STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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 investigation survey was conducted 11/04/19 through 11/08/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# OO0U11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted 11/04/19 through 11/08/19. A total of 62 allegations were investigated and 9 were substantiated.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a manual wheelchair with specific dimensions as agreed upon for 1 of 1 resident reviewed for accommodation of needs (Resident #37). Findings included: Resident #37 was admitted to the facility on 09/18/18 with multiple diagnoses that included heart failure, chronic pain, and diabetes. The annual Minimum Data Set (MDS) dated 09/12/19 indicated Resident #37 had intact cognition and required extensive staff assistance	F 558	1) Resident #37 is not longer here to correct that specific deficient practice. 2) To ensure other residents were not affected by this deficient practice a 100 percent audit of all residents in wheelchairs to ensure they are satisfied with their wheelchair fit on 11/29/19 by the therapy department, Unit Manager, and Social Services Director with no other concerns noted. 3) Effective start date 11/27/19 the facility staff were re-educated by Administrator that any specific requests be documented on a Complaint/Grievance report sheet, logged, reviewed with IDT	12/5/19

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

Electronically Signed | 12/05/2019

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F 558	Continued From page 1 with most activities of daily living. The MDS noted activity for locomotion on and off the unit did not occur during the assessment period. The Occupational Therapy treatment encounter note dated 03/26/19 read in part, Resident #37 seen by this Occupational Therapist (OT) to measure and discuss wheelchair options. The following dimensions were agreed upon: manual wheelchair that is 26 inch in width, 22 inch seat depth, and 21 to 22 inch height, dependent on availability. Other wheelchair characteristics to be solid seat construction, adjustable height arms, standard seat and back angle and elevating leg rests 16 to 20 inch. Plan is to order a custom wheelchair that will meet patient needs, desires and mobility issues. Review of the order form dated 09/10/19 that was filled out by Resident #37 revealed the dimensions for the wheelchair frame width and depth were circled to indicate preference for a 26 inch seat width and 20 inch seat depth. Review of the invoice dated 09/11/19 provided by the facility revealed a wheelchair was ordered for Resident #37 with the measurements of 28 inch by 18 inch. The Occupational Therapy treatment encounter note dated 10/16/19 read in part, reviewed ordered wheelchair specifications against measurements of wheelchair that arrived with Resident #37 with noted discrepancies that the wheelchair is 28 inch and not 26 inch as ordered. Resident #37 notes he prefers a snugger fit. Height is 19 and one-half inch without cushion and depth of seat 20 inch.	F 558	and honored if appropriate. Any new employees will also be educated on honoring request during orientation. 4) Social services/Administrator will begin conducting audits the week of December 2nd, 2019 of the Grievance Log once a week for the first four weeks; twice a month for the second month; then once a month for the third month. They will utilize the Grievance Log Audit tool to record the results of all audits. Results of audits will be brought to monthly Quality Assurance and Performance Improvement meeting each month for 3 months. Review and revisions will be made as necessary. Date of compliance is December 6, 2019.	

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F 558	Continued From page 2	F 558		

On 11/06/19 at 9:54 AM, the Director of Rehab (DR) revealed therapy had worked with Resident #37 off and on since his admission and he had been very specific about the type of wheelchair he felt would meet his needs. She explained they had measured him several times to determine the appropriate measurements for proper positioning when seated but he always disagreed with their measurements. She added the facility had provided Resident with at least 4 different manual wheelchairs for him to use but nothing they supplied was correct and he refused to even try them because the wheelchairs did not meet his specifications. The DR confirmed Resident #37 had a manual wheelchair that was recently ordered but he had voiced the 28 inch seat was too uncomfortable and he had informed the OT that he would not use it. She stated last week she contacted a supply company to inquire about purchasing a specialty cushion, with a soft foam top and a hard plastic bottom, that would be more comfortable for him to sit on and would keep the seat from sagging in the middle which had been an area of concern for him. She added the process would take time since the cushion had to be custom made.

On 11/06/19 at 12:15 PM, the OT confirmed Resident #37 currently had a manual wheelchair provided by the facility but he refused to use it because the wheelchair ordered was not per his specifications. The OT stated Resident #37 reported the wheelchair that was supposed to be ordered had a 26 inch seat not a 28 inch seat. He explained during a therapy session, Resident #37 agreed to try out the wheelchair and sat up in it for 30 minutes but after approximately 10 minutes stated his legs were falling asleep. He added Resident #37 preferred a snugger fit and

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F 558	Continued From page 3	F 558		

his main concerns was the wheelchair could not be too low because his legs would fall asleep or too wide for fear of falling out of the wheelchair when his weight fluctuated. The OT shared Resident #37 voiced feeling unsatisfied and frustrated with the process because his expectations were not met related to the ordering of a manual wheelchair and communicated he wanted the wheelchair he originally set out to get.

On 11/06/19 at 2:27 PM, Resident #37 stated he had been without a proper fitting manual wheelchair since his admission and the facility had continued to order wheelchairs that were not the correct size for him. Resident #37 explained he was unable to use the manual wheelchairs provided by the facility thus far because the wheelchairs were too wide for him to sit in comfortably and too low causing his legs to fall asleep. Resident #37 stated on 09/10/19, Nurse #6 helped him fill out an order form with the exact wheelchair specifications he needed and when it was received, it was not what he had ordered and refused to use it. Resident #37 confirmed the OT stated the wheelchair would work for him once modifications were made but he had "proved them all wrong" because within 10 minutes of sitting up in the wheelchair, his legs started to fall asleep. Resident #37 shared that he felt the facility continued to order the wrong wheelchair on purpose and did not feel he should have to settle for a modified wheelchair that would not meet his needs due to the facility's inability to order the correct size.

On 11/06/19 at 4:04 PM, Nurse #6 confirmed she assisted Resident #37 with filling out the order form for the facility to purchase him a manual wheelchair. She explained the 28 inch circle was

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F 558	Continued From page 4	F 558		

already blackened in on the order form when they started, so she circled the specific size of 26 inch that he requested just to make sure it was ordered with the correct specifications. She added Resident #37 confirmed several times during the process that he wanted a 26 inch wide seat. Nurse #6 verified she gave the order form to the Administrator once completed and was not sure why Resident #37 did not get the manual wheelchair with the specifications he requested.

On 11/8/19 at 3:08 PM, the Administrator revealed the facility had provided Resident #37 with several manual wheelchairs since his admission that he refused to use stating they did not fit him properly. She explained due to his continued refusals, she received explicit instructions from the Vice President of Clinical Services (VPCS) to have Resident #37 fill out the order form for the exact measurements he wanted and the wheelchair would be ordered. She added she faxed the form to the VPCS on 09/11/19 and the order was placed that same day. Upon reviewing the order form, she confirmed Resident #37 had circled his preference for a 26 inch seat width and 20 inch seat depth and explained she did not notice what was marked on the form when she faxed it to the VPCS on 09/11/19. The Administrator clarified she did not personally place the order and was unsure why the manual wheelchair received was not what Resident #37 had specified on the order form. She stated Resident #37 refused to even try he wheelchair purchased on 09/11/19 because it was not what he had requested and although the wheelchair that was ordered was not per his specifications, she felt the wheelchair would meet his functional needs once modified by Occupational Therapy.

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F 558	Continued From page 5 On 11/08/19 at 9:26 AM, a telephone attempt to speak with the VPCS was unsuccessful.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to honor a resident's	F 561	1) Resident #37 is not longer here to correct that specific deficient practice.	12/4/19

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F 561	Continued From page 6 choice to utilize a power wheelchair by delaying a safety reassessment for 1 of 5 residents reviewed for choices (Resident #37). Findings included: Resident #37 was admitted to the facility on 09/18/18 with multiple diagnoses that included heart failure, chronic pain, and diabetes. The annual Minimum Data Set (MDS) dated 09/12/19 indicated Resident #37 had intact cognition and required extensive staff assistance with most activities of daily living. The MDS noted activity for locomotion on and off the unit did not occur during the assessment period. On 11/6/19 at 2:27 PM, Resident #37 shared that on 08/08/19, an incident occurred in the hallway when he accidentally bumped a Nurse in her leg with his power wheelchair as he tried to back away from her. As a result of this incident, Resident #37 stated he was informed by the Director of Nursing (DON) he was no longer allowed to use his power wheelchair. Resident #37 explained he was unable to use the manual wheelchairs provided by the facility thus far because the wheelchairs were too wide for him to sit in comfortably and too low causing his legs to fall asleep. Resident #37 stated he preferred to use his power wheelchair for locomotion because it had been customized to fit him properly and was reassessed to use his power wheelchair by the Occupational Therapist (OT) on 10/09/19. Resident #37 shared that he felt isolated because the facility had not allowed him to use his power wheelchair since 08/08/19 and he had no way of getting out of his room.	F 561	2) To ensure other residents were not affected by the same deficient practice, a 100 percent audit was conducted of all current power chair/scooter users by the Social Services Director on 11/26/19 to ensure they all reviewed and signed the new Accordius Electronic Motorized Vehicles Operating Rules and Procedures with no other issues noted. 3) Effective start date of 11/27/19 the Administrator educated the Admissions Director, Administrative nursing team, and the therapy department on our Electric Motorized Vehicles operating rules and procedures. Any new Admission team members, therapy team members, and administrative nursing staff will be educated upon hire. 4) The Administrator or Admissions Director will begin audits the week of December 2nd, 2019 for signed Operating Rule and Procedures on applicable current residents and all applicable new admissions once a week for the first month; twice a month for the second month; and once a month for the third month. The Operating Rules/procedures for Power Chair Audit tool will be utilized for recording the results of all audits. Results of audit will be brought to quarterly Quality Assurance and Performance Improvement meeting for 3 months. Review and revisions will be made as necessary. The date of compliance is December 6, 2019.	

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F 561	Continued From page 7	F 561		

Review of the Occupational Therapy treatment encounter note dated 10/09/19 for Resident #37 read in part, this visit was requested by facility and patient for electric wheelchair assessment to assess patient's safety and ability to functionally use electric wheelchair in room and in facility. Patient demonstrated accurate and conservative, safe use of wheelchair, demonstrating functional independence with this form of mobility. Patient demonstrated understanding of controls for pivot turns, speed, horn and functional navigation with joystick.

On 11/06/19 at 9:54 AM, the Director of Rehab (DR) verified Resident #37 was reassessed for safety when operating his power wheelchair by the OT on 10/09/19. She explained the OT only completed the reassessment and it was up to the Administrator to determine if or when Resident #37's privileges were returned.

On 11/06/19 at 12:15 PM, the OT confirmed he conducted the safety reassessment on Resident #37 on 10/09/19 and indicated in his treatment note that Resident #37 had demonstrated safe techniques when operating his power wheelchair.

On 11/08/19 at 2:25 PM, the DON recalled on 08/08/19, Resident #37 was observed driving "erratically" around a Nurse in his power wheelchair and when the Nurse came out of another patient's room, he "bumped" her leg with his power wheelchair. She added when the Administrator was informed on 08/08/19 of the incident, she was instructed by the Administrator to remove Resident #37's power wheelchair from his room, explain why it was being removed and provide him with a manual wheelchair to use. She explained after removing his power

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wheelchair, she took 2 different manual wheelchairs to his room but he stated he would not use them and refused to allow her to leave either wheelchair in his room. The DON stated it was not their intent to punish Resident #37 by removing his power wheelchair, they just wanted to make sure he wasn't able to use it so that no one else would get hurt and added it was returned to his room the very next day. The DON confirmed she instructed staff that if Resident #37 requested to get up out of bed, he was to be assisted into a manual wheelchair and not his power wheelchair until further notice. She could not explain the delay in getting Resident #37 reassessed for safety to use his power wheelchair and felt the delay was due to a "lack of knowledge on their part as well as lack of a formal policy."

On 11/05/19 at 3:51 PM, the Regional Nursing Home Director (RNHD) explained she had been working with the Administrator and Compliance Officer on developing an electric wheelchair safety policy and procedure with plans to send the policy through the facility's Quality Assurance process and to the Interdisciplinary Team for review next week The RNHD added the policy would apply to all residents in the facility utilizing power wheelchairs including a reassessment by Occupational Therapy for safety. She confirmed Resident #37 was reassessed for power wheelchair safety in October of 2019. She stated she was informed the wheelchair policy was presented to Resident #37 for review and he made some modifications but would not sign.

On 11/08/19 at 3:08 PM, the Administrator shared that she was not present in the facility on 08/08/19 but was notified via telephone of the

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F 561	Continued From page 9 incident when Resident #37 struck a Nurse in the leg with his power wheelchair and since this was the second incident where he had used his power wheelchair in an unsafe manner, she had instructed the DON to remove the power wheelchair from Resident #37's room, inform him he was no longer able to use it and provide him with a manual wheelchair. She admitted after the incident on 08/08/19, she had no plans to have Resident #37 reassessed by Occupational Therapy for safety or reinstating his privileges and added, at the time, she felt the facility was within their right to revoke his privileges to utilize his power wheelchair due to the unsafe manner in which he operated it. The Administrator indicated after several conversations with the Vice President of Clinical Services, she made a referral to Occupational Therapy and Resident #37 was reassessed for wheelchair safety on 10/09/19 and determined to be safe by the OT. She added Resident #37's power wheelchair privileges had not yet been reinstated because he refused to sign the facility's wheelchair policy agreeing to the facility's operating and safety rules. The Administrator restated that although Resident #37 had not been allowed to use his power wheelchair, she felt he had isolated himself due to his unwillingness to utilize the manual wheelchairs the facility had provided him to use.	F 561		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the	F 568		12/5/19

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F 568	Continued From page 10 resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to maintain an accurate accounting of the Resident Council trust fund account for 1 of 3 trust fund records reviewed. Findings included: The Resident Council minutes for the period December 2018 to April 2019 included a line item labeled "Treasurer's Report" and listed the following dollar amounts in the Resident Council Trust Fund: 12/10/18: $3,410.70 01/04/19: $3,410.70 02/08/19: no dollar amount was listed 03/08/19: $3.410.70 04/05/19: "about" $3,300.00 There was no line item for Treasurer's Report or dollar amount listed on the Resident Council minutes for the months of May 2019 to October 2019. There were no Resident Council trust fund statements from December 2018 until September 2019. Therefore, it was unknown how much interest the trust fund earned and how much money was deposited or withdrawn. The Resident Council trust fund statement	F 568	On 9/11/19, a separate Resident Council trust account was opened with an opening deposit as provided from the previous operator and managed by the BOM. 2) All residents were at risk by this deficient practice. No other accounts were identified to be deficient in practice. 3) Facility Administrator in-serviced the Activities Director, Assistant Business Office Manager, and the Business Office Manager on November 27, 2019 on the requirement for accounting and records of personal funds to maintain an accurate accounting of the Resident Council fund, including providing a monthly statement to the RC president. Resident Council President was also educated on how to withdraw and deposit money in the account and request a statement of the account. New staff will be trained upon hire. 4) Assistant Business Office Manager or Administrator will begin conducting random audits the week of December 2, 2019 of Resident trust accounts to ensure accuracy once a week for four weeks; twice a month for the next second month; then once a month for the third month. The audit tool to be used is the Audit of	

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F 568	Continued From page 11 labeled "Resident Council Money" revealed the account was opened on 09/11/19 with a balance of $2,286.63 and included line items indicating interest applied on 10/01/19 and 11/01/19. There was no other documentation listed on the statement of any money withdrawn or deposited. On 11/06/19 at 11:26 AM, the Business Office Manager (BOM) revealed she had been employed at the facility since August of 2019 and confirmed the Resident Council has its own trust fund account. The BOM was unsure how the account was funded and explained since the account was started on 09/11/19, no money had been deducted from the account. On 11/07/19 at 3:30 PM, the Resident Council President (RCP) stated she was unaware there was a Resident Council trust fund until she noticed there was an amount listed on the previous minutes and asked to see an accounting of the funds. The RCP added she was informed of the current balance but no one could explain why there was a discrepancy in the amounts listed on the minutes compared to the actual balance in the account. On 11/07/19 at 4:12 PM, the Activity Director (AD) revealed she had been employed at the facility since July 2019 and was not aware there was a Resident Council trust fund until the RCP started asking about the money. She explained, other than the monthly balance listed on the Resident Council minutes, she was only able to find one statement of account dated 09/30/16 that indicated the balance at that time was $2,089.51. The AD added she had not used any of the funds and was not sure where the money originated.	F 568	Resident Trust Accounting tool. Results of audit will be brought to quarterly Quality Assurance and Performance Improvement meeting for 3 months. Review and revisions will be made as necessary. The date of completion is December 6th, 2019.	

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F 568	Continued From page 12 On 11/08/19 at 3:08 PM, the Administrator explained when the resident trust fund accounts were balanced and transferred to the new accounting service under the current corporation, the Resident Council trust fund balance was determined to be $2,286.63. She stated typically, the Resident Council did not have a trust fund account and any money used for Resident Council activities was provided by the facility and included in the facility's annual budget. She added she was not aware a Resident Council trust fund existed until the RCP started inquiring. The Administrator indicated she nor the AD had used any of the funds in the Resident Council trust fund and verified the Resident Council now had its own separate account with interest applied monthly as applicable. The Administrator confirmed that other than the statement dated 09/30/16 and the monthly balance listed on the Resident Council minutes, they were unable to locate any other statements of account prior to 09/11/19 that itemized deposits, withdrawals or any interest applied.	F 568		
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	F 578		12/5/19

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F 578	Continued From page 13 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have advanced directives on the medical record for 1 of 1 residents review for advanced directives (Resident #284). The finding included: Resident #284 was admitted to the facility on 10/16/19 with diagnoses included high blood pressure, and ovarian cancer.	F 578	1) To correct the deficient practice the Director of Nursing addressed and corrected the advanced directive for resident #284 on 11/27/19. 2) To ensure that other residents were not affected the Director of Nursing did a 100% audit of all residents on 11/27/19 to ensure that each resident had a documented advanced directive. 3) Director of Nursing educated the unit	

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F 578	Continued From page 14 Review of the electronic and hard copy medical records for Resident #284 revealed there were no advanced directives for a full code or Do Not Resuscitate directives in the chart. During an interview conducted on 11/05/19 at 11:28 AM, Resident #284's Responsible Party (RP) stated Resident #284's preference was to have a full code. The RP denied any staff had asked him about preferred code status for Resident #284 since admission. An interview was conducted on 11/07/19 at 10:51 AM with Nurse #1 who admitted Resident #284 to the facility from the hospital. She stated the hospital called around 9:00 PM and Resident #284 arrived the facility at around 10:45 PM. She recalled she had completed body audits, approved the medications, and uploaded the information into the electronic records for Resident #284. As her shift ended at 11:00 PM, she passed the unfinished admission process to the incoming nurse (Nurse #2) and informed her of what she had done. The incoming nurse acknowledged her understanding. Nurse #1 stated she did not tell Nurse #2 what she needed to do for the remaining admission process assuming Nurse #2 knew how to admit a new resident. A phone interview was conducted on 11/07/19 at 11:11 AM with Nurse #2. She acknowledged that she was working third shift on 10/16/19 when Resident #284 was admitted. She could not recall she had any conversations with Nurse #1 regarding Resident #284's remaining admission process during the shift change that night. She could not remember she had done anything	F 578	manager on 11/27/19 on the procedure for ensuring all residents have an advanced directive. The Director of Nursing and the Unit Manager will be responsible for all residents having advanced directives. All new staff will be trained upon hire. 4) The Director of Nursing/unit manager will conduct an audit on 100% of residents beginning the week of December 2nd, 2019 once weekly for the first month; then twice a month for the next months; then once a month for the third month. The audit tool to be utilized is the Advanced Directives Audit tool and all results will be included on that audit form. Results of audits will be brought to the monthly Quality Assurance and Performance Improvement meeting each month times 3 months. The date of compliance is December 6, 2019. .	

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F 578	Continued From page 15 related to Resident #284's admission process, especially advanced directives after Nurse #1 had left. An interview was conducted on 11/07/19 at 4:57 PM with the Director of Nursing (DON). She stated the admitting nurse was responsible to document the advanced directives during the admission process. The DON denied there was a system breakdown in documenting advanced directives. She attributed the incident as a result of confusion of remaining tasks between 2 nurses during the admission process. The DON expected the Unit Manager to update and document the advanced directives in the electronic and hard copy medical records immediately. She further stated the advanced directive should have been on Resident #284's chart along with a physician order of preferred code status immediately after admission.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		12/5/19

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written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation and interviews with staff and resident, the facility failed to protect the private health information for 1 of 1 sampled resident (Resident #335) by leaving confidential medical information unattended and exposed in an area accessible to the public for 1 of 4 medication carts.

The finding included:

Resident #335 was admitted to the facility on 10/29/19 with diagnoses included anxiety, insomnia, and high blood pressure.

A continuous observation was made on 11/05/19 from 10:48 AM through 10: 55 AM for an unattended medication cart (West-North hall medication cart). Nurse #3 left the Medication Administration Record (MAR) visible on the

1) To correct the deficient practice, education was immediately completed with the nurse on that immediate med cart where the privacy screen was not utilized on 11/6/19 by the Director Of Nursing.
2) To ensure no other residents were affected by that deficient practice, education was begun on 11/6/19 to include all Nurses and Medication aides, by Director of Nursing to be completed no later than 12/4/19 on HIPPA compliance measures to be taken with the laptops on all medication carts.
3) The Director of Nursing in-serviced the nurses, medication aides, unit manager, and IDT starting 11/6/19 to 12/5/19 as to the procedure to maintain HIPPA compliance on all medication cart computers.

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F 583	Continued From page 17 medication cart computer screen when he went into the nourishment room about 10-11 feet away. During the observation, the MAR for Resident #335 showed a picture of the resident, his room numbers, a list of medications he was receiving, and diagnoses on the computer screen which was left unattended for others to read and not covered up. During an interview conducted on 11/05/19 at 11:02 AM with Nurse #3, he stated while he was reviewing Resident #335's medications, 2 residents requested assistance to go into the nourishment room. He stepped away to help the 2 residents and had forgotten to close the computer screen. Nurse #3 acknowledged that it was not an appropriate action to leave the MAR screen with residents' private health information unattended. An interview was conducted on 11/05/19 at 11:08 AM with Resident #335. He stated he had received his morning medications more than 1 hour ago and denied he had requested any "as needed" medication in the past 1 hour. On 11/05/19 at 11:11 AM, as the surveyor passed by the same medication cart, the computer screen was showing Resident #335's MAR and it was again left unattended. The screen was readily observable or accessible by others who were not authorized to view this private health information. Nurse #3 was seen working inside the nurse station facing away from the computer screen approximately 7-8 feet away. During an interview conducted on 11/05/19 at 11:15 AM, the Director of Nursing (DON) stated the facility had provided Health Insurance	F 583	4) The Director of Nursing/Unit Manager(s), and the weekend MOD will conduct random audits beginning the week of December 2nd, 2019 three times a week for the first month; twice monthly for the second month; then once a month for the third month. The audit tool to be utilized is the HIPPA/Med Cart audit tool and all results will be documented on it. Results of audits will be brought to the monthly Quality Assurance and Performance Improvement meeting each month times 3 months. The date of compliance is December 6th, 2019.	

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F 583	Continued From page 18 Portability and Accountability Act (HIPAA) training for all the staff during orientation and subsequent annual HIPAA training. She attributed the incident as Nurse #3 was distracted by residents but could not explain why Nurse #3 repeated the same violation again in less than 30 minutes. The DON added all the staff had been instructed to keep confidential for all information contained in resident's records regardless of the form or storage method of the records. She reiterated that the facility had zero tolerance toward any HIPAA violations. It was her expectation for all the staff to comply with the HIPAA privacy and security rules.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		12/5/19

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being

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F 585	Continued From page 20 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide timely resolution of a grievance by not supplying a manual wheelchair with specific dimensions as agreed upon for 1 of 1 resident reviewed for grievances (Resident #37).	F 585	1) The resident is no longer here to correct that specific deficient practice. 2) To ensure other residents were not affected by this the Social Service Director completed a 100% audit of the grievances for the past 30 days on 11/27/19 to ensure they were resolved per our Grievance	

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F 585	Continued From page 21 Findings included: Resident #37 was admitted to the facility on 09/18/18 with multiple diagnoses that included heart failure, chronic pain, and diabetes. The annual Minimum Data Set (MDS) dated 09/12/19 indicated Resident #37 had intact cognition and required extensive staff assistance with most activities of daily living. The MDS noted activity for locomotion on and off the unit did not occur during the assessment period. The Occupational Therapy treatment encounter note dated 10/16/19 read in part, reviewed ordered wheelchair specifications against measurements of wheelchair that arrived with Resident #37 with noted discrepancies that the wheelchair is 28 inch and not 26 inch as ordered. Resident #37 notes he prefers a snugger fit. Height is 19 and one-half inch without cushion and depth of seat 20 inch. The facility's Monthly Service Concern Log for October 2019 revealed an entry dated 10/23/19 for Resident #37. The concern was noted as "various" and the date of resolution as "ongoing." The handwritten concerns provided by the facility from Resident #37 dated 10/1/19, 10/15/19, 10/19/19, and 10/22/19 indicated he requested, among other things, the status of a proper fitting manual wheelchair. The Administrator's response to Resident #37's concerns included a bulleted list dated 10/23/19 addressing his concerns and read in part, "We were under the impression that Occupational Therapy could modify the manual wheelchair and you would be ok with this. Is this not the case? Occupational Therapy is ordering items for your current manual	F 585	Policy. No other issues were found. 3) The Leadership Team members: Director of Nursing, Nursing Administration, Admissions Director, Social services Director, Dietary Manager and his assistant, Medical records, Housekeeping Director, Maintenance director, Business Office Manager, Central Supply, and Activities Director were in-serviced on timely resolution of grievances according to the Grievance Policy and Procedure by the Administrator on 11/27/19. New staff will be educated upon hire. 4) The Administrator or the Director of Nursing will begin conducting random audits the week of December 2nd, 2019 of the Grievance Logs and correlating grievances to ensure timely resolution of all grievances. The audit tool to be used is the Grievance Log audit tool. Once a week for the first month; twice a month for the second month; and once a month for the third month. Results of audits will be brought to monthly Quality Assurance and Performance Improvement meeting each month for 3 months. Review and revisions will be made as necessary. The date of compliance is December 6, 2019.	

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wheelchair to make it more functional per your specifications." A unsigned, handwritten note written on top of the bulleted list of responses read, "a copy given to resident on 10/23/19 via resident mail."

On 11/06/19 at 9:54 AM, the Director of Rehab (DR) revealed therapy had worked with Resident #37 off and on since his admission and he had been very specific about the type of wheelchair he felt would meet his needs. She explained they had measured him several times to determine the appropriate measurements for proper positioning when seated but he always disagreed with their measurements. She added the facility had provided Resident with at least 4 different manual wheelchairs for him to use but nothing they supplied was correct and he refused to even try them because the wheelchairs did not meet his specifications. The DR confirmed Resident #37 had a manual wheelchair that was recently ordered but he had voiced the 28 inch seat was too uncomfortable and he had informed the Occupational Therapist (OT) that he would not use it. She stated last week she contacted a supply company to inquire about purchasing a specialty cushion, with a soft foam top and a hard plastic bottom, that would be more comfortable for him to sit on and would keep the seat from sagging in the middle which had been an area of concern for him. She added the process would take time since the cushion had to be custom made.

On 11/06/19 at 12:15 PM, the OT confirmed Resident #37 currently had a manual wheelchair provided by the facility but he refused to use it because the wheelchair ordered was not per his specifications. The OT stated Resident #37

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reported the wheelchair that was supposed to be ordered had a 26 inch seat not a 28 inch seat. He explained during a therapy session, Resident #37 agreed to try out the wheelchair and sat up in it for 30 minutes but after approximately 10 minutes stated his legs were falling asleep. He added Resident #37 preferred a snugger fit and his main concerns was the wheelchair could not be too low because his legs would fall asleep or too wide for fear of falling out of the wheelchair when his weight fluctuated. The OT shared Resident #37 voiced feeling unsatisfied and frustrated with the process because his expectations were not met related to the ordering of a manual wheelchair and communicated he wanted the wheelchair he originally set out to get.

On 11/06/19 at 2:27 PM, Resident #37 stated he had been without a proper fitting manual wheelchair since his admission and the facility had continued to order wheelchairs that were not the correct size for him. Resident #37 explained he was unable to use the manual wheelchairs provided by the facility thus far because the wheelchair was too wide for him to sit in comfortably and too low causing his legs to fall asleep. Resident #37 stated Nurse #6 helped him fill out an order form with the exact wheelchair specifications he needed and when it was received, it was not what he had ordered and refused to use it. He indicated he previously spoke with the Administrator as well as various Corporate Representatives regarding the wheelchair but his concerns remain unresolved. Resident #37 acknowledged he received a typed list of responses from the Administrator on 10/23/19 and indicated the brief explanations that were provided did not truly address the concerns he had voiced. He stated he felt the facility

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continued to order the wrong wheelchair on purpose and admitted he now refused to speak to the Administrator or allow her in his room to discuss any of his concerns.

On 11/06/19 at 4:04 PM, Nurse #6 confirmed she assisted Resident #37 with filling out the order form for the facility to purchase him a manual wheelchair. She explained the 28 inch circle was already blackened in on the order form when they started, so she circled the specific size of 26 inch that he requested just to make sure it was ordered with the correct specifications. She added Resident #37 confirmed several times during the process that he wanted a 26 inch wide seat. Nurse #6 verified she gave the order form to the Administrator once completed and was not sure why Resident #37 did not get the manual wheelchair with the specifications he requested.

On 11/8/19 at 3:08 PM, the Administrator shared that the facility tried to address grievances as timely as possible, depending on the grievance, with a goal of providing resolution to the complainant within 48 hours. She confirmed Resident #37 had voiced concerns that the manual wheelchairs provided by the facility did not fit him properly but despite their best efforts, nothing they seemed to do was sufficient. She added in an effort to address his repeated concerns related to the wheelchair, she received explicit instructions from the Vice President of Clinical Services (VPCS) to have Resident #37 fill out the order form for the exact measurements he wanted and the wheelchair would be ordered. She explained she faxed the form to the VPCS on 09/11/19 and the order was placed that same day. Upon reviewing the order form, she confirmed Resident #37 had circled his

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F 585	Continued From page 25 preference for a 26 inch seat width and 20 inch seat depth and explained she did not notice what was marked on the form when she faxed it to the VPCS on 09/11/19. The Administrator stated she did not personally place the order and was unsure why the manual wheelchair received was not what Resident #37 had specified on the order form. She added she felt the wheelchair that was ordered would meet his needs once modified by Occupational Therapy and since Resident #37 refused to speak to her, had communicated her response to him in writing. On 11/08/19 at 9:26 AM, a telephone attempt to speak with the VPCS was unsuccessful.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		12/5/19

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F 609	Continued From page 26 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to submit 24-hour and 5-day reports to the State Agency for 1 of 3 residents (Resident #37) residents reviewed for abuse. Findings included: Resident #37 was admitted to the facility on 09/18/18 with multiple diagnoses that included heart failure, chronic pain, and diabetes. The annual Minimum Data Set dated 09/12/19 indicated Resident #37 had intact cognition and required extensive staff assistance with most activities of daily living. The facility's investigation completed by the Administrator related to Resident #37's allegation of abuse included witness statements from staff present at the time of the alleged incident and copies of the 24-hour and 5-day investigation reports completed by the facility. There was no was no evidence the completed reports were submitted to the State Agency (SA). On 11/6/19 at 2:27 PM, Resident #37 shared that on 08/08/19, Nurse Aide (NA) #1 had to physically hold Nurse #4 back from lunging forward to	F 609	1) To correct the deficient practice the survey team received a copy of the MU State Reportable during our annual survey (11/4/19 □ 11/8/19). 2) To ensure other residents were not affected by this, a 100 percent audit was completed on 12/3/19 ,by the Administrator, of the past three months Allegations of Abuse reports to ensure no one else was affected by the deficient practice. No other safety concerns were noted. 3) Facility Administrator and Director of Nursing were educated by the Regional Director of Operations on 11/29/19 on Abuse Reporting regulations and expectations. New staff will be educated upon hire. 4) Social Services Director will begin conducting random audits the week of December 2nd, 2019 on Abuse Reporting Log and Grievance log to ensure no allegations of abuse go unreported once a week for the first four weeks; twice a month for the second month; and once a month for the third month. The audit tool to be utilized is the Abuse Reporting Log audit tool. Results of audits will be brought to monthly Quality Assurance and	

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F 609	Continued From page 27 attack him during a verbal exchange. Resident #37 added later that same day, another incident occurred in the hallway with Nurse #4 when he accidentally bumped her leg with his power wheelchair as he tried to back away from her. Resident #37 could not recall if he reported Nurse #4 attempting to lunge at him to facility staff at the time of occurrence. Resident #37 added he was not interviewed by facility staff for his statement of events related to the incident on 08/08/19. On 11/7/19 at 9:18 AM, NA #1 confirmed she was present during the incident involving Resident #37 and Nurse #4 on 08/08/19. NA #1 recalled Nurse #4 was standing at her medication cart crying as Resident #37 was being verbally abusive and calling her names. NA #1 stated at one point, Nurse #4 turned to look at Resident #37 and walked around to the side of his power wheelchair but had her arms crossed and never made any movements directly toward him. She added she pulled on Nurse #4's arm to try and convince her to walk away from the situation but Nurse #4 pulled her arm back stating she did not want to leave because she had other residents that needed attention. NA #1 indicated as the incident was occurring, she never witnessed Nurse #4 raise her voice or display argumentative behavior toward Resident #37 and denied ever having to physically restrain Nurse #4 from attempting to lunge or attack Resident #37. On 11/6/19 at 5:20 PM, Nurse #4 confirmed an incident occurred with Resident #37 on 08/08/19 when he hit the lower part of her leg with his power wheelchair and stated prior to the incident, Resident #37 had ridden up and down the hall in his power wheelchair, going back and forth in "half circles" by the medication cart where she	F 609	Performance Improvement meeting each month for 3 months. Review and revisions will be made as necessary. The date of compliance is December 6th, 2019.	

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stood, talking loudly and calling her "derogatory names." She could not recall how long Resident #37's behavior continued and added she never turned around to respond or taunt him, just stood at the medication cart crying, until he stopped his power wheelchair up close and directly behind her. Nurse #4 admitted it was at that point she turned around to face him, walked around his wheelchair, stood a little way off to the side and told him, "if you are going to say anything, say it to my face." Nurse #4 remembered NA #1 pulling on her arm to get her to leave the hall but she pulled her arm back telling her "no, I have other residents to tend to." Nurse #4 was not sure if Resident #37 felt she was attempting to strike at him when she pulled her arm away from NA #1 and denied staff ever had to hold her back from lunging at or attempting to strike Resident #37.

On 11/08/19 at 8:30 AM, a staff member at the State's Health Care Personnel Registry (HCPR) Section confirmed there were no 24-hour or 5-day reports for Resident #37 processed or currently in queue for processing submitted by the facility for the month of August 2019.

On 11/08/19 at 3:08 PM, the Administrator confirmed she was the facility's abuse coordinator and described a process in place for investigating and reporting allegations of abuse. She explained when allegations of abuse were reported, the required 24-hour and 5-day reports were faxed to the SA and copies of the fax transmittals were kept as part of the facility's investigative documentation. The Administrator stated she was not present in the facility on 08/08/19 but was notified via telephone of the incident when Resident #37 struck Nurse #4 in the leg with his power wheelchair. She explained

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F 609	Continued From page 29 since the incident occurred toward a staff member and not another resident, it was not reported to the SA. She added according to statements obtained from staff that witnessed the incident, Resident #37 never made any accusation on 08/08/19 that Nurse #4 attempted to lunge at him and indicated she was not informed of his allegation against Nurse #4 until it was reported to her by a third party on 08/19/19. The Administrator explained when notified, an investigation was initiated and she attempted to discuss the incident with Resident #37 but he refused to talk to her and told her to get out of his room. She recalled submitting the 24-hour and 5-day reports via fax transmission to the SA as part of the facility's investigation process and was surprised the facility documentation did not include confirmation of the fax transmittals. The Administrator was unable to provide documentation that the 24-hour and 5-day reports were submitted to the SA.	F 609		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 636		12/5/19

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F 636	Continued From page 30 (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or	F 636		

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F 636	Continued From page 31 mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Care Area Assessments (CAA) on an annual comprehensive Minimum Data Set (MDS) within 14 days of the Assessment Reference Date (ARD) (Resident #66) and failed to complete an admission MDS and CAA assessments within 13 days of the admission date (Resident #239) for 2 of 32 sampled residents reviewed. Findings included: 1. Resident #66 was admitted to the facility on 09/24/15 with multiple diagnoses that included impairment in the sensory or motor function of the lower extremities and depression. Resident #66's electronic medical record revealed the most recently completed comprehensive MDS was an annual assessment with an ARD of 10/17/18. Resident #66's electronic medical record also revealed an incomplete comprehensive annual MDS assessment with an ARD of 10/18/19. The status of this assessment was "in progress" which indicated it was not completed. On 11/07/19 at 4:36 PM, the MDS Coordinator confirmed she was responsible for completing resident MDS assessments. The MDS Coordinator explained she had not realized an	F 636	1) The Minimum Data Set Coordinator provided immediate corrective action for the alleged deficient practice regarding failure to complete an Annual Comprehensive Minimum Data Set (MDS) and Care Area assessments (CAAs) within 14 (fourteen) days of the Assessment Reference Date (ARD) 10/18/19 for Resident #66. The MDS is now current as per RAI guidelines. The Minimum Data Set Coordinator provided immediate corrective action for the alleged deficient practice regarding failure to complete an Admission Comprehensive Minimum Data Set (MDS) and Care Area Assessments (CAAs) within 14 (fourteen) days of the Assessment Reference Date (ARD) 10/10/19 for Resident #239. The MDS is now current as per RAI guidelines. 2) All residents have the potential to be affected by the alleged deficient practice. A 100% audit of current facility Residents, MDS schedule has been reviewed for completion timing of MDS assessments on 11/29/19 with no other issues found. 3) The MDS Consultant educated the Leadership Team: Administrator, Minimum Data Set Coordinator(s), Director of Nursing, Social Worker, Dietary Manager, Director of Rehab, and	

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F 636	Continued From page 32 annual MDS assessment was due to be completed for Resident #66 until after she had already completed a quarterly MDS assessment. She added a comprehensive MDS was initiated for Resident #66 with the ARD of 10/18/19 and all sections of the MDS, except for Section V Care Area Assessments (CAA), were completed on 10/31/19. The MDS Coordinator confirmed the CAA were not completed within the regulatory timeframe. On 11/08/19 at 2:25 PM, the Director of Nursing (DON) explained the MDS Coordinator only had assistance with completing MDS assessments a few days a week and felt the MDS assessments that were not completed timely were due to human error. The DON added it was her expectation that MDS assessments were completed with the regulatory time frame. 2. Resident #239 was admitted to the facility on 10/08/19 with multiple diagnoses that included congestive heart failure, diabetes, and mild cognitive impairment. Resident #239's electronic medical record revealed an admission MDS with an ARD of 10/10/18. The MDS indicated the MDS was marked as completed on 11/05/19 and the CAA were marked as completed on 11/07/19. On 11/07/19 at 4:36 PM, the MDS Coordinator confirmed she was responsible for completing resident MDS assessments. She explained when a resident was admitted to the facility under a Medicare Part A stay, she initially completed 2 separate assessments: a Prospective Payment System (PPS) MDS for Medicare and an Omnibus Budget Reconciliation Act (OBRA)	F 636	Activities Director on 11/26/2019 to review the guidelines set forth in the RAI manual regarding all requirements needed to schedule, data entry, and completed based upon MDS regulations and timeframes. All new hires that include completion of a resident assessment will be educated on the requirements during orientation. 4) The Comprehensive assessments scheduled will be audited beginning the week of December 2, 2019 5 times a week for 3 months by the Administrator or Director of Nursing for ensuring timely completion and transmittals of assessments on required due dates. The Administrator will audit and track all assessments and transmittals using an audit tracking tool which includes: residents□ name, assessment type, assessment reference date (ARD), due date and completion date on a weekly basis for three months. The Administrator is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services. The date of compliance is December 6, 2019.	

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F 636	Continued From page 33 admission MDS. The MDS Coordinator reviewed Resident #239's electronic medical record and confirmed the OBRA admission MDS dated 10/10/19 was not completed within the regulatory time frame. She stated it was an oversight and verified the MDS was not marked as complete until 11/7/19 which made the assessment late. On 11/08/19 at 2:25 PM, the Director of Nursing (DON) explained the MDS Coordinator only had assistance with completing MDS assessments a few days a week and felt the MDS assessments that were not completed timely were due to human error. The DON added it was her expectation that MDS assessments were completed with the regulatory time frame.	F 636		
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 and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 2 of 6 residents (Resident #19 and #45) identified as PASRR Level II. 1. Resident #19 was admitted to the facility on 12/01/17 with diagnoses of depression and post-traumatic stress disorder (PTSD). The PASRR Level II Determination Notification dated 05/13/19 indicated Resident #19 was	F 641	1) To correct the deficient practice, regarding Accuracy of Assessment for Residents #19 and #45. Minimum Data Set (MDS) Assessment with Assessment Reference Date (ARD) 08/02/2019 has been modified to include Level II Preadmission Screening and Resident Review (PASRR) status. The MDS for Resident #19 and #45 are now current as per Resident Assessment Interview (RAI)guidelines to include Level II PASRR status 2) To ensure other residents were not affected by the deficient practice, the MDS	12/5/19

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F 641	Continued From page 34 determined as PASRR Level II. The annual MDS assessment dated 08/02/19 indicated Resident #19 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. On 11/05/19 at 03:04 PM an interview was conducted with the MDS Coordinator who stated she missed coding that Resident #19 was PASRR Level II because she was not used to coding Section A 1500 Preadmission Screening and Resident Review (PASRR) because that had been the responsibility of the social worker and the social worker had been on leave. The MDS Coordinator shared the PASRR determination letters were kept in the social workers office and she did not realize Resident #19 was determined as PASRR Level II. The MDS Coordinator indicated she would have to modify and submit the annual MDS assessment dated 08/02/19 to indicate Resident #19 was PASRR Level II. On 11/05/19 at 03:49 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the annual MDS assessment dated 08/02/19 would have been accurately coded to reflect Resident #19 was determined as PASRR Level II. The DON indicated the facility had been without a social worker who was responsible to code PASRR Level II and Resident #19's annual MDS	F 641	coordinator completed a 100 percent audit of all Level 2 PASRR MDS section A residents to ensure accuracy on 12/2/19. Ten additional MDS were identified, corrected, and resubmitted on 12/2/19 by the MDS Coordinator. 3) Facility Administrator educated MDS coordinator and MDS staff on 12/2/19 on coding of PASRR accurately and instructed the MDS Coordinator and staff to code Section A in the MDS from this point forward. All new staff will be educated on this process upon hire. 4) Administrator or Social Worker will begin auditing the week of December 2, 2019 the care plans for oxygen, pain, and hospice goals/interventions twice a week for the first month; once a week for the second month; and once a month for the third month. In addition, the DON or the Unit Managers will monitor the halls/residents rooms for fall interventions to be in place per the careplan twice a week for the first month; once a week for the second month; and once a month for the third month. Results of audits will be brought to monthly Quality Assurance and Performance Improvement meeting each month for 3 months. Review and revisions will be made as necessary. The date of compliance is December 6, 2019.	

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assessment was missed for coding. The DON shared it was her expectation that the MDS Coordinator would submit a modification to the annual MDS assessment dated 08/02/19 to indicate Resident #19 was determined as PASRR Level II.

On 11/05/19 at 03:54 PM an interview was conducted with the Administrator who stated her expectation was that the annual MDS assessment dated 08/02/19 would have been accurately coded to indicate Resident #19 was PASRR Level II. The Administrator indicated the facility did not have a social worker who was responsible to code PASRR Level II and Resident #19's annual MDS assessment was missed for coding. The Administrator shared her expectation was that the MDS Coordinator would submit a modification to the annual MDS assessment dated 08/02/19 to indicate Resident #19 was determined as PASRR Level II.

2. Resident #45 was admitted to the facility on 09/17/19 with diagnoses of anxiety and schizophrenia.

The Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 09/13/19 indicated Resident #45 was determined as PASRR Level II.

The admission Minimum Data Set (MDS) assessment dated 09/24/19 indicated Resident #45 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an

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appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care.

On 11/05/19 at 03:04 PM an interview was conducted with the MDS Coordinator who stated she missed coding that Resident #45 was PASRR Level II because she was not used to coding Section A 1500 Preadmission Screening and Resident Review (PASRR) because that had been the responsibility of the social worker and the social worker had been out on leave. The MDS Coordinator indicated the PASRR determination letters were kept in the social workers office and she did not realize Resident #19 was determined as PASRR Level II. The MDS Coordinator shared she would have to modify and submit the admission MDS assessment dated 09/24/19 to indicate Resident #45 was determined as PASRR Level II.

On 11/05/19 at 03:49 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the admission MDS Assessment dated 09/24/19 would have been accurately coded to reflect Resident #45 was determined as PASRR Level II. The DON indicated the facility had been without a social worker who was responsible to code PASRR Level II and Resident #45's admission MDS assessment was missed for coding. The DON shared it was her expectation that the MDS Coordinator would submit a modification to the admission MDS assessment dated 09/24/19 to indicate Resident #45 was determined as PASRR Level II.

On 11/05/19 at 03:54 PM an interview was conducted with the Administrator who stated her

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F 641	Continued From page 37 expectation was that the admission MDS assessment dated 09/24/19 would have been accurately coded to indicate Resident #45 was PASRR Level II. The Administrator indicated the facility did not have a social worker who was responsible to code PASRR Level II and Resident #45's admission MDS assessment was missed for coding. The Administrator shared her expectation was that the MDS Coordinator would submit a modification to the admission MDS assessment dated 09/24/19 to indicate Resident #45 was determined as PASRR Level II.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		12/5/19

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(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an

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F 645	Continued From page 39 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) after the initial thirty-day approval for nursing home placement expired for one of six residents reviewed for PASRR (Resident #42). Findings included: Resident #42 was admitted on 9/13/19 for aftercare following surgery for neoplasm. Additional diagnoses included malignant neoplasm, anxiety disorder, depression and schizoaffective disorder. The quarterly Minimum Data Set (MDS) assessment dated 10/11/19 revealed Resident #42 was moderately cognitively impaired. The MDS further revealed that Resident #42 required limited assistance with transfers, bed mobility and walking, extensive assistance with toileting, was not steady with balance. The resident was noted to exhibit verbal behaviors towards others. Review of Resident #42's medical record showed that a care plan was in place for Level II PASRR. A review of the PASRR Level II Determination Notification document dated 8/23/19 revealed nursing facility placement was appropriate for a limited stay of no more than 30 days. The notification further explained if the resident was expected to extend beyond that 30-day period (9/22/19) further approval and screening must be	F 645	1) To correct the deficient practice, the Social Services Director had submitted PASRR II for Resident #42 and it is now completed and in place on 11/14/19. Modifications were completed by the Social Services Director and submitted on 11/14/19. 2) All residents are at risk for deficient practice, A 100 percent audit was conducted by the Social Services Director on Date_11/27/19 for all residents to ensure we had current PASRR Level IIs on the respective residents. No other issues were identified. 3) The facility Administrator in-serviced the Social Services Director, Admissions Director, and the MDS Coordinator on 11/29/19 that all residents must have a printed copy of their current PASRR letter (both I and II) placed in their electronic medical record. Any new Social Services or Admissions staff will be educated upon hire. 4) The Administrator/Social worker will begin conducting audits the week of December 2, 2019 two audits per week for the first and second quarter; two audit per week for the third and fourth quarter to ensure the PASRR is correctly coded. The audit tool to be used is the PASRR level II audit tool and all results will be placed on there. Results of audits will be brought to monthly Quality Assurance and Performance Improvement meeting each	

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F 645	Continued From page 40 obtained within 5 days of the PASRR expiration date. An interview was conducted with the facility's Administrator on 11/7/19 at 3:39 PM who reported that the PASRR expiration was missed and the renewal process had started late. The Administrator further reported that the facility was currently without a Social Worker and therefore the Administrator was undertaking the PASRR responsibilities.	F 645	month for the next 12 months. Review and revisions will be made as necessary. The date of compliance is December 6th, 2019.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		12/5/19

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F 656	Continued From page 41 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 and staff interviews, the facility failed to: develop a care plan for a resident who elected to receive Hospice services (Resident #234); failed to develop a care plan that included individualized interventions to manage a resident's pain (Resident #78); failed to develop a care plan for a resident dependent on oxygen supplementation (Resident #35): and failed to implement care plan interventions by not utilizing fall mats and placing call bell within reach to minimize the risk of fall related injuries (Resident #42) for 4 of 11 residents reviewed for hospice, pain management, respiratory care, and accidents. Findings included: 1. Resident #234 admitted to the facility on 01/05/19 with multiple diagnoses that included Alzheimer's disease, vascular dementia without behavioral disturbance, diabetes, and dysphagia	F 656	1) To correct the deficient practice, the MDS coordinator reviewed and corrected the following: Resident #234 care plan for Hospice was not corrected due to being closed file due to discharged status of the resident; Resident # 35 care plan was updated to reflect his dependence on Oxygen on 11/7/19 by the MDS Coordinator; Resident #78 care plan was updated to reflect an individualized intervention for his Pain careplan; and Resident #42 fall intervention of fall matts were placed by his bed and his call bell was placed in proximity to his person. 2) To ensure other residents were not affected by the deficient practice, the MDS Coordinator and MDS Regional Director completed a 100 percent care plan audit pertaining to: Oxygen use, pain, Hospice, and fall interventions to ensure all care plan and interventions are in place both in	

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F 656	Continued From page 42 (difficulty swallowing) following cerebrovascular disease (condition that affects the blood vessels of the brain). Review of Resident #234's care plans, last revised on 12/31/18, revealed no care plan for end of life care or Hospice services. A Hospice contract, with an effective date of 02/13/19, revealed Resident #234 was admitted under Hospice services to receive end of life care. The significant change Minimum Data Set (MDS) dated 02/14/19 indicated Resident #234 received hospice care and had a prognosis of a life expectancy of less than six months. During an interview on 11/08/19 at 10:05 AM the MDS Coordinator explained when a resident received Hospice care, a care plan was typically developed that included interventions addressing terminal prognosis, death with dignity and collaboration with the Hospice provider. She confirmed Resident #234 was admitted under Hospice services for end of life care on 02/13/19 and after reviewing her medical record, verified a care plan for Hospice care had not been developed. The MDS Coordinator explained it was an oversight on her part and a care plan should have been developed when Hospice services were initiated for Resident #234. During an interview on 11/08/19 at 2:25 PM the Director of Nursing stated she felt it was an oversight that a Hospice care plan was not developed by the MDS Coordinator when Resident #234 was admitted under Hospice services. She added it was her expectation for a	F 656	the careplan itself and in their environment. No other issues noted. 3) Facility Administrator in-serviced all facility staff and the Leadership Team (Director of Nursing, Nursing Administration, Admissions Director, Social services Director, Dietary Manager and his assistant, Medical records, Housekeeping Director, Maintenance director, Business Office Manager, Central Supply, and Activities Director) on the expectation that they ensure that care plans are developed for residents who elected Hospice services, Interventions for residents having actual pain care plan and Oxygen supplementation. The Director of Nursing initiated education 12/04/19 to ensure residents that have care plan interventions for fall mat in place and call bell within reach to all nursing staffs to include all certified nursing assistants. All new staff will be educated upon hire. 4) Administrator or Social Worker will audit care plans for oxygen, pain, and hospice goals/interventions twice a week for the first month; once a week for the second month; and once a month for the third month. In addition, the DON or the Unit Managers will monitor the halls/residents rooms for fall interventions to be in place per the careplan twice a week for the first month; once a week for the second month; and once a month for the third month. Results of audits will be brought to monthly Quality Assurance and Performance Improvement meeting each month for 3 months. Review and	

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F 656	Continued From page 43 care plan to be developed that addressed a resident's condition and needs when receiving Hospice care. 2. Resident #78 was admitted to the facility on 07/19/19 with diagnoses included chronic pain, chronic osteomyelitis, rhabdomyolysis, and present of orthopedic joint implants. The most recent Minimum Data Set (MDS) assessment dated 10/04/19 revealed Resident #78 was cognitively intact. He required supervision with most of activities of daily living (ADLs) and had been receiving scheduled and "as needed" pain medications. The MDS indicated Resident #78 had frequent pain at level of 7 out of 10 and had been receiving opioid in the 7-day look back period. The Care Area Assessment (CAA) summary sheet revealed Resident #78 was admitted to the facility for aftercare following infectious disease and bone removal of diabetic foot ulcer with chronic and acute osteomyelitis. Resident #78 had external fixator and wound vac in place. Most of his pain related to the recent surgery. Review of physician orders dated 07/29/19 revealed Resident #78 had an order of "as needed" oxycodone 5 to 10 milligram (mg) every 3 hours as needed for pain as well as Tylenol 650 mg every 4 hours as needed for pain or fever. On 10/10/19, Resident #78 received a scheduled order of 10 mg oxycodone daily at bed time for 10 days. Review of the care plan for pain that was initiated on 11/06/19 revealed Resident #78 had chronic pain related to chronic osteomyelitis, constipation, and diabetic foot ulcer. The goal was for Resident	F 656	revisions will be made as necessary.	

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#78 to be able to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. This care plan did not have any interventions related to the treatment, prevention, or management of pain.

An interview was conducted with the MDS Coordinator on 11/07/19 at 1:26 PM. She acknowledged that she was responsible to develop the care plan related to pain for Resident #78. She agreed that the care plan which did not contain information related to pain management was incomplete and not comprehensive. She stated it was an isolated incident as she was distracted when she worked on this particular care plan. She added she would complete the care plan for pain immediately.

During an interview conducted on 11/07/19 at 1:41 PM, the Director of Nursing (DON) stated the care plan for Resident #78's pain was incomplete as it did not contain the component of interventions. She denied the facility had a system failure related to care plan as the incident was caused by distraction during the developing process. She expected the care plan for Resident #78's pain management to be completed as soon as possible. It was her expectation for the MDS Coordinator to develop a complete, comprehensive, and person-centered care plan that updated in timely manner and accurately reflected the needs and condition of the resident.

3. Resident #35 was admitted to the facility 07/29/19 with diagnoses including colon cancer, diabetes, and anemia.

Resident #35's Physician orders dated 08/23/19 for oxygen at 2 to 4 l/min (liters per minute) via

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nasal cannula continuously.

Resident #35's significant change Minimum Data Set (MDS) dated 09/09/19 revealed he was moderately cognitively impaired and used oxygen.

Resident #35's care plan last updated 10/16/19 revealed no care plan for oxygen use.

Observation of Resident #35 on 11/05/19 at 12:44 PM and 4:19 PM revealed he had oxygen in place at 2 l/min via nasal cannula. Subsequent observations on 11/06/19 at 10:10 AM, 11/07/19 at 9:02 AM and 11/08/19 at 9:06 AM revealed Resident #35 had oxygen in place via NC at 2 l/min.

An interview with the MDS Nurse on 11/06/19 at 3:18 PM revealed she was responsible for creating and updating care plans. The MDS Nurse confirmed Resident #35 did not have a care plan for oxygen use and stated he should have had a care plan for oxygen use. The MDS Nurse stated she should have developed a care plan for oxygen use when she reviewed Resident #35's care plan 10/16/19. She stated the failure to develop the oxygen care plan was human error.

An interview with the Director of Nursing (DON) on 11/06/19 at 3:32 PM revealed Resident #35 should have had a care plan for oxygen use. The DON stated care plans were reviewed in risk management meetings and the lack of a care plan for oxygen use for Resident #35 just got missed.

An interview with the Administrator on 11/08/19 at

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10:18 AM revealed she expected Resident #35 to have a had care plan for oxygen use.

4. Resident #42 was admitted on 9/13/19 for aftercare following surgery for neoplasm. Additional diagnoses included malignant neoplasm, anxiety disorder, and Wernicke's encephalopathy (a neurological condition with symptoms that can include unsteady gait and confusion).

The quarterly Minimum Data Set (MDS) assessment dated 10/11/19 revealed Resident #42 was moderately cognitively impaired. The MDS further revealed that Resident #42 required limited assistance with transfers, bed mobility and walking, extensive assistance with toileting, was not steady with balance and had sustained one fall with no injury.

A fall risk assessment was completed on 10/12/19 and revealed Resident #42 was at high risk for falls.

Review of Resident #42's medical record revealed a care plan was in place for fall prevention. Interventions to provide Resident #42 with a safe environment included: call light in place, the bed in low position at night, fall mats in place while in bed.

Fall reports reviewed from 9/13/19 to 10/31/19 revealed that Resident #42 had experienced 10 falls with no major injuries noted.

An observation was made on 11/04/19 at 10:32 AM and 2:21 PM of Resident #42 in bed. The call bell was on the floor at the foot of the bed and there was no fall mat in place. An observation

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was made on 11/6/19 at 9:24 AM Resident #42 was observed in bed. The call bell was on the floor at the foot of the bed and there was no fall mat in place.

An interview at 9:26 AM on 11/07/19 with Nurse Aide (NA) #3 revealed that Resident #42 was able to use his call bell but often did not and would get up on his own despite being encouraged to call for help. NA #3 reported that Resident #42 often knocked his call bell to the floor and that staff had to monitor for this. NA #3 further explained that fall preventions for Resident #42 included non-slip socks, the bed in the lowest position, and frequent observations.

An observation was made on 11/07/19 at 9:33 AM of Resident #42 in bed. The bed was in a low position the call bell was on the floor between the wall and bed without a fall mat in place.

An interview with Licensed Practical Nurse (LPN) #3 on 11/7/19 at 1:50 PM revealed that Resident #42 was a fall risk, was able to use his call bell, but often did not. LPN #3 stated that Resident #42's fall interventions included change in blood pressure medications and close monitoring. LPN #3 further explained that fall mats were not an intervention for this resident.

An interview with the MDS Coordinator on 11/7/19 at 2:03 PM confirmed that Resident #42 had a care plan in place for falls with interventions that included a call bell within reach and fall mats in place while in bed. The MDS coordinator further explained that these interventions were supposed to be in place.

An interview with the Director of Health Services

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F 656	Continued From page 48 (DOHS) at 3:52 PM on 11/7/19 revealed that Resident #42 was a fall risk and was able to use his call bell. The DOHS further explained that Resident #42 was supposed to have care plan interventions of fall mats and call bell within reach in place.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §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	F 690		12/5/19

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F 690	Continued From page 49 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews the facility failed to keep the urinary catheter bag off the floor to reduce the risk of infection (Resident #49) and failed to change the urinary catheter every 30 days per standing orders for 1 of 3 residents reviewed for urinary catheter (Resident #49). The findings included: 1. a. Resident #49 was admitted to the facility 07/03/18 with diagnoses including anemia and neurogenic bladder (a condition in which a person lacks the ability to control the bladder due to a brain, spinal cord, or nerve condition). Review of the quarterly Minimum Data Set dated 10/01/19 revealed Resident #49 was cognitively intact and had an indwelling urinary catheter. The MDS also indicated Resident #49 required extensive assistance with bed mobility and transfers. A review of Resident #49's care plan for indwelling urinary catheter initiated 11/04/19 revealed the catheter bag and tubing were to be positioned below the level of the bladder. Observation of Resident #49 on 11/04/19 at 10:06 AM revealed she was lying in bed with her eyes closed and her urinary catheter bag was lying on the floor beside her bed.	F 690	1) To correct the deficient practice, Resident #49 order to change resident□s catheter bag every 30 days or PRN was placed into PCC in addition to having the actual catheter changed on 11/26/19. The catheter bag for Resident #49 was placed on the side of resident□s bed and not on the floor on 11/8/19 by the Director of Nursing. 2) To ensure that other residents were not affected by the deficient practice an audit of 100% of urinary catheters was done on 12/3/19 to ensure that the catheter had been changed within the last 30 days and that catheter bags were not on the floor. 3) The Director of Nursing educated the unit manager on 12/3/19 on the Accordius process to be utilized for ensuring urinary catheters are changed every 30 days and for ensuring catheter bags are not on the floor. 4) The DON and the Unit manager will be responsible for ensuring compliance. Residents with urinary catheters will be audited starting the week of December 2nd, 2019 once a week for the first month, twice monthly for the next month, then once the third month. The audit tool to be used is the Catheter audit tool and all findings will be placed on there. Results of audits will be brought to the monthly	

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F 690	Continued From page 50 An interview with nurse aide (NA) #1 on 11/04/19 at 10:17 AM revealed NA #1 did not know how Resident #49's urinary catheter bag got on the floor or how long it had been in the floor. NA #1 stated when she was in Resident #49's room for the initial round at approximately 7:15 AM the catheter bag was hanging on Resident #49's bed below the level of the bladder. An interview with Nurse #5 on 11/04/19 at 10:22 AM revealed urinary catheter bags were to be below the level of the bladder but not in the floor. Nurse #5 did not know how long Resident #49's urinary catheter bag had been on the floor. An observation of Resident #49 on 11/08/19 at 9:00 AM revealed she was lying in bed with her eyes closed and her urinary catheter bag was lying on the floor at the foot of her bed. An interview with NA #2 on 11/8/19 at 9:03 AM revealed he had been in Resident #49's room at 8:40 AM and her urinary catheter bag had been hanging on the side of her bed. NA #2 stated he did not know how the catheter bag got on the floor or how long it had been in the floor. An interview with Nurse #5 on 11/08/19 at 9:05 AM revealed urinary catheter bags were to be below the level of the bladder but not in the floor. Nurse #5 did not know how long Resident #49's catheter bag was in the floor or how it got on the floor. b. Review of Physician's orders revealed an order to insert a urinary catheter 09/14/19. There was no order specifying how often the urinary catheter should be changed.	F 690	Quality Assurance and Performance Improvement meeting each month times 3 months. The date of compliance is December 6, 2019.	

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Nurse #6 who received the order to place the urinary catheter for Resident #49 on 09/14/19 was unavailable for interview during the survey.

The Treatment Administration Record (TAR) from September 2019 through November 2019 did not contain any information regarding when the indwelling urinary catheter should be changed.

An interview with the Director of Nursing (DON) on 11/08/19 at 9:57 AM revealed urinary catheter bags were to be below the level of the bladder but not on the floor. The DON confirmed there was no order for the frequency of changing the urinary catheter and the catheter had not been changed since it was placed 09/14/19. The DON also stated urinary catheters should be changed every 30 days or as needed and there was a standing order to change the urinary catheter every 30 days and as needed unless the Physician stated otherwise. She also stated it was the nurse's responsibility receiving the urinary catheter order to activate the standing order for the frequency of changing the urinary catheter and place the order on the TAR.

An interview with the Nurse Practitioner (NP) on 11/08/19 at 11:03 AM revealed urinary catheter bag should not be on the floor and urinary catheters were to be changed every 30 days and as needed unless otherwise ordered. The NP stated nursing usually put the standing order to change urinary catheters every 30 days and as needed in the computer.

An interview with Unit Manager (UM) #1 on 11/08/19 at 11:09 AM revealed the nurse who received the order to insert the urinary catheter

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F 690	Continued From page 52 for Resident #49 on 09/14/19 should have initiated the standing order for changing the urinary catheter when the order was received and placed the order on the TAR. UM #1 stated every morning in the morning meeting all orders from the previous day were reviewed for completeness and the order just got missed.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		12/5/19

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F 758	Continued From page 53 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Nurse Practitioner (NP) and Pharmacy Consultant interviews the facility failed to follow Physician's orders per pharmacy recommendations for antianxiety medication for 1 of 5 residents reviewed for unnecessary medications (Resident #2). The findings included: Resident #2 was admitted to the facility 09/30/18 with diagnoses including anxiety and hypertension (high blood pressure). Review of the annual Minimum Data Set (MDS) dated 10/08/19 revealed Resident #2 was cognitively intact and received antianxiety medication 7 out of 7 days during the look back period.	F 758	1) To correct the deficient practice, the medications were reviewed and discontinued as per the physician□s recommendation for Resident #2 on 11/6/19 by the Director of Nursing. 2) This practice has the potential to affect all residents who receive antianxiety medications. To ensure that other residents were not affected by the deficient practice. The Director of Nursing immediately reviewed the pharmacy recommendations for on 100% of residents for the last 3 months to ensure all orders were carried out as per the physician recommendations. This audit was completed and reviewed with the Administrator on 12/4/19 with no other issues found. 3) Regional Clinical Nurse Consultant	

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F 758	Continued From page 54 Review of the care plan for psychotropic medications including antianxiety medication dated 10/23/19 revealed Resident #2 was to receive psychotropic medications as ordered and receive a consult from the pharmacy and Physician to consider dosage reduction when clinically appropriate and at least quarterly. Review of Resident #2's Physician's orders revealed an order for lorazepam (an antianxiety medication) 0.5 milligrams (mg) every 12 hours as needed for anxiety dated 03/25/19 with no stop date. Review of Resident #2's Medication Administration Record (MAR) revealed she received 4 doses of lorazepam in March 2019, 18 doses of lorazepam in April 2019, 16 doses of lorazepam in May 2019, 13 doses of lorazepam in June 2019, 8 doses of lorazepam in July 2019, 10 doses of lorazepam in August 2019, 15 doses of lorazepam in September 2019, 12 doses of lorazepam in October 2019, and no doses of Ativan in November 2019. The facility switched to the current pharmacy provider in May 2019. Pharmacy conducted an undated medication review informing the Physician that Resident #2 was on prn (as needed) lorazepam 0.5mg and had no stop date. The pharmacy consult requested the Physician either put a time limit for the medication or discontinue the medication. The Physician signed a pharmacy consult to discontinue the prn (as needed) lorazepam 06/09/19.	F 758	educated the Director of Nursing on 12/4/19 on the procedure of reviewing all pharmacy recommendations and following through per our procedures. 4) Director of Nursing will audit pharmacy recommendations monthly starting December 2019 to ensure that the recommendations are completed and carried out as written. After which the administrator will review the pharmacy recommendations for completeness. The audit tool to be used is the Pharmacy Recoomendation audit tool and all results will be placed on it. Results of audits will be brought to the monthly Quality Assurance and Performance Improvement meeting each month times 6 months. The date of compliance is December 6th, 2019.	

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Pharmacy conducted a medication review 07/13/19 informing the Physician that prn lorazepam was ordered 03/25/19 with no stop date. The pharmacy consult requested the Physician either put a time limit on the medication or discontinue the medication. The Physician signed a pharmacy consult to discontinue prn lorazepam on 07/23/19.

Pharmacy conducted a medication review on 09/13/19 informing the Physician that prn lorazepam was ordered and had no stop date. The pharmacy consult requested the Physician either put a time limit for the medication or discontinue the medication. The Physician signed a pharmacy consult on 10/08/19 for lorazepam 0.5mg by mouth every 12 hours as needed for anxiety for 90 days.

An interview with the Director of Nursing (DON) on 11/06/19 at 3:36 PM revealed the pharmacy sent her the results of the pharmacy consults monthly and she was responsible for getting the pharmacy recommendations to the Physician or Nurse Practitioner (NP). Once the Physician or NP responded to pharmacy recommendations, she was responsible for putting the orders in the computer. The DON stated she should have put the order to discontinue the prn lorazepam in the computer when the Physician ordered to discontinue the medication on 06/09/19 and again when the Physician discontinued the medication on 07/23/19. She stated she overlooked the orders and Resident #2 received prn lorazepam from March 2019 through October 2019.

An interview with the Pharmacy Consultant on 11/07/19 at 9:41 AM revealed she did a medication review for Resident #2 on 05/22/19

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and requested the Physician respond to a request to either add a stop date for prn lorazepam or discontinue the medication. She stated she had not heard back from the Physician and when she did the medication review 07/13/19 she again asked the Physician to either discontinue the prn lorazepam or put a stop date on the medication. The Pharmacy Consultant stated she had not heard back from the Physician and when she did the medication review on 09/13/19 she asked the Physician to either discontinue the prn lorazepam or put a stop date on the medication. The Physician signed the pharmacy consult for lorazepam 0.5mg every 12 hours prn for 90 days on 10/08/19. The Pharmacy Consultant she was never notified by the facility that the Physician discontinued the prn lorazepam on 06/09/19 or 07/23/19.

The Physician was unavailable for interview during the survey.

An interview with the Nurse Practitioner (NP) on 11/07/19 at 9:16 AM revealed the Physician had been addressing Resident #2's lorazepam orders and he was out of town. The NP stated she could not speak for the Physician but she was familiar with Resident #2 and she had episodes of intermittent anxiety that were not always controlled with her other medications so ordering the lorazepam as prn was the most appropriate treatment for her.

A follow up interview with the NP on 11/07/19 at 10:26 AM revealed Resident #2 would have had no adverse effects from receiving prn lorazepam from March 2019 through October 2019 after the Physician signed the pharmacy recommendation to discontinue the medication on 06/09/19.

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F 758	Continued From page 57 An interview with the Administrator on 11/08/19 at 10:06 AM revealed she expected staff to follow Physician's orders and the prn lorazepam should have been discontinued 06/09/19 and since it was not it should have been discontinued 07/23/19.	F 758		
F 814 SS=B	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep the dumpster area free of debris for 3 of 3 dumpsters. The findings included: During the initial tour of the dumpster area on 11/06/19 at 12:57 PM with the Food Service Director (FSD), observations revealed a few plastic cups and an aluminum can in between dumpsters #2 and #3 and a plastic wrapper in front of dumpster #1. A second observation of the dumpster area took place on 11/07/19 at 11:30 AM with FSD which revealed 2 soda cans beside dumpster #2, a garbage bag sticking out from under dumpster #3 and 3 crushed juice cups observed in the area in between dumpster #2 and #3. The FSD stated he was not sure who was supposed to keep the dumpster area clean, but he would not expect the dumpster area to have debris on the ground. An interview with Environmental Services (EVS) Director on 11/07/19 at 3:47 PM revealed that	F 814	1 To correct the deficient practice the Maintenance Director cleaned any remaining garbage that was outside the container immediately on 11/7/19 once it was known. 2) To ensure other residents were not affected by the deficient practice, the Maintenance Director rounded daily starting November 6th, 2019 through November 8th, 2019 on all three garbage container sites to ensure all areas were kept free of garbage/refuse. 3) Facility Administrator educated the Leadership Team: Director of Nursing, Nursing Administration, Admissions Director, Social services Director, Dietary Manager and his assistant, Medical records, Housekeeping Director, Maintenance director, Business Office Manager, Central Supply, and Activities Director along with all facility staff on 12/2/19 on the procedure for ensuring the garbage dumpsters and the areas around them remain free of garbage and refuse. The Maintenance Department,	12/5/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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 814	Continued From page 58 cleaning around the dumpster area was the responsibility of EVS staff. EVS director stated that he had been outside to dumpster area earlier on 11/7/19 and observed debris around the area. He reported that the area had since been cleaned up and was free of debris. EVS director reported that the area around the dumpster should be free of debris. EVS director reported that they are starting a daily cleaning process that will be undertaken by EVS staff, they are also working with Nursing and Dietary departments to ensure if something is seen on the ground, it is cleaned up.	F 814	Environmental Services, the Dietary department and Nursing will ensure all garbage and refuse is disposed of properly. 4) Environmental Services will begin conducting audits the week of December 2nd, 2019 of all three garbage sites for once a week for the first month; twice a month for the second month; and once a month for the third month. They will utilize the audit tool Garbage/Refuse audit tool to record all results accordingly. Results of audits will be brought to monthly Quality Assurance and Performance Improvement meeting each month for 3 months. Review and revisions will be made as necessary. The date of compliance is December 6th, 2019.	
F 867 SS=D	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 record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 11/29/18. This was for one recited deficiency that was originally cited in November 2018 and subsequently recited on the current recertification and complaint	F 867	1) On 12/5/2019 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Administrator, DON, MDS Coordinator, maintenance director, Central Supply, Dietary Manager, Assistant Dietary Manager, Social Services Director,	12/5/19

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F 867	Continued From page 59 investigation survey of 11/08/19. The recited deficiency was in the area of Accuracy of Assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F-641 Accuracy of Assessments: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 2 of 6 residents (Residents #19 and #45) identified as PASRR Level II. During the annual recertification survey of 11/29/18 the facility was cited for failure to accurately code MDS assessments for residents identified as Level II PASRR. During an interview on 11/08/19 at 4:52 PM, the Administrator indicated it was the responsibility of the Social Worker (SW) to code MDS assessments for residents identified as Level II PASRR. The Administrator stated she felt the system broke down when the previous SW resigned her position and for a period of time, the facility did not have a dedicated person responsible for keeping track of residents' Level II PASRR in order to accurately code MDS assessments.	F 867	Activities Director and Housekeeping Supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. 2) Corrective action has been taken for the identified concerns related to F641-accuracy of assessments 3) On 12/5/2019 the Regional Vice President of Operations in-serviced the administrator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F-641. On 12/5/19 the administrator in-serviced the department heads related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641-accuracy of assessments. 4) The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns b they executive QAPI committee with timing and revision.	

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F 867	Continued From page 60	F 867	The executive QAPI committee will continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator is responsible for implementation of the acceptable plan of correction.	