Continued From page 1 §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 observations, staff interviews and record reviews, the facility failed to cover a urinary catheter drainage bag for 1 (Resident #55) of 4 residents reviewed for dignity. The findings included: Resident #55 was admitted on 9/25/17 with cumulative diagnoses of Cerebral Vascular Accident and neurogenic bladder. Review of Resident #55's revised care plan dated 7/23/19 read he had an altered pattern of elimination with an indwelling urinary catheter. Interventions included catheter care per facility protocol, catheter tubing stabilizer in place, catheter to drain by gravity and report any signs of hematuria to the Physician. Review of Resident #55's significant change	F 550	F 550 For the Resident affected: The facility replaced the Hospice catheter bag with one of the facilities catheter bags on 10/15/19 that included the leaf cover to provide privacy of the drainage bag. Hospice was in-serviced on 10-22-2019 on Resident Rights and that catheter bags need to be covered at all times. For other potentially affected residents: The facility completed a 100% audit of residents with a drainage bag. No other issues were found. The facility Treatment Nurse completed the audits and they were completed on 10-23-2019. Facility nursing staff were in-serviced and completed by 10-30-2019 on Resident Rights and that catheter bags need to be covered at all times. The in-services were completed by the Director of Nursing. All Nursing staff were in-serviced. Any Staff not in-serviced	

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F 550	Continued From page 2 Minimum Data Set (MDS) dated 8/26/19 read Resident #55 had severe cognitive impairment and exhibited rejection of care. He was coded for a urinary catheter. In an observation on 9/30/19 at 10:20 AM, Resident #55 was sitting up in bed. There was no observed privacy cover on his urinary catheter drainage bag. In an observation on 10/1/19 at 2:00 PM, Nursing Assistant (NA) #3 provided urinary catheter care without any concerns. There was no observed privacy cover to his urinary catheter drainage bag. NA #3 stated all urinary catheter drainage bags should have a privacy cover. In an interview on 10/1/19 at 3:00 PM, Nurse #5 stated she thought Resident #55 had a privacy cover on his urinary catheter bag, but she would address it. In an observation on 10/2/19 at 9:07 AM, Resident #55 was sitting up in bed. There was no observed privacy cover on his urinary catheter drainage bag. In an observation on 10/2/19 at 2:35 PM, Resident #55 was sitting up in bed. There was no observed privacy cover on his urinary catheter drainage bag. In an observation on 10/3/19 at 8:43 AM, Resident #55 was sitting up in bed. Observed	F 550	would not be allowed to work until completing the in-service. Measures implemented: The facility in-serviced the facility staff and hospice staff on proper drainage coverage. During orientation the clinical facility staff will receive education catheter care and Resident Rights. Annually clinically staff will complete annual competency training to include catheter care and Resident Rights. Monitoring to maintain compliance: The facility Wound Nurse will audit drainage bags five times a week for two months and then once a week for a month. Areas of concern will be corrected at the time of identification of issue and issues will be reported to the Director of Nursing or their designee. The Director of Nursing or designee will report to the Quality Assurance/Performance Improvement committee compliance of the corrective action for three months. Corrective Action Compliance date: October 31, 2019	

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F 550	Continued From page 3 was a privacy cover to his urinary catheter drainage bag. In an interview on 10/3/19 at 10:10 AM, the Director of Nursing stated it was her expectation that Resident #55's urinary catheter drainage bag be covered at all times to maintain his dignity.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		10/31/19

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F 578	Continued From page 4 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Doctor interview, the facility failed to have an advance directive in the medical record for 1 of 1 resident reviewed for advance directives (Resident #72). The findings included: Resident #72 was admitted to the facility on 8/31/19 with diagnoses that included heart disease and dementia. The admission Minimum Data Set (MDS) assessment dated 9/6/19 indicated Resident #72 ' s cognition was moderately impaired. A physician ' s note dated 9/10/19 completed by the Medical Director who was Resident #72 ' s physician indicated his code status was Do Not Resuscitate (DNR). A review of Resident #72 ' s hard chart record and the electronic record was conducted on 9/30/19. This review revealed no advance directives or physician ' s orders that indicated Resident #72 ' s code status.	F 578	F578 For the Resident affected: The facility documented in the resident record, resident #72, the code status desired (Do Not Resuscitate - DNR) by the resident which corresponded to the medical order. Doctor McGhee signed the DNR order on 9-30-19. For other potentially affected residents: The facility completed a 100% audit of resident code status in the facility. The audit was completed by the facility Social Worker and finished by 10-30-19. Any issues found were corrected timely. There were 13 changes completed. Measures implemented: A 100% audit of the residents in the facility was completed. Corrections completed. The facility staff were in-serviced by the Director of Nursing on 10-22-19 on proper code status documentation to include all Facility Licensed Nurses, Social Worker, Admissions staff and Nursing Administration. Any Staff not in-serviced would not be allowed to work until	

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F 578	Continued From page 5 An interview was conducted with Nurse #4 on 9/30/19 at 12:40 PM. Nurse #4 was asked where she obtained information for a resident ' s code status. She stated that this information was in the electronic record and the hard chart record. Resident #72 ' s hard chart record and electronic record were reviewed with Nurse #4. Nurse #4 revealed that there was no code status indicated in Resident #72 ' s hard chart record or electronic record. She further revealed that she would have to contact Resident #72 ' s Responsible Party (RP) to find out his code status. An interview was conducted with the Director of Nursing (DON) on 10/2/19 at 10:15 AM. The DON revealed that the facility presently had no process in place to ensure code status was obtained and/or clarified on admission. She further revealed that the facility was aware of some issues with ensuring the physician ' s orders related to code status were in the medical records. The DON reported that the facility planned to conduct a code status audit, but it had not yet been completed. An interview was conducted with the Medical Director/Resident #72 ' s physician on 10/2/19 at 12:30 PM. The 9/10/19 physician ' s note that indicated Resident #72 ' s code status was DNR was reviewed with the physician. The hard chart record and electronic record that contained no indication of Resident #72 ' s code status were reviewed with the physician. The physician revealed he signed a hard copy DNR order for Resident #72 on 9/30/19 in the afternoon. He was unable to explain why the DNR code status for Resident #72 from his 9/10/19 note was not reflected in the resident ' s hard chart record or	F 578	completing the in-service. Monitoring to maintain compliance: Daily Unit Managers will review the orders 5 times a week, Monday through Friday. Advance Directive Audit Tool will be reviewed during the Inter-Disciplinary Team meeting Monday through Friday. The Director of Nursing or designee will report to the Quality Assurance/Performance Improvement Committee on compliance for three months. Corrective Action Compliance date: October 31, 2019	

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F 578	Continued From page 6 electronic record prior to 9/30/19. The physician reported that he expected the code status to be accessible in the electronic record and/or the hard chart record and for DNR physician ' s orders to be in place for any resident who chose this code status.	F 578		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		10/31/19

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F 604	Continued From page 7 restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and physician interview, the facility utilized a lap buddy (a cushion that sits over the resident ' s lap when seated in a wheelchair) daily for over 4 months with the purpose of physically restraining Resident #54 in her wheelchair to prevent her from standing independently and falling. This was for 1 of 2 residents reviewed for physical restraints. The findings included: Resident #54 was admitted to the facility on 12/21/17 and most recently readmitted on 5/11/19 with a primary diagnosis of a femur fracture and additional diagnoses of repeated falls, schizoaffective disorder, and Alzheimer ' s disease. The admission Minimum Data Set (MDS) assessment dated 5/18/19 indicated Resident #54 ' s cognition was severely impaired. She required the extensive assistance of 2 or more for bed mobility, dressing, and personal hygiene. Resident #54 was dependent on 2 or more with transfers, locomotion on the unit, and toileting. She was dependent on 1 for walking room/corridor and locomotion off the unit. Resident #54 had functional impairment with range of motion on 1 side of her lower extremities and she utilized a wheelchair. Her active diagnoses included a fracture of her right femur and she was coded with no physical restraints. An incident report dated 5/19/19 indicated Resident #54 had a fall out of a reclining	F 604	F604 For the Resident affected: The facility Therapy department assessed the resident and recommended a different style chair and a new wheelchair was ordered for the resident and the lap buddy removed from the residents use. The facility gave the resident the new scoot chair on 10-31-19 and the physician signed the discontinue order for the lap buddy on 10-31-19. An order was also signed for the new scoot chair on 10-31-19 by the physician. For other potentially affected residents: A 100% audit was completed by the Regional Nurse Consultant on 10-16-19 in the facility for all other residents, no other issues were observed. All nursing staff were in-serviced on restraint use, the in-service was completed for all staff on 10-30-19. Any Staff not in-serviced would not be allowed to work until completing the in-service. Measures implemented: The facility completed a 100% audit of all other residents. The facility Director of Nursing completed an in-service with Licensed Nurse staff, Certified Nursing Assistants, and Inter-Disciplinary Team on physical restraint guideline policy. Monitoring to maintain compliance: The facility will complete weekly review of residents identified as having a restraint and the medical appropriateness of the restraint use. The Director of Nursing or designee will report to the Quality	

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F 604	Continued From page 8 wheelchair onto the floor. No new injuries were identified. The fall investigational summary indicated the care plan was to be updated with an assistive device for positioning. A physician ' s order dated 5/21/19 for Resident #54 indicated a lap buddy (a cushion that sits over the resident ' s lap when seated in a wheelchair) was to be used when the resident was up in wheelchair related to severe kyphosis (outward curve of the spine), unsafe transfers/ambulation, cognitive deficits, difficulty walking, lack of coordination, unsteadiness on feet, and Alzheimer ' s disease with repeated falls. A physical device use evaluation dated 5/21/19 for Resident #54 indicated the device in use was a lap buddy when in wheelchair. This form included the following information: - Specific medical symptom which led to consideration of device use: severe kyphosis, unsafe transfers and ambulation related to cognitive deficits, difficulty walking, lack of coordination, unsteadiness on feet, and Alzheimer ' s disease with repeated falls - How frequently does the symptom occur: when out of bed - List contributing diagnosis, conditions, and confounding problems: dementia - What is the underlying cause of the medical symptom: impaired balance, impaired cognitive status, unsteady gait - Can the medical symptom be altered or removed: no - Alternatives attempted: currently participating in occupational therapy and physical therapy - How long were the alternatives attempted: current	F 604	Assurance/Performance Improvement committee on any use of restraints and medical appropriateness. Corrective Action Compliance date: October 31, 2019	

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F 604	Continued From page 9 - What was resident ' s response to the alternatives attempted: fall from reclining wheelchair - When, where, how long, and under what circumstances should the device be used: when in wheelchair, release at meals and for incontinent care - What are the benefits of the device use for this resident: prevent attempts to transfer and/or ambulate without assistance - Can the resident easily remove the device: no - Does the device prevent the resident from access to one ' s body or restrict freedom of movement: yes A physical device use evaluation dated 8/21/19 indicated a lap buddy continued to be utilized for Resident #54 when she was out of bed and in wheelchair. This evaluation stated that Resident #54 was not able to easily remove the device and that it had prevented her from access to body and/or restricted freedom of movement. The quarterly MDS assessment dated 8/23/19 indicated Resident #54 ' s cognition was severely impaired. She required the extensive assistance of 1 for bed mobility, dressing, toileting, and personal hygiene and the extensive assistance of 2 or more for transfers. Resident #54 was assessed as requiring supervision with set up help only for locomotion on the unit. Locomotion off the unit and walking in room/corridor had occurred only once or twice during the MDS review period. Resident #54 had functional impairment with range of motion on 1 side of her lower extremities and she utilized a wheelchair. Her active diagnoses included a fracture of her right femur and she was coded with a trunk	F 604		

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restraint used daily when in chair/out of bed.

Resident #54 ' s active care plan was reviewed on 9/30/19 and included the focus area of the application of a physical restraint device, lap buddy, for positioning and prevention of injury to self characterized by high risk for severe kyphosis, unsafe transfers/ambulation, cognitive deficits, difficulty walking, lack of coordination, unsteadiness on feet, and Alzheimer ' s disease with repeated falls. The interventions included, in part, release device during supervised activities, release device for toileting/provision of incontinence care, and release device during meals and as needed. Resident #54 ' s active care plan also included the risk for falls characterized by a history of falls with the intervention of a lap buddy enabler/device when in wheelchair.

An interview was conducted with Nurse #4 on 9/30/19 at 12:05 PM. She stated that Resident #54 ' s lap buddy was a physical restraint and the purpose was to prevent falls. She indicated Resident #54 was not able to remove the lap buddy independently. Nurse #4 confirmed the lap buddy had been utilized daily for several months.

An observation was conducted of Resident #54 on 10/2/19 at 8:59 AM. Resident #54 was seated in her wheelchair finishing her breakfast at a table in a dining area of the memory care unit. A lap buddy was observed leaning against the wall near Resident #54.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/2/19 at 9:00 AM. She reported that she was the Unit Manager (UM) of the memory care unit. The ADON stated

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that Resident #54 ' s lap buddy was a physical restraint as it was keeping her from standing up out of her wheelchair. She reported that the lap buddy was implemented to prevent falls as Resident #54 was a frequent faller related to her standing up independently and trying to ambulate. She stated that Resident #54 had previously fractured her femur as a result of a fall. The ADON reported that the lap buddy was taken off for meals which was why the lap buddy was not in place at the current time. She stated that it was also removed for toileting and when she was in an activity with constant supervision from staff. She confirmed the lap buddy had been utilized daily for several months and revealed that there was no attempt to discontinue it since its initiation on 5/21/19. She reported that she believed the physician had not felt it was safe to discontinue its use.

An interview was conducted with Medication Technician #1 on 10/2/19 at 9:05 AM. She indicated that Resident #54 ' s lap buddy was in place for fall prevention. She reported that Resident #54 was not able to remove the lap buddy independently.

An interview was conducted with Resident #54 ' s physician on 10/2/18 at 12:30 PM. The physician reported that Resident #54 was a severe fall risk having had multiple falls resulting in injury. He stated the lap buddy physical restraint was implemented after a fall. He indicated that Resident #54 also had kyphosis, but that the primary reason for the lap buddy physical restraint was for fall prevention to keep her from standing up independently and falling. The physician acknowledged that fall prevention was not an adequate medical symptom to justify the

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F 604	Continued From page 12 use of the lap buddy in place for the purpose physically restraining Resident #54 in her wheelchair. The physician stated that he would re-evaluate the use of the lap buddy physical restraint for Resident #54. An interview was conducted with the Director of Nursing (DON) on 10/3/19 at 10:07 AM. The DON reported that she was new to the facility as a DON having become interim DON on 9/20/19 and more recently becoming the permanent DON. She reported that her expectation was for all physical restraints to have a medical symptom identified that justified their use and for the least restrictive physical restraint to be used for the least amount of time necessary.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of behaviors (Resident #72), nutrition (Resident #37), and range of motion (Resident #58) for 3 of 19 residents reviewed. The findings included: 1. Resident #72 was admitted to the facility on 8/31/19 with diagnoses that included heart disease and dementia. A nursing note dated 8/31/19 indicated Resident	F 641	F641 For the Resident Affected: The most recent Minimum Data Set (MDS) assessments completed for all current residents were audited to identify issues in coding by the Regional MDS Consultant. Modifications were completed on 10-07-19. For other potentially affected residents: MDS assessments were audited by the MDS Regional Consultant and modifications completed on 10-07-19. The Regional MDS Consultant in-serviced on 10-04-19 the Assistant Director of	10/31/19

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F 641	Continued From page 13 #72 was yelling for someone to let him out and was hitting on the locked double doors that led from the facility ' s secured unit to the unsecured unit. A nursing note dated 9/1/19 indicated Resident #72 had taken all of his clothing out of his closet and put them on the bed stating that he was waiting for his family member to arrive. A nursing note dated 9/3/19 indicated Resident #72 was standing at the locked double doors of the secured unit with a laundry basket full of clothing and shoes. He was knocking on the door asking for staff to open the door, so he could leave. A nursing note dated 9/4/19 indicated Resident #72 had cut his wander/elopement alarm bracelet off twice since admission. A nursing note dated 9/5/19 indicated Resident #72 refused his shower and became agitated when staff asked him about the shower. A nursing note dated 9/6/19 indicated Resident #72 pulled the fire alarm. The admission Minimum Data Set (MDS) assessment dated 9/6/19 indicated Resident #72 ' s cognition was moderately impaired. The MDS was coded to indicate physical behaviors directed toward others on 1 to 3 days and no other behavioral symptoms not directed toward others. The behavior section of the MDS was coded by MDS Nurse #1. An interview was conducted with MDS Nurse #1 on 10/2/19 at 11:45 AM. She confirmed she	F 641	Nursing, Minimum Data Set Nurse on coding accuracy. The MDS Regional Consultant identified 12 additional modifications needed and modifications were completed by 10/04/19. Monitoring to maintain compliance: The Director of Nursing or designee will complete audits using the MDS audit tool for three completed MDS assessments weekly for 12 weeks to monitor accuracy of coding. The Director of Nursing will report to the Quality Assurance/Performance Improvement committee for three months on MDS coding accuracy. Corrective Action Compliance date: October 31, 2019	

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F 641	Continued From page 14	F 641		

coded the behavior section of Resident #72 ' s 9/6/19 admission MDS. The nursing notes dated 8/31/19 through 9/6/19 were reviewed with MDS Nurse #1. MDS Nurse #1 revealed that she should have coded Resident #72 ' s behaviors as "other behavioral symptoms not directed toward others" rather than physical behaviors directed toward others on the 9/6/19 MDS. She reported that she was still learning all of the Resident Assessment Instrument (RAI) manuals rules for coding.

An interview was conducted with the Director of Nursing on 10/3/19 at 10:07 AM. She indicated that she expected the MDS to be coded accurately.

2. Resident #37 was most recently readmitted to the facility on 4/29/19 with diagnoses that included schizophrenia.

A review of Resident #37 ' s September 2019 physician ' s orders indicated her diet was mechanical soft, no added salt, and no concentrated sweets.

The quarterly Minimum Data Set (MDS) assessment dated 9/19/19 indicated Resident #37 ' s cognition was moderately impaired. She was coded as being on a physician ' s prescribed weight gain regimen. The nutrition section of this MDS was coded by MDS Nurse #1.

An interview was conducted with MDS Nurse #1 on 10/3/19 at 9:30 AM. She confirmed she coded the nutrition section of Resident #37 ' s 9/19/19 quarterly MDS. This section of the MDS that

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indicated Resident #37 was on a physician prescribed weight gain regimen was reviewed with MDS Nurse #1. MDS Nurse #1 revealed this was a typo. She stated that Resident #37 was not on a physician prescribed weight gain regimen.

An interview was conducted with the Director of Nursing on 10/3/19 at 10:07 AM. She indicated that she expected the MDS to be coded accurately.

3) Resident #58 was admitted to the facility on 10/5/18 with diagnoses that included contractures to the left and right knee and history of Cerebrovascular Accident (CVA-stroke) with hemiplegia (paralysis to one side of the body).

A review of Resident #58's quarterly Minimum Data Set (MDS) dated 5/25/19 revealed the resident with severe cognitive impairment and required total assistance from staff for all Activities of Daily Living (ADLs) except supervision for eating. He was coded with limited range of motion to both upper and lower extremities.

Review of a physician progress note dated 8/23/19 indicated Resident #58 had bilateral contractures of lower extremities and left hand with fingers spread apart.

A review of Resident #58's quarterly MDS dated 9/2/19 revealed the resident with cognitive impairment and required extensive to total assistance from staff for all ADLs, except

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F 641	Continued From page 16 supervision for eating. He was coded with limited range of motion to one side of the upper and lower extremity. On 9/30/19 at 10:15am an observation was made of Resident #58 while he was sitting up in the wheelchair. He was noted to have contractures to bilateral knees and left elbow, with the inability to straighten them out and to several fingers on his left hand to include his pinky finger at a lateral position away from his hand. An interview occurred with the MDS Nurse #1 on 10/2/19 at 9:50am. She reviewed the MDS dated 5/25/19 and confirmed the limited range of motion should have been coded for one upper extremity and both lower extremities. MDS Nurse #1 also reviewed the MDS dated 9/2/19 and confirmed limited range of motion should have been checked for both sides of the lower extremities. On 10/3/19 at 10:10am an interview occurred with the Administrator and Director of Nursing who stated it was their expectation for the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		10/31/19

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F 656	Continued From page 17 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to develop a comprehensive care plan for range of motion and contracture prevention (Resident #58) and failed to implement the care plan interventions related to wandering behaviors (Resident #72) for 2 of 19 residents whose care plans were reviewed.	F 656	F656 For the Resident Affected: For the affected residents the minimum data set (MDS) Nurse updated on 10-02-19 care plans to reflect resident condition. For other potentially affected residents:	

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F 656	Continued From page 18 The findings included: 1. Resident #58 was admitted to the facility on 10/5/18 with diagnoses that included contractures to the left and right knee and history of Cerebrovascular Accident (CVA-stroke) with hemiplegia (paralysis to one side of the body). A review of Resident #58's quarterly Minimum Data Set (MDS) dated 5/25/19 revealed the resident with severe cognitive impairment and required total assistance from staff for all Activities of Daily Living (ADLs) except supervision for eating. He was coded with limited range of motion to both upper and lower extremities. No therapy or restorative programs were indicated. Resident #58's active care plan dated 7/24/19 was reviewed and there was no care plan that addressed any contractures or his limited range of motion. Review of a physician progress note dated 8/23/19 indicated Resident #58 had bilateral lower extremity and left-hand contractures. A review Resident #58's quarterly MDS dated 9/2/19 revealed the resident with cognitive impairment and required extensive to total assistance from staff for all ADLs, except supervision for eating. He was coded with limited range of motion to one side of the upper and lower extremity. No therapy or restorative programs were indicated. On 9/30/19 at 10:15am an observation was made of Resident #58 while he was sitting up in the	F 656	A 100% audit was completed to assure the care plan is updated to reflect resident changes and physician orders updates and was completed on 10-24-19 by the Assistant Director of Nursing (ADON). One other correction was made by the ADON on 10-24-19. The Regional MDS Consultant in-serviced on 10-04-19 the Assistant Director of Nursing, Minimum Data Set Nurse on coding accuracy. On 10-17-19 the Regional Nurse Consultant in-serviced the Director of Nursing, Assistant Director of Nursing, Unit Manager and the Minimum Data Set Nurse on care guide and resident plan updating. The Director of Nursing completed in-servicing with all licensed nurses by 10-30-19 on care guide and resident plan updating. Any Staff not in-serviced would not be allowed to work until completing the in-service. Monitoring to maintain compliance: The Director of Nursing or the designee will complete audits once weekly for one month, once every other week for one month, then 1 time monthly for one month. Any discrepancies will be reported to the Quality Assurance/Performance Improvement committee monthly for three months and a performance improvement plan implemented to resolve any issues. Corrective Action Compliance date: October 31, 2019	

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wheelchair. He was noted to have contractures to bilateral knees with the inability to straighten them out and to several fingers on his left hand to include his pinky finger at a lateral position away from his hand.

An interview occurred with the MDS Nurse #1 on 10/2/19 at 9:50am. She reviewed the care plan for Resident #58 and acknowledged there was no care plan developed for the bilateral knee and left-hand contractures and stated it was an oversight. MDS Nurse #1 indicated that residents with contractures should have a care plan developed.

On 10/3/19 at 10:10am an interview occurred with the Administrator and Director of Nursing who stated it was their expectation for care plans to be developed for residents with contractures and was unaware that Resident #58 did not have one in place.

2. Resident #72 was admitted to the facility on 8/31/19 with diagnoses that included dementia.

A physician ' s order dated 8/31/19 indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was implemented for Resident #72.

The admission Minimum Data Set (MDS) assessment dated 9/6/19 indicated Resident #72 ' s cognition was moderately impaired. He required supervision with no set up help for walking in room and corridor and he utilized no mobility devices. The MDS specified a wander/elopement alarm was in use for Resident #72.

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Resident #54 ' s active care plan was reviewed on 10/2/19 and included the focus area of wandering and the risk for unsupervised exits from the facility. The interventions included a wanderguard alarm bracelet to his lower extremity.
An observation was conducted of Resident #72 on 10/2/19 at 2:30 PM on the locked unit. He was observed ambulating independently in a common area without a wanderguard in place.

An interview was conducted with Medication Technician (Med Tech) #1 on 10/2/19 at 2:40 PM. She stated that Resident #72 had no wanderguard in place. She indicated the resident had removed the wanderguard 3 times after it was implemented. She said that after the third time it was not replaced as Resident #72 resided on the secured unit and he was monitored closely by staff. She stated that she was unsure what date it was discontinued but reported it was several weeks ago.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/2/19 at 3:00 PM. She stated that Resident #72 had no wanderguard in place. She reported that Resident #72 had removed his wanderguard on multiple occasions. She explained that after the 3rd removal she informed staff not to replace the wanderguard. She was unable to recall the exact date the wanderguard was removed. The ADON revealed a physician ' s order for the discontinuation of the wanderguard had not been obtained.

On 10/2/19 at 4:14 PM the Administrator provided a copy of the wanderguard monitoring log for

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F 656	Continued From page 21 Resident #72. This log indicated his wanderguard was discontinued on 9/5/19. An interview was conducted with MDS Nurse #1 on 10/2/19 at 3:32 PM. MDS Nurse #1 confirmed the active care plan related to wandering for Resident #72 included the intervention of a wanderguard alarm bracelet to his lower extremity. She revealed she was not made aware the wanderguard was no longer in use for Resident #72. MDS Nurse #1 reported that normally she was informed during the morning meeting held on Monday through Friday of any changes with the residents and that was what prompted her to make care plan updates. She acknowledged that Resident #72 ' s active care plan intervention of a wanderguard alarm bracelet was not implemented since staff discontinued its use on 9/5/19. An interview was conducted with the Director of Nursing (DON) on 10/3/19 at 10:07 AM. The DON reported that she expected care plan interventions to be implemented. She additionally indicated she expected staff to report changes to MDS Nurse #1 as she was responsible for ensuring the care plans reflected the current status of the residents.	F 656		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		10/31/19

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F 688	Continued From page 22 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews, and physician interview the facility failed to evaluate and provide care of upper extremity contractures for 1 of 4 sampled residents reviewed with limited range of motion (Resident #58). The findings included: Resident #58 was admitted to the facility on 10/5/18 with diagnoses that included contractures to the left and right knee and history of Cerebrovascular Accident (CVA-stroke) with hemiplegia (paralysis to one side of the body). Resident #58's medical record from 4/5/19 to present revealed no therapy screens or evaluations related to limited range of motion (ROM) to his left hand or elbow. Resident #58's active care plan dated 7/24/19 was reviewed and there was no care plan that addressed any contractures or his limited range of motion.	F 688	F688 For the Resident Affected: The facility Occupational Therapist assessment and took hand range of motion measurements and found no change in movement of the hand when compared to the assessment and treatment in 2018. The resident refused any further evaluation and treatment of the left hand and wrist and elbow on 10-02-19. For other potentially affected residents: The facility Therapy department will complete 100% audit of residents for potential range of motion issues. The audit was completed on 10-30-19. No additional issues with residents were found. New admissions will be screened at the time of admission to the facility. Monitoring to maintain compliance: Residents will be screened by the Therapist upon admission, change of condition, quarterly assessments and at any other time deemed necessary. The Director of Nursing or the designee will	

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F 688	Continued From page 23 A physician progress note dated 8/23/19 indicated Resident #58 had bilateral lower extremity and left-hand contractures. A physician's order dated 8/27/19 was present for Physical Therapy to evaluate and treat as indicated. Resident #58's quarterly Minimum Data Set (MDS) dated 9/2/19 revealed the resident with severe cognitive impairment and required extensive to total assistance from staff for all Activities of Daily Living (ADLs), expect supervision for eating. He was coded with limited range of motion to one side of upper and lower extremity. No therapy or restorative programs were indicated on the MDS. On 9/30/19 at 10:15am an observation was made of Resident #58 while he was sitting up in the wheelchair. He was noted to have contractures to both knees and the left elbow, with the inability to straighten them out. Several fingers on his left hand were in varied degrees of contracture and flexion contractures to include his 5th finger on his left hand that was observed at a lateral position, approximately 35-40 degrees away from his hand. The resident was unable to grasp objects with his left hand. On 9/30/19 at 1:10pm an interview with Nurse Aide (NA) #1, who provided care to Resident #58, revealed the resident was not able to hold cups or objects with his left hand or extend his left elbow out to assist with personal care. She was unaware if Resident #58 was receiving any type of therapy, or treatment to his left arm or hand contractures.	F 688	report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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Resident #58 was observed on 10/1/19 at 10:30am, lying in bed with his left arm against his abdomen. He was unable to extend the left elbow completely out or grasp the sheets with his left hand.

An interview was conducted with the Rehab Director on 10/1/19 at 2:10pm. She verified the resident had never been evaluated by the Occupational Therapist for limited ROM to his left hand or elbow since his admission to the facility on 10/05/18 and was unable to state if there had been a decline in Resident #58's ROM. She explained Medicare Part A residents were automatically evaluated by the therapy department for needs but all other admissions would require a nursing or physician recommendation for an evaluation for deficits such as balance issues, contractures, limited mobility, etc. Resident #58 was a transfer from another facility on 10/5/18 and would have required a referral from the nursing department upon his admission assessment. The Rehab Director stated that currently residents are not screened routinely but are evaluated by referrals from the nursing department or physician orders. She further stated Resident #58 is currently working with Physical Therapy for bed mobility, sitting balance, left ankle/right knee range of motion and bilateral knee extension splints.

Interview with the administrator occurred on 10/2/19 at 9:45am. He indicated when a resident was admitted with Medicare Part A, they would receive an evaluation by the therapy department and all other admissions would be referred by the nurses who completed the admission assessment or when a deficit was noted. He further explained a quarterly screen was to be

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made by the therapy department on all residents.

On 10/2/19 at 11:28am an interview occurred with the Medical Director. He was unaware Resident #58 had not been screened or evaluated by the therapy department for his limited range of motion to his left hand or elbow since admission to the facility on 10/5/18 and was unable to say if the resident had experienced a decline in his ROM. The Medical Director stated he would expect all residents to be screened or evaluated by the therapy department on admission and periodically during their stay at the facility.

On 10/2/19 at 4:55pm an interview occurred with the Unit Manager and Nurse #1. They both explained that all new admissions were evaluated by the therapy department. The nurses were able to send a therapy referral through the Electronic Medical Record system if a deficit or concern was identified on admission or after. The therapy department would then act on the referral when received. They both indicated Resident #58 received routine range of motion daily during his personal care and was unable to state why a referral had not been sent to Occupational Therapy to evaluate his limited range of motion to left hand and elbow.

An interview with the Administrator and Director of Nursing (DON), took place on 10/3/19 at 10:10am. The administrator stated he was unaware quarterly therapy screens were not being made until yesterday. They both stated their expectation was for all newly admitted residents to be evaluated by the therapy department regardless of payor source, periodically during their stay at the facility and as needed to prevent further decrease in range of

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F 688	Continued From page 26 motion.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide a cognitively impaired resident, who exhibited wandering behaviors, with a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) as ordered by the resident ' s physician and as specified on the resident ' s care plan for 1 of 1 residents reviewed for elopement risk (Resident #72). The findings included: Resident #72 was admitted to the facility on 8/31/19 with diagnoses that included dementia. A physician ' s order dated 8/31/19 indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was implemented for Resident #72.	F 689	F689 For the Resident Affected: The order for discontinuing the waderguard was obtain for the resident on 10-02-19. The resident resides in the facility's secure dementia unit. For other potentially affected residents: The facility Assistant Director of Nursing completed a 100% audit by 10-24-19 of residents with wanderguards to review the resident's medical orders for accuracy in the use or disuse of wanderguards. No other issues were identified. Monitoring to maintain compliance: The facility nursing staff was in-serviced by 10-30-19 on the facility wanderguard policy and if removed determine cause of removal and that physician orders are accurate on status of wanderguard use. Any staff that were not in-serviced would not be allowed to work until the individual was in-serviced on the wanderguard policy. The facility Director of Nursing or	10/31/19

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F 689	Continued From page 27 A nursing note dated 9/4/19 completed by the Assistant Director of Nursing (ADON) indicated Resident #72 removed his wanderguard twice since admission. The ADON indicated the wanderguard was going to be replaced. The admission Minimum Data Set (MDS) assessment dated 9/6/19 indicated Resident #72 ' s cognition was moderately impaired. He required supervision with no set up help for walking in room and corridor and he utilized no mobility devices. The MDS specified a wander/elopement alarm was in use for Resident #72. Resident #72 ' s active care plan was reviewed on 10/2/19 and included the focus area of wandering and the risk for unsupervised exits from the facility. This area was initiated on 9/2/19 and included the interventions of a wanderguard alarm bracelet to his lower extremity. An observation was conducted of Resident #72 on 10/2/19 at 2:30 PM on the locked unit. He was observed ambulating independently in a common area without a wanderguard in place. An interview was conducted with Medication Technician (Med Tech) #1 on 10/2/19 at 2:40 PM. She stated that Resident #72 had no wanderguard in place. She indicated the resident had removed the wanderguard 3 times after it was implemented. She said that after the third time it was not replaced as Resident #72 resided on the secured unit and he was monitored closely by staff. She stated that she was unsure what date it was discontinued but reported it had been several weeks. Med Tech #1 reviewed the hard chart record and electronic record and was unable to find a physician ' s order that	F 689	designee will audit wanderguards for appropriate orders weekly for one month and then once a month for two months. The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance with orders for wanderguards. Corrective Action Compliance date: October 31, 2019	

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discontinued the use of Resident #72 ' s wanderguard. She reported that the ADON was the person who notified her that the wanderguard was discontinued for Resident #72. Med Tech #1 indicated that Resident #72 continued to wander throughout the secured unit daily.

An interview was conducted with the ADON on 10/2/19 at 3:00 PM. She stated that Resident #72 had no wanderguard in place. She reported that Resident #72 had removed his wanderguard on multiple occasions. She explained that after the 3rd removal she informed staff not to replace the wanderguard. The ADON revealed that she did not discuss the removal of the resident ' s wanderguard with the resident ' s physician and had not obtained a physician ' s order to discontinue the wanderguard for Resident #72. She was unable to recall the exact date the wanderguard was removed. The ADON indicated that Resident #72 continued to wander throughout the secured unit daily.

On 10/2/19 at 4:14 PM the Administrator provided a copy of the wanderguard monitoring log for Resident #72. This log indicated his wanderguard was discontinued on 9/5/19.

A physician ' s order dated 10/2/19 indicated a discontinuation of Resident #72 ' s wanderguard.

An interview was conducted with the Director of Nursing (DON) on 10/3/19 at 10:07 AM. The DON reported that she expected staff to obtain a physician ' s order prior to discontinuing the use of a wanderguard.

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F 690	Continued From page 29	F 690		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		10/31/19

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F 690	Continued From page 30 Based on observations, record reviews, and interviews with staff, resident, Medical Director (MD), and Hospice Physician, the facility failed assess and to notify the Medical Director and hospice provider of pain Resident #55 experienced due to changes in the resident ' s catheter and the care that was provided. The facility also failed to follow physician ' s orders for urinary catheter flushes (Resident #58) and failed to follow up on a urology consultation (Resident #27). This was for 3 of 4 residents reviewed for catheter care. The findings included: 1. Resident #55 was admitted on 9/25/17 with cumulative diagnoses of Cerebral Vascular Accident and neurogenic bladder. Resident #55 was sent to the hospital on 6/10/19 due to urinary retention. At the hospital an indwelling urinary catheter was placed due to Benign Prostatic Hyperplasia (BPH-defined as an enlarged prostrate). with instructions to follow up with Urology. A Urology note dated 6/21/19 read Resident #55 ' s penis and meatus were normal in appearance. He was to follow up again with the Urologist in two weeks. A Non-Ulcer Skin Condition report dated 7/8/19 read Resident #55 had an indwelling urinary catheter with blood in urine." Sees Urology." There was no documented skin condition. A Urology note dated 7/9/19 read Resident #55 presented as follows: catheter with blood today. The catheter was changed, and his bladder irrigated until the urine was clear. He was to have	F 690	F690 For the Residents Affected: For resident #58 clarifying orders were obtained (10-09-19) on catheter flushes and changed from every shift to as needed flushes. Resident #27 a urology appointment was scheduled (10-21-19) and the resident attended the appointment, new orders were obtained for resident's care and have been initiated. For resident #55 the floor nurse will assess and monitor weekly for any changes in residents' condition and staff have been reeducated completed by 10-30-19 on catheter care by the Staff Development Coordinator (SDC). For other potentially affected residents: The facility SDC in-serviced nursing staff, Certified Nursing Assistant's and Nurses, on catheter care by 10-30-19. The floor nurses have been in-serviced by the Director of Nursing to include obtaining proper physician orders and obtaining new orders for changes in resident care, along with following current physician orders. Any staff not attending the in-service will not work on the floor until they complete the in-service. Monitoring to maintain compliance: The facility Director of Nursing or designee will audit flushes daily 5 days a week for one month and then weekly for two months. The Inter-Disciplinary Team meets daily Monday through Friday and will review new consult orders and what actions are required or follow-up with the facility tracking tool. The facility will complete weekly skin assessments with residents that have indwelling catheter.	

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F 690	Continued From page 31 his catheter changed monthly. A Non-Ulcer Skin Condition report dated 7/15/19 read Resident #55 had an indwelling urinary catheter. It was patient and draining amber colored urine." Seen Urologist recently." There was no documented skin condition. A Skin Check report dated 7/18/19 read there were no skin integrity issues, urinary catheter was patent and intact. A Non-Ulcer Skin Condition report dated 7/22/19 read Resident #55 had an indwelling urinary catheter that was patent and draining at the bedside. There was no documented skin condition. Resident #55 ' s revised care plan dated 7/23/19 read he had an altered pattern of elimination with an indwelling urinary catheter. Interventions included catheter care per facility protocol, catheter tubing stabilizer in place, catheter to drain by gravity and report any signs of hematuria to the MD. A Skin Check report dated 7/25/19 read there were no skin integrity issues, urinary catheter was patent and intact. A Skin Check report dated 8/1/19 read there were no skin integrity issues, urinary catheter was patent and intact. A Skin Check report dated 8/8/19 read there were no skin integrity issues, urinary catheter was patent and intact. A Non-Ulcer Skin Condition report dated 8/12/19 read Resident #55 had an indwelling urinary	F 690	The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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catheter that was patent with bloody drainage. "Sees Urology." There was no documented skin condition.

A nursing note dated 8/14/19 at 11:54 PM, read Resident #55 had blood tinged urine in his urinary catheter and was passing blood clots. Resident #55 complained of pain and his as needed (prn) medication was given. Resident #55 ' s Responsible Party (RP) was notified who was concerned about the blood clots and pain. The note read the Director of Nursing (DON) was aware of the blood in the urinary catheter and asked the nurse to continue to monitor resident.

An Emergency Department Provider note dated 8/15/19 read Resident #55 was seen due to blood in his catheter and he was complaining of pain at the catheter insertion site with onset date of 8/12/19. Continuous bladder irrigations were initiated along with a Urology Consult.

The Urology Consult dated 8/16/19 read Resident #55 penis was without lesion and his indwelling urinary catheter was draining clear yellow urine. The note read the option of a suprapubic tube placement had been discussed but it was the patient ' s choice to keep the indwelling urinary catheter. Resident #55 was to follow up with the Urologist for catheter changes and a cystoscopy.

Resident #55 ' s hospital discharge note dated 8/19/19 read he was discharged back to the facility with an indwelling urinary catheter and treated for a urinary tract infection (UTI).

Resident #55 ' s significant change Minimum Data Set (MDS) dated 8/26/19 read Resident #55 had severe cognitive impairment and exhibited

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rejection of care. He was coded for total assistance with toileting and limited assistance with hygiene. He was coded for a urinary catheter and hospice. His Care Area Assessment dated 8/26/19 for incontinence read Resident #55 had an indwelling urinary catheter. Interventions were to assist with toileting and monitoring of his skin integrity.

The August 2019 Treatment Administration Record (TAR) revealed no documented evidence that Resident #55 urinary catheter was changed for leaking or dislodgement and noted he was in the hospital from 8/15/19 through 8/19/19.

A nursing note dated 8/19/19 at 3:30 PM read Resident #55 ' s was readmitted with an indwelling urinary catheter. He returned to the facility with orders for hospice. Family reported Resident #55 was suspected of having bladder or prostrate cancer but was unable to have testing due to the urinary tract infection (UTI). The plan was to have the cystoscopy once the UTI cleared up.
A Non-Ulcer Skin Condition report dated 9/3/19 read Resident #55 had an indwelling urinary catheter that was patent and draining at the bedside. The securement device was intact. There was no documented skin condition.

A Non-Ulcer Skin Condition report dated 9/23/19 read Resident #55 had an indwelling urinary catheter that was patent and draining at the bedside. The urine was dark amber colored and on hospice services. There was no documented skin condition.
A nursing note dated 9/23/19 at 1:48 PM, read Resident #55 ' s aide reported that his scrotum was swollen. On assessment, there was no

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evidence of redness for skin breakdown. The urinary catheter was draining amber colored urine.

A hospice progress note dated 9/25/19 read Resident #55 ' s scrotum was still swollen, and his indwelling urinary catheter was draining clear amber urine.

The September 2019 TAR revealed no evidence that Resident #55 ' s urinary catheter was changed due to leaking or dislodgment.
In a telephone interview on 10/2/19 at 11:29 AM, Treatment Nurse #1 stated she last worked on 9/26/19. She stated she checks the urinary catheter securement devices daily and changes them weekly. Treatment Nurse #1 stated on 9/26/19, she did not notice any evidence of a penile tear or erosion. She stated she always assessed the catheter insertion site when the checks for the placement of the securement device.

A nursing note dated 9/27/19 at 5:27 PM written by Nurse #5 read the hospice nurse assessed Resident #55 and noted greenish drainage around his penis area with associated pain. New orders received for an antibiotic for 7 days.

A hospice progress note written by Hospice Nurse #1 dated 9/27/19 read Resident #55 ' s penis was swollen with a small circular open area noted under the meatus about the size of a pencil eraser. The skin was described as red with a light green (almost neon) drainage noted in the brief. The urinary catheter was draining clear amber urine. Resident #55 reported the head of his penis burns at times. The Hospice Physician was notified and orders were given for an antibiotic for

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7 days. There was no documented evidence that the hospice nurse made anyone aware of her findings on 9/27/19.

In a telephone interview on 10/2/19 at 3:03 PM, Hospice Nurse #1 stated she assessed Resident #55 on 9/27/19 and noted his penis was swollen and there was what appeared to be an ulcer to the right side of his penis. She stated there was no evidence of blood, but she observed bright green drainage. She stated she contacted the Hospice Physician and he gave orders for an antibiotic. Hospice Nurse #1 stated she thought she told the DON about the drainage on 9/27/19. Hospice Nurse #1 stated she was first made aware of the penile tear on 10/1/19 and she contact the Hospice Physician. She stated the Hospice Physician stated nothing could be done because it would not heal.

In a telephone interview on 10/2/19 at 4:56 PM, the Hospice Physician stated he was notified Friday 9/27/19 about the penile swelling and drainage. He stated there was no report of trauma on 9/27/19. He stated Hospice Nurse #1 texted him on 10/1/19 and reported the acute condition was improved but there was now penile tearing. He further stated it was possible that the drainage and edema first noted on 9/27/19 was the manifestation of the erosion. The Hospice Physician stated the penile tear would not heal and the goal was to keep Resident #55 comfortable.

Resident #55 ' s electronic and hard chart revealed no documentation regarding assessment of his urinary catheter insertion site on 9/28/19, 9/29/19 and 9/30/19.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Resident #55 ' s September 2019 TAR indicated Treatment Nurse #3 assessed his urinary catheter securement device on 9/28/19 and 9/29/19 but there was no documented evidence that his urinary catheter securement device was assessed 9/30/19. Review of Resident #55 ' s October 2019 TAR also indicated no documented evidence that his urinary catheter securement device was assessed on 10/1/19.

In an interview on 10/2/19 at 11:56 AM, NA #5 stated she worked Sunday 9/29/19 with Resident #55. She stated it was the first time working with him since he got the urinary catheter in June 2019. She stated while performing his catheter care she observed the catheter tubing was coming out the underside of his penis. NA #5 stated he did not say it was painful at that time. NA #5 stated she stopped and went to get Treatment Nurse #3 to assess Resident #55. She stated Treatment Nurse #3 assessed Resident #55 ' s urinary catheter and penis. NA #5 recalled Treatment Nurse #3 stating she did not know if anyone was aware of it, but she was going to report it. She stated she was not aware of Resident #55 pulling at his catheter.

In a telephone interview on 10/2/19 at 3:14 PM, Treatment Nurse #3 stated she was new to her position as of late August 2019. She stated she vaguely recalled an aide reporting something about Resident #55 ' s penis but she did not assess it. Treatment Nurse #3 further stated she did not report it, did not contact MD or hospice on 9/29/19 when it was reported to her.

In another interview on 10/2/19 at 11:38 AM, Treatment Nurse #2 stated he did not assess Resident #55 ' s urinary catheter on 9/30/19 and

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10/1/19 because he did not want a male nurse in his room. Treatment Nurse #2 was unable to recall if he asked another nurse to assess Resident #55 ' s securement device and insertion site on 9/30/19 and 10/1/19.

In an observation on 9/30/19 at 10:20 AM, Resident #55 was sitting up in bed There was no observed securement device in place for the catheter. His urinary collection bag was noted to have dark amber urine and the urinary catheter tubing was blood tinged. Resident #55 reported his "peter" hurt.

In a urinary catheter care observation on 10/1/19 at 2:00 PM, Nursing Assistant (NA) #3 stated she had not worked with Resident #55 in the last month. When NA #3 removed Resident #55 ' s brief, there was observed an indwelling urinary catheter with and penile tear approximately 5 centimeter (cm) in length down the underside of his penis. NA #3 stated when she last worked with Resident #55, his penis did not have a tear and stated she was not aware of him pulling at his catheter. There was no evidence of blood observed to his penis or in the brief. There was a securement device observed the top of Resident #55 ' s right thigh. Resident #55 reported no pain and stated he was given something for pain earlier because his penis hurt.

In an interview on 10/1/19 at 2:10 PM, the Director of Nursing (DON) stated she found out about the drainage last week from Hospice Nurse #1. She further stated she had not been in to assess Resident #55 ' s penis but found out about the penile tear 10/1/19.

In an interview on 10/1/19 at 3:00 PM, Nurse #5

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stated she thought Resident #55 had a suprapubic catheter until today when she found out he has an indwelling urinary catheter. Nurse #5 stated it would be the floor nurse or the treatment nurse ' s responsibility to assess the catheter insertion site and ensure the securement device was in place. She stated she had not been assessing his catheter and the floor aides or the hospice aide had not reported the tear to her. Nurse #5 stated she found out about the penile tear 10/1/19.

In an interview on 10/1/19 at 4:00 PM, Treatment Nurse #2 stated it was the responsibility of the treatment nurse to ensure the securement devices were in place and changed weekly on all resident with urinary catheters. He stated when he changed the securement devices, he would assess the insertion site if the resident reported pain. He stated he was filling in for Treatment Nurse #1 who was on vacation.

A nursing note dated 10/1/19 at 4:02 PM read the MD was notified of Resident #55 ' s penile erosion. There were no new orders.
In an interview on 10/2/19 at 9:07 AM, Resident #55 stated his "peter" was hurting but he got something for pain earlier.
In an interview on 10/2/19 at 11:50 AM, NA #4 stated she noted the penile tear today and reported it to Nurse #5 because Resident #55 was complaining that it was hurting. NA #4 stated Resident #55 did not pull at his catheter and often refused to let the hospice aide provide his care. NA #4 stated when he refused hospice, it was the reasonability of the hall aides to reattempt and provide his care. NA #4 stated she understood that the penile tear was first observed on Sunday 9/29/19 and NA #5 reported it to Treatment Nurse

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#3 who only worked weekends. NA #4 stated she worked with Resident #55 last week and his penis did not have any evidence of tearing or erosion.

In an interview on 10/2/19 at 12:25 PM, the Medical Director (MD) stated he was made aware of the penile drainage neon green in color noted last week and the penile tear on 10/1/19. He stated apparently Hospice Nurse #1 called the Hospice Physician and obtained orders for an antibiotic. He stated had he known about the drainage first noted on 9/27/19, he would have ordered a culture to determine what organism to treat. He stated it was his expectation that Resident #55 ' s urinary catheter site be assessed daily for drainage, trauma such as penile tearing or erosion and assessment of the securement device. He further stated it was his expectation that the facility notified him of any concerns related to Resident #55 even though the Hospice Physician was being notified by the hospice nurses.

In an interview on 10/3/19 at 10:10 AM, the Administrator and DON stated it was their expectation that the aides report any new concerns to the floor nurses and the floor nurses assess the resident and notified the MD if needed. The DON stated it was her expectation that the treatment nurses assess urinary catheter insertion sites and ensure the securement devices were in place daily. She further stated her expectation that when Resident #55 ' s penile tear was first noted on 9/29/19 by Treatment Nurse #3, it would have been reported to the MD and the hospice provider immediately.

A Hospice Physician progress note dated 10/4/19 at 7:40 AM read he was contacted on 10/1/19

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about suspicion of a urethral tear. The exam was consistent with iatrogenic hypospadias (preventable injury to the male urethra produced by the downward pressure of an indwelling catheter). It read he contacted the Urologist and it was decided to treat conservatively since Resident #55 was not a candidate for a suprapubic catheter. It was described and a complication of prolonged catheter use. The Urologist stressed good hygiene and catheter care.
2) Resident #58 was admitted to the facility on 10/5/18 with diagnoses that included a history of a Cerebrovascular Accident (CVA-stroke) with hemiplegia (paralysis to one side of the body), urethral stricture, obstructive and reflux uropathy and retention of urine.

Resident #58's April 2019 physician orders, revealed an order to flush the suprapubic catheter with 100 milliliters (ml) of sterile water every shift.

Review of the monthly MAR's for April 2019 revealed to flush the suprapubic catheter with 100ml sterile water every shift and was signed off as completed by nursing staff.

Review of the May 2019 physician orders showed the order to flush the suprapubic catheter with 100ml sterile water every shift marked as discontinued on 4/26/19 by Nurse #3.

Review of Resident #58's medical record from April 2019 to present did not reveal a physician's order to discontinue suprapubic catheter flushes every shift.

A review of the June 2019 physician orders revealed the order to flush the suprapubic

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catheter with 100ml sterile water every shift to be recorded on the Treatment Administration Record (TAR) written in by Nurse #3.

Review of the June 2019 MAR or TAR did not have an entry for staff to flush the suprapubic catheter with 100ml sterile water every shift.

The July 2019 and August 2019 physician orders indicated an order to flush the suprapubic catheter with 100ml sterile water every shift.

Review of the July 2019 and August 2019 TAR's revealed the order for the suprapubic catheter flush had been struck through and "floor nurse" was written in by Treatment Nurse #1
Review of the July 2019 and August 2019 MAR's did not reveal an entry for the suprapubic catheter flush.

The September 2019 physician orders indicated an order to flush the suprapubic catheter with 100ml sterile water every shift.

Review of the September 2019 TAR revealed the order to flush the suprapubic catheter had been marked through with a line. There was no order present to flush the suprapubic catheter on the September MAR.

Resident #58's active care plan dated 7/24/19 was reviewed and revealed he used an indwelling catheter due to altered patterns of urinary elimination. The goal was no infection from the catheter use until the next review. The approaches were in part, catheter care as ordered.

A review of Resident #58's quarterly Minimum

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Data Set (MDS) dated 9/2/19 revealed the resident with cognitive impairment. He required extensive to total assistance from staff for all Activities of Daily Living (ADLs), expect supervision for eating and used an indwelling urinary catheter.

On 10/2/19 at 8:25am an interview occurred with Nurse #5. She could not recall doing a catheter flush on Resident #58.

A phone interview was conducted with Treatment Nurse #1 on 10/2/19 at 11:29am, who was the nurse that completed the July 2019 and August 2019 TAR review. She was able to recall the order was to be moved to the MAR and not the TAR since the flush was to occur every shift, per the previous unit manager. She was unable to state why the order was not placed on the MAR and did not investigate it further. Treatment Nurse #1 could not recall doing a catheter flush for Resident #58.

On 10/2/19 at 12:28pm an interview occurred with the Medical Director. The MAR's and TAR's from April 2019 to September 2019 were reviewed and he could not recall giving an order to discontinue the suprapubic catheter flushes. He stated it was his expectation for the orders to be followed as written and would be addressing this situation with the DON as well as assessing the resident.

An interview was conducted with the Treatment Nurse #2 on 10/2/19 at 2:40pm and stated he had not provided a catheter flush on Resident #58.

An interview occurred with Nurse #2 on 10/2/19 at 2:45pm. Nurse #2 completed the September 2019 physician order and MAR/TAR review. She

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verified the order to flush the suprapubic catheter with 100ml sterile water every shift was on the TAR at the time of review and stated it was not marked through with a line at that time. She further stated that she had not completed a catheter flush for Resident #58.

A phone call was placed to Nurse #3 on 10/2/19 at 3:28pm. She had previously worked at the facility and was the nurse who indicated on the May 2019 physician orders and MAR that the catheter flush order had been discontinued on 4/26/19 and had also indicated on the June 2019 physician orders and MAR that the order was on the TAR. The phone number had been disconnected.

A phone call was placed to Nurse #6 on 10/2/19 at 3:30pm who had previously worked at the facility. He had completed the Physician Order and MAR/TAR review for May 2019. A message was left for a return call that was not received during the time of the survey.

On 10/3/19 at 9:30am an interview occurred with the DON. She reviewed the physician orders, MAR's and TAR's from April 2019 to present and verified she could not locate a discontinuation order on 4/26/19 for the suprapubic catheter flushes every shift. She could not explain why the orders were marked through or not carried over to either the TAR or MAR. She explained that normally catheter care was the responsibility of the Treatment Nurse however a catheter flush that should occur every shift really should have been on the MAR, so it was done as ordered. The DON could not explain why the order has not been completed as ordered but stated she had spoken with the Medical Director with orders

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received to continue the suprapubic catheter flushes. She stated it was her expectation for the orders to be transcribed correctly and followed from month to month if a discontinuation order was not present. She felt the error with the transcription should have been caught when the orders were reviewed for the new month.
3.Resident # 27 was admitted on 9/25/2018 with diagnoses including neurogenic bladder. Resident #27 ' s quarterly Minimum Data Set (MDS), dated 7/26/2019, indicated the resident had moderately impaired cognition and was totally dependent with toileting. The MDS also documented Resident #27 had a diagnosis of neurogenic bladder, had an indwelling urinary catheter, and always incontinent of bowel.

Resident # 27 ' s care plan dated 9/26/2019 indicated the resident had neuromuscular dysfunction of the bladder causing an altered pattern of urinary elimination requiring urinary catheter placement. The care plan also indicated Resident #27 was to receive catheter care per facility protocol.

Nurses notes on 9/11/2019 at 9:04 AM noted the resident had a red area between skin folds of penis. Nurse documentation also indicated Resident #27 was going to wound clinic that day for wounds to lower extremities. The nurse documented she made the wound clinic aware of the new skin breakdown with mild swelling on the resident ' s penis.

On 9/11/2019 at 3:19 PM nursing documentation indicated the resident had received new orders from the wound clinic and antibiotic order had been faxed to pharmacy and transcribed to medication administration record (MAR). The

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nurse also documented the urinary catheter would be discontinued once resident was seen by facility physician and consult order approved, due to resident ' s urology diagnosis.

Record review revealed a written order dated 9/16/2019 for referral to surgeon for suprapubic catheter placement. Additionally, there is a written order dated 9/17/2019 for referral to urology for suprapubic catheter placement. Both orders are signed by the facility ' s physician.

Nursing progress notes dated 9/26/2019 at 12:59 PM indicated Resident #27 had a follow up appointment with the wound clinic. The discharge orders from the wound care clinic stated the area to the folds of the penis were healed but some swelling remained. Orders were to continue current treatment and increase the resident ' s protein intake. The nurse also documented the resident had a pending consult for suprapubic catheter placement.

On 10/2/2019 at 9:53 AM observation of urinary catheter and wound care revealed the resident did not have a suprapubic catheter. The resident did not report any discomfort during the treatment. An interview with the Treatment Nurse was conducted after the observation. The Treatment Nurse stated he was aware there was a consult or referral made for suprapubic catheter but was not sure if the resident had been seen by the Urologist yet.

On10/02/19 at 01:00 PM an interview with the facility Physician and Director of Nursing (DON) was conducted. The facility physician indicated he wasn ' t entirely sure why he had requested the urology referral for Resident #27 but he was

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F 690	Continued From page 46 aware the resident had an indwelling urinary catheter. The DON stated Resident #27 had experienced swelling and skin breakdown and it was determined he might be a candidate for a suprapubic catheter due to his diagnosis of neurogenic bladder. The DON further stated the referral had not been made. The facility Physician stated it is his expectation all ordered referrals and/or outside consults are followed up on. On 10/2/2019 at 1:30 PM and interview with the Director of Nursing (DON) was conducted. She stated the procedure referrals or consults begins with the physician writing the order. The order is then given to the unit secretary who would make the appointment and place the appointment information (time, date, physician seeing resident the resident) in the "unit appointment book". The DON further stated the unit secretary would write the appointment on a sheet of paper and post it in the nurse ' s station to make the nurse ' s aware. Review of the unit appointment book on 10/2/2019 at 1:30 PM with the DON confirmed Resident #27 had been made an appointment with urology as ordered by the facility physician on 9/17/2019. On 10/2/2009 at 3:30 PM in an interview with the Unit Manager, it was revealed the Unit Secretary had been out on leave for a while. The Unit Manager stated she was not sure if or when the Unit Secretary would be returning to her position with the facility.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		10/31/19

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F 695	Continued From page 47 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen. This was for 1 of 3 residents reviewed for respiratory care (Resident #79). The findings included: Resident #79 was admitted on 10/4/18 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Resident #79's care plan last revised 4/19/19 read she was at risk for ineffective breathing and was prescribed continuous oxygen due to COPD. Interventions included oxygen therapy as ordered. Review of Resident #79's Respiratory Care Evaluation dated 9/13/19 read she required continuous oxygen at 3 L/M. Review of Resident #79's quarterly Minimum Data Set (MDS) dated 9/14/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for the use of oxygen. In an observation on 9/30/19 at 10:43 AM, Resident #79 was sitting at the nursing station wearing oxygen running at 3 liters per minute (L/M) via a portable tank. She stated she required	F 695	F695 For the Residents Affected: For the affected resident the facility obtained the physician order for the continuous 3 liters of oxygen. The order was obtained on 10-04-19 from the resident's physician. For other potentially affected residents: The facility completed a 100% audit of residents using oxygen for physician orders on 10-18-19 for accuracy of orders. Two other orders were corrected. The facility nurses were in-serviced by the Director of Nursing on 10-30-19 on the facility oxygen policy. Staff not in-serviced would not be allowed to work until after being in-serviced. Monitoring to maintain compliance: The facility Director of Nursing or designee will audit oxygen orders weekly for one month and monthly for an additional two month to ensure oxygen orders are present for appropriate residents. The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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F 695	Continued From page 48 supplemental oxygen at 3 L/M 24 hours a day due to her respiratory failure. In an observation on 10/1/19 at 9:33 AM, Resident #79 was sitting in her wheelchair in her room. She was wearing her oxygen running at 3 L/M via concentrator. Review of Resident #79's September 2019 and October 2019 Physician orders did not include any orders for oxygen. In an interview on 10/1/19 at 3:56 PM Nursing Assistant (NA) #6 and NA #7 stated Resident #79 was always dependent of oxygen. In an interview on 10/3/19 at 9:40 AM, Nurse #4 stated Resident #79 required continuous oxygen for her COPD. Nurse #4 verified there was no order in the hard chart or electronic chart for her continuous oxygen and stated there should be a written order for it. In an interview on 10/3/19 at 10:10 AM, the Director of Nursing (DON) stated she was unable to find an order for Resident #79's continuous oxygen and was only able to find evidence of her continuous oxygen at 3 L/M on her old hospital records from 2017. The DON stated it was her expectation that there be a Physician order for her continuous oxygen.	F 695		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	F 745		10/31/19

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F 745	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, staff and physician interviews, the facility failed to help a resident to schedule a neurology consult (Resident #29) as ordered by the physician which caused a delay in resident being evaluated for neuropathic pain in 1 of 1 residents sampled for pain. The findings included: Resident #29 was admitted on 9/21/2017 for diagnoses including type one diabetes mellitus, and hepatic failure. Resident #29's most recent Minimum Data Sheet (MDS) dated 9/25/2019 indicated resident had a moderately impaired cognition and required one-person physical assistance for all activities of daily living, personal hygiene, transfers, and used a wheelchair for locomotion. The MDS also indicated the resident did not have scheduled pain medication but received opioids 7 out of 7 days in the assessment period. The resident's October 2019 medication administration record included Gabapentin (medication to treat nerve pain) 300mg orally three times daily for neuropathic pain and oxycodone 10mg orally every 4 hours as needed for pain. Review of Resident #29 record revealed a handwritten physician's order dated 7/11/2019 in which the physician wrote an order for the resident to have a neurology consult for neuropathy pain. Review of the record revealed no documentation that the neurology consult was	F 745	F745 For the Residents Affected: The facility physician assessed the resident for pain on 10-07-19. The resident #29 stated he no longer had any neuropathic pain. The facility physician wrote a discontinuation order on 10-07-19 for the neurology consult. For other potentially affected residents: The facility completed a 100% chart audit for orders for consults from 09-23-19 through 10-22-19. The audit was completed on 10-30-19 by the Unit Manager and the Assistant Director of Nursing. No other issues were found. Monitoring to maintain compliance: The facility instituted Consult tracking tool to monitor consult orders to assure timely follow up on physician consults. The Director of Nursing or designee will review telephone orders Monday through Friday during the morning meeting. The facility nursing staff was in-serviced by the Director of Nursing on following up on consult orders and the in-services completed by 10-30-19. Staff that were not in-serviced would not have been allowed to work until they were in-serviced The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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F 745	Continued From page 50	F 745		

scheduled.

On 10/02/19 at 11:06 AM Resident #29 was observed in the hall in his wheelchair, dressed appropriately, clean and well groomed.

An interview with Resident#29 was conducted on 10/2/2019 at 11:15 AM. Resident # 29 did not remember seeing a neurologist in July or August for his neuropathy.

On10/02/19 at 1:00 PM an interview with the facility physician and director of nursing (DON) was conducted. The facility physician indicated he wrote an order for a neurology consult for Resident #29 due to the resident's frequent complaints of pain. He further stated he does not recall if the consult was ever followed up on. The DON stated she was not acting DON at the time the order was written and she just recently learned that all referrals/consults were emailed to the previous DON. The information in those emails was made available to her prior to this interview. The DON further stated she was not aware the referral had not been made. The facility physician stated it was his expectation all ordered referrals and/or outside consults are followed up on.
On 10/2/2019 at 1:30 PM an interview with the DON was conducted. She stated the procedure for referrals or consults began with the physician writing the order. The order would be given to the unit secretary who would make the appointment and place the appointment information (time, date, physician seeing resident the resident) in the "unit appointment book". The DON further stated the unit secretary would write the appointment on a sheet of paper and post it in the nurse's station to make the nurses aware of the

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F 745	Continued From page 51 appointment. The facility's unit appointment book was reviewed on 10/2/2019 at 1:30 PM with the DON. The appointment book indicated Resident #29 did not have an appointment scheduled with neurology as ordered by the facility physician on 7/11/2019.	F 745		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		10/31/19

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F 791	Continued From page 52 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and Physician interviews and record review, the facility failed to refer a resident with identified dental needs to the oral surgeon for recommended extractions. This was for 1 (Resident #79) of 1 residents reviewed for dental care. The findings included: Resident #79 was admitted on 10/4/18 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #79's dental care plan last revised 10/15/18 read she was edentulous and had upper denture. Interventions included coordination of arrangements for dental care needed and refer to a Dentist/hygienist for evaluations, recommendations and other issues as needed. Review of an in-house dental consult dated 5/1/19 read as follows: "Patient seen bedside today for periodic exam. Patient states teeth are broken to the gum line and causing pain. Referral to Dr. R****** (a long term care oral surgeon) to	F 791	F791 For the Residents Affected: The facility Social Worker scheduled an appointment for the resident's (#79) dental care for 10/29/2019. For other potentially affected residents: All residents identified as having dental needs were scheduled for dental services. The Facility Social worker interviewed and determined any residents with dental concerns on 10-02-19. The first appointments were concluded on 10/08/2019. Additional appointments are scheduled based on the services required. Eleven residents were identified as needing services. Monitoring to maintain compliance: The facility Social worker and Unit Secretary are responsible for scheduling resident dental services. Monday through Friday the daily orders are reviewed at the Inter-Disciplinary Team meeting for dental consults. Residents using the in-house dental services are now placed on routine dental	

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F 791	Continued From page 53 extract teeth #'s 22-28 was previously left. Left another referral." Review of Resident #79's quarterly Minimum Data Set (MDS) dated 9/14/19 indicated she was cognitively intact and exhibited no behaviors. She not coded for any weight loss. In an interview on 9/30/19 at 10:43 AM, Resident #79 stated she had nine teeth on her bottom gum line down to the root and she wore upper dentures. Resident #79 stated she thought she was supposed to be sent out to another dentist months ago. In an observation on 10/1/19 at 12:45 PM, Resident #79 was eating fast food (burger and fries) in her room with her family. There was no evidence of problems chewing and she voiced no pain. On 10/1/19 at 1:47 PM, evidence of the referral made to the oral surgeon in May 2019 was requested from the Director of Nursing (DON). In an interview on 10/1/19 at 3:46 PM, Nursing Assistant (NA) #6 and NA #7 stated Resident #79 had never complained of oral pain to them and she frequently ate food brought in by her family. They reported Resident #79 was on a renal diet, but it was not mechanically altered. In an interview on 10/1/19 at 4:39 PM, the DON stated she recently started working at the facility and was originally hired as the Unit Manager. She became the Interim DON on 9/20/19 but the week prior to this survey, she became the DON.	F 791	care and review. All residents are reviewed (by the Minimum Data Set Nurse – MDS) on their quarterly MDS assessment for dental needs. Any residents requesting dental services or complaining of oral pain will be scheduled (by the Social Worker or the Unit Secretary) for an assessment and possible dental services. The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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She stated she was trying to get into the previous DON's email account to see if the dental referral was ever made.

Review of Resident #79's nursing notes from 6/1/19 to 10/2/19 included no documentation of complaints of oral pain.

In an observation on 10/2/19 at 9:15 AM, Resident #79's bottom gum appeared to have blackish colored remains of her teeth level with her gum line. She stated due to her numerous medication allergies, she was only able to take Tylenol as needed for pain. Resident #79 voiced no pain at present but stated her family brought in the "baby stuff you rub on your gums" and she used it as needed.

In an interview on 10/2/19 at 10:15 AM, the DON stated she was able to get into the previous DON's email and discovered the referral was never done. She stated the referral was faxed to the oral surgeon's office earlier this morning. The DON stated she was waiting to hear back from the provider for an appointment day and time. The DON stated it was her expectation that the dental referral would have been completed immediately after the 5/1/19 dental examination. The DON stated Resident #79 never complained of pain and she was not aware of her using a numbing agent provided by her family.

In an interview on 10/2/19 at 12:25 PM, the Medical Director stated it was his expectation that Resident #79 had a timely dental referral but stated she had not complained of pain to him during his visits.

In an interview on 10/2/19 at 2:30 PM, NA #5

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F 791	Continued From page 55 stated she was not aware of any complaints of oral pain by Resident #79. In an interview on 10/3/19 at 9:40 AM, Nurse #4 stated she worked with Resident #79 at her previous facility and at current facility but never recalled her complaining of oral pain. The DON provided evidence of an appointment on 10/29/19 at 2:00 PM with the oral surgeon to determine if Resident #79 could be cleared for sedation due to her advance age and Atrial Fibrillation.	F 791		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		10/31/19

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 57 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and physician, Hospice staff and staff interviews, the facility failed to maintain complete and accurate medical records for 3 of 19 residents medical records reviewed (Residents #55, #25, and #24). The findings included: 1. Resident #55 was admitted on 9/25/17 with cumulative diagnoses of Cerebral Vascular Accident and neurogenic bladder. Review of Resident #55's revised care plan dated 7/23/19 read he had an altered pattern of elimination with an indwelling urinary catheter. Review of the Urology Consult dated 8/16/19 read Resident #55 read the option of a suprapubic catheter placement had been discussed but it was the patient's choice to keep the indwelling urinary catheter. Review of Resident #55's significant change Minimum Data Set (MDS) dated 8/26/19 read Resident #55 had severe cognitive impairment and exhibited rejection of care. He was coded for a urinary catheter. His Care Area Assessment dated 8/26/19 for incontinence read Resident #55 had an indwelling urinary catheter. Review of Resident August 2019 Physician order read to change catheter as needed due to dislodgement or leaking.	F 842	F842 For the Residents Affected: For resident #24 the labs were discontinued on 10-02-19 and reordered, they were obtained on 10-11-19. A 100% lab audit was completed to review the past 30-day lab orders for completion of lab draws. For other potentially affected residents: The facility Unit Manager and Assistant Director of Nursing (ADON) completed a 100% lab audit for the past 30 days orders to assure completion of lab ordered, it was completed on 10-24-19. A lab monitoring tool was put into place to track lab orders for completion. The ADON reviewed the September 2019 weights for accuracy and documented in medical record. The resident weights will be input into the medical record by the Assistant Director of Nursing, the Restorative Aide will continue collecting the weights. The licensed nursing staff were in-serviced on weight collection protocol and lab process. The in-services were completed on 10-30-19 Monitoring to maintain compliance: The facility Director of Nursing or designee will monitor the resident weight collection and documentation at the weekly weight committee meeting for three months for compliance. The lab orders will be reviewed daily for one month weekly for an additional two	

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F 842	Continued From page 58 Review of a nursing note dated 8/21/19 at 3:09 PM read Resident #55's suprapubic catheter was patent. Review of a nursing note dated 8/23/19 at 11:53 PM read Resident #55's suprapubic catheter was patent. Review of a nursing note dated 8/24/19 at 2:30 PM read Resident #55's suprapubic catheter was patent. Review of a nursing note dated 8/29/19 at 2:38 PM read Resident #55's suprapubic catheter was patent. Review of a nursing note dated 8/30/19 at 10:40 PM read Resident #55 complained of pain to his suprapubic catheter site. In a urinary catheter care observation on 10/1/19 at 2:00 PM, there was no evidence of a suprapubic catheter but rather an indwelling catheter. Nursing Assistant (NA) #3 stated Resident #55 never had a suprapubic catheter. In an interview on 10/1/19 at 3:00 PM, Nurse #5 confirmed she documented that Resident #25 had a suprapubic catheter and stated she thought Resident #55 had a suprapubic catheter instead of an indwelling urinary catheter. In an interview on 10/3/19 at 10:10 AM, the Administrator and DON stated it was their expectation that Resident #55's medical record be accurate and reflect the presence of an indwelling urinary catheter and not a suprapubic catheter.	F 842	months using the lab audit tool. The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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2. Resident #25 was admitted on 12/14/18 with a diagnosis of Cerebral Vascular Accident.

Resident #25's quarterly Minimum Data Set (MDS) dated 9/23/19 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for a feeding tube.

Review of Resident #25's care plan last revised on 9/27/19 read he required a feeding tube to maintain or improve nutritional status. Interventions included weights per facility's protocol.

Review of Resident #25's electronic and hard chart indicated the last weight obtained on him was 7/12/19.

On 10/2/19 at 4:50 PM, Resident #25's August and September 2019 weights were requested from the Director of Nursing (DON). She confirmed the weights were not in his medical record and stated the restorative aides obtained the monthly weights and they were not yet entered into the medical record.

On 10/3/19 at 10:08 AM, the Director of Nursing (DON) provided the weights for August and September 2019 on Resident #25. She confirmed the weights were in the restorative notebook. She stated it was her expectation that Resident #25's weights be entered into his medical record when obtained.

3. Resident #24 was admitted to the facility on 1/20/11 and most recently readmitted on 4/4/17 with diagnoses that included diabetes mellitus and heart disease.

The quarterly Minimum Data Set (MDS) dated

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7/23/19 indicated Resident #24 ' s cognition was severely impaired. She had physical behaviors and other behavioral symptoms on 1 to 3 days during the MDS review period.

A nursing note dated 9/17/19 indicated Resident #24 was observed by staff to be having seizure-like activity. The resident was noted to be combative and vital signs were not able to be obtained. The physician was notified, and he ordered the laboratory tests CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel).

A physician ' s order dated 9/17/19 indicated CBC and CMP for Resident #24.

A nursing note dated 9/19/19 by Nurse #5 indicated a laboratory technician attempted to draw Resident #24 ' s blood, but due to her behaviors of restlessness, swinging of arms, and spitting she was unable to complete the blood draw.

A review of the hard chart record and electronic record on 10/1/19 revealed no results for the CBC and CMP ordered on 9/17/19, no notation of the blood draw being re-attempted after the resident ' s refusal on 9/19/19, and no indication that the physician ' s order for the CBC and CMP had been discontinued.

On 10/1/19 at 11:30 AM the Director of Nursing (DON) was asked to provide information on the outcome of the 9/17/19 physician ' s order for CBC and CMP laboratory tests for Resident #24. The DON reported she would look into it.
On 10/1/19 at 2:05 PM the DON provided a copy of the 9/19/19 nursing note completed by Nurse

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#5 that indicated Resident #24 refused the blood draw. The DON revealed she was unable to find any further information in the medical record on if the blood draw was re-attempted or if the physician ' s order was discontinued.

An interview was conducted with Nurse #5 on 10/1/19 at 2:07 PM. Nurse #5 reported that she informed the Unit Manager (UM) of Resident #24 ' s refusal of the blood draw on 9/19/19. She stated that she believed she informed the physician in person on 9/19/19 that Resident #24 refused the blood draw. She indicated that she had not known if the blood draw was re-attempted. Nurse #5 stated that the physician provided her with no direction on whether to re-attempt the blood draw or if he wanted to discontinue the order.

An interview was conducted with the UM on 10/2/19 at 9:35 AM. The UM recalled Nurse #5 informing her of Resident #24 ' s refusal for her blood draw on 9/19/19, but she was unable to recall if the blood draw was re-attempted or if the order was discontinued. The UM reported she would contact the laboratory to find out additional information.

A follow up interview was conducted with the UM on 10/2/19 at 11:45 AM. She reported that she spoke with staff from the laboratory and they informed her the physician had cancelled the blood draw for the 9/17/19 order and he re-ordered the CBC and CMP to be taken in addition to Resident #24 ' s previously scheduled Hemoglobin (Hgb) A1C to be conducted on 10/11/19. The UM reported that facility staff were unaware of this information and there was no documentation in the medical record that

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F 842	Continued From page 62 provided this information. She was unable to explain why this information had not been obtained and included in Resident #24 ' s medical record. An interview was conducted with the physician on 10/2/19 at 12:30 PM. The physician stated that he thought he had informed one of the nursing staff that he had cancelled the blood draw for the 9/17/19 order and re-ordered the CBC and CMP to be taken with Resident #24 ' s Hgb A1C scheduled for 10/11/19. He indicated he was unable to say for certain who he spoke to, but that he normally had not communicated directly to the laboratory facility without nursing staff being involved. He reported that he expected the facility staff to coordinate and communicate with the laboratory staff and for complete documentation related to laboratory information to be included in the medical record. An interview was conducted with the DON on 10/3/19 at 10:07 AM. She indicated that she expected the facility staff to coordinate and communicate with the laboratory staff and for complete documentation related to laboratory information to be included in the medical record.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice	F 849		10/31/19

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services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.

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F 849	Continued From page 64 (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown	F 849		

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source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

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F 849	Continued From page 66 (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interviews, hospice staff interviews, Physician interviews and record review, the facility failed to coordinate care with the hospice provider by not permitting hospice staff access to a resident's medical record for 1 of 1 resident's (Resident #55) reviewed for hospice care. The findings included:	F 849	F849 For the Residents Affected: The facility received documentation on resident #55 on 10/01/2019 from Hospice services. The facility additionally placed a request for Hospice access to the electronic medical records for Hospice	

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F 849	Continued From page 67 Review of the hospice contract dated 4/24/17 indicated the agreement between the facility and hospice provider access to the resident's medical record and the exchange of information to coordinate care. Resident #55 was admitted on 9/25/17 with cumulative diagnoses of Cerebral Vascular Accident and neurogenic bladder. Resident #55 was sent to the hospital on 8/15/19 and readmitted to the facility on 8/19/19 with orders for hospice services. Review of Resident #55's significant change Minimum Data Set (MDS) dated 8/26/19 read Resident #55 had severe cognitive impairment and exhibited rejection of care. He was coded for hospice services with a prognosis of 6 months or less. Review of Resident #55's care plan initiated 8/26/19 read he was to receive hospice care due to his terminal illness. Interventions included the involvement of family in discussion about his wishes, concerns and end of life decisions. Review of the electronic and hard chart revealed evidence of a hospice comprehensive assessment dated 8/26/19 and a hospice plan of care dated 9/5/19. There was no evidence of any hospice progress notes in Resident #55's medical record. On 10/1/19 at 9:42 AM, the hospice documentation for Resident #55 providing evidence of the coordination of care was	F 849	staff to review the residents electronic record. This was approved 10-25-19. For other potentially affected residents: The facility placed a hospice communication binder at the nurse's station and in-serviced the hospice organizations on the use and purpose. Hospice was in-serviced by the Director of Nursing and the in-services were completed by 10-30-19. This communication book will be monitored by the Director of Nursing (DON) or the designee. The DON completed a 100% audit of Hospice residents on 10/30/19 to identify any other issues to include documentation, no other issues were found. Monitoring to maintain compliance: The facility Director of Nursing or designee will monitor the hospice communication book weekly for one month and once a month for two additional months for compliance. The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	

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requested from the Director of Nursing (DON).

In an interview on 10/1/19 at 12:25 PM, the Medical Director stated the hospice agency involved recently returned to the facility at the request of Resident #55 and his family. He stated it was his expectation that all hospice documentation be shared and available to the facility.

In an interview on 10/1/19 at 1:56 PM, Hospice Nurse #2 stated her agency just recently returned to the facility. She stated in the past, she was able to document in the electronic medical record but the facility management refused to allow access to chart in the electronic record or the hard chart. Hospice Nurse #2 stated it was the previous DON who denied access. She stated she was told today to bring in all copies of the progress notes but she stated the facility never asked for notes until 10/1/19. Hospice Nurse #2 stated the only thing requested before 10/1/19 was the hospice comprehensive assessment and the hospice plan of care. She stated she was aware that it was a long term care and a hospice regulation for hospice notes to be part of the resident's medical record.

On 10/1/19 at 2:00 PM, the DON provided copies of the hospice progress notes. She stated Hospice Nurse #2 delivered the progress notes to the Social Worker on 10/1/19. She stated she was unsure why the previous DON denied hospice access to the medical record.

In an interview on 10/2/19 at 2:33 PM, the Social Worker stated prior to yesterday, hospice was not providing weekly progress notes but provided copies of Resident #55's progress noted on

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F 849	Continued From page 69 10/1/19. In an interview on 10/3/19 at 10:10 AM, the DON stated she expected care to be coordinated with the hospice provider and indicated she expected the hospice documentation to be available at the facility as required per the regulation.	F 849		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 4/4/19 recertification survey. This was for 3 recited deficiencies in the areas of F550 Dignity, F656 Comprehensive Care Plans, and F688 Range of Motion/Mobility. These 3 deficiencies were cited again on the current recertification survey of 10/3/19. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: 1. F550: Based on observations, staff interviews,	F 867	F867 The facility Quality Assurance/Performance Improvement (QAPI) committee met on 10/25/2019 to review repeat citations and other citations received. The Plan of Corrections were reviewed and actions required were reviewed along with the implementation of corrected actions. On 10/25/19 the corporate facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, admissions, activities director, maintenance director, dietary manager, medical records, therapy director, and housekeeping supervisor related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related F550,	10/31/19

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F 867	Continued From page 70 and record reviews, the facility failed to cover a urinary catheter drainage bag for 1 (Resident #55) of 4 residents reviewed for dignity. During the recertification survey of 4/4/19 the facility was cited at F550 for failing to provide dignity by not covering a urinary catheter drainage bag. 2. F656: Based on record review, observation and staff interviews, the facility failed to develop a comprehensive care plan for range of motion and contracture prevention (Resident #58) and failed to implement the care plan interventions related to wandering behaviors (Resident #72) for 2 of 19 residents whose care plans were reviewed. During the recertification survey of 4/4/19 the facility was cited at F656 for failing to develop a comprehensive care plan in the area of range of motion/contracture prevention. 3. F688: Based on record review, observation, staff interviews, and physician interview the facility failed to evaluate and provide care of upper extremity contractures for 1 of 4 sampled residents reviewed with limited range of motion (Resident #58). During the recertification survey of 4/4/19 the facility was cited at F688 for failing to provide care and services to prevent further contractures. An interview was conducted with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on 10/3/19 at 10:20 AM. The Administrator indicated the ADON was in the lead role of the facility ' s Quality Assessment and Assurance (QAA) Committee, but that she was new to the position	F 867	F656 and F688. The facility QAPI committee will meet monthly and areas of focus will be based on this plan of correction and any other areas of concern identified by the committee or brought to their attention.	

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F 867	Continued From page 71 having taken the role a couple of months ago. The DON reported that she was also new to the facility as a DON having become interim DON on 9/20/19 and more recently becoming the permanent DON. The repeat citations, F550, F656, and F688, were reviewed with the Administrator, DON, and ADON. The Administrator reported that in addition to the new ADON and DON there had been other changes in facility leadership since the 4/4/19 recertification survey. He stated that with these facility leadership changes there had been many improvements made, but he recognized that the areas identified as repeat citations were works in progress. He indicated that he believed the new leadership team would be able to continue to improve upon and resolve these areas of deficient practice.	F 867		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		10/31/19

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 72 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NA's) received annual Dementia training. This was for 2 (NA #8 and NA #9) of 5 NA's reviewed for staffing. The findings included: NA #8's date of hire was 2/19/13. Review of NA #8's Education/In-services records indicated no record of Dementia training since 10/24/17. NA #9's date of hire was 11/4/11. Review of NA #9's Education/In-services records indicated no record of Dementia training since 10/24/17. In an interview on 10/2/19 at 11:45 AM, the Administrator stated he recently hired a new Staff Development Coordinator (SDC) because the previous SDC left in June 2019. He confirmed NA #8 and NA #9 had not completed any dementia training since 10/24/17. He stated by the end of 2019, he planned to schedule a day of in-servicing the get the staff current on all the required training but to date, it has not been scheduled. The Administrator stated it was his expectation that the NA's receive annual Dementia training.	F 947	F947 For the Residents Affected: The Staff Development Coordinator (SDC) completed an in-service on 10-21-19 with the two Certified Nursing Assistants that did not have up to date Dementia training for 2019. The SDC completed an all staff dementia management training 10/30/19. For other potentially affected residents: The SDC reviewed other potential missed in-services identified no other staff member missing the Dementia training, she completed the review on 10-30-19. The SDC completed all staff training on dementia management on 10-30-19 to assure no other training concerns. Monitoring to maintain compliance: The Staff Development Coordinator put into place training logs for nursing staff members to track required training and in-services, the logs were implemented on or before. The Director of Nursing or the designee will report to Quality Assurance/Performance Improvement committee on compliance. Corrective Action Compliance date: October 31, 2019	