STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	C 10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 observations and staff interviews the facility failed to make reasonable accommodations of needs for one of four residents investigated for functional call lights (Resident #68). The findings included: Resident #68 was originally admitted to the facility on 4/16/16 and was most recently readmitted on 10/10/18. The resident's cumulative diagnoses included: Diabetes, quadriplegia (paralysis of both legs and both arms), anxiety, and heart failure. A review was completed of Resident #68's most recent Minimum Data Set (MDS). The review revealed a quarterly assessment with an Assessment Reference Date (ARD) of 9/29/18. The resident was coded as having required extensive assistance of two people for bed mobility. The resident was coded as having been totally dependent on one to two people for the following Activities of Daily Living (ADLs): dressing, eating, toilet use, personal hygiene, and bathing. A review was completed of Resident #68's care plan which was most recently reviewed on 9/30/18. The review revealed the resident had	F 558	Richmond Pines Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Healthcare and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Healthcare and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F 558 How corrective action will be accomplished for those residents found to	11/15/18

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

Electronically Signed | 11/08/2018

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F 558	Continued From page 1 several Focus areas related to the resident having been a quadriplegic and requiring total care including: Bathing, personal hygiene, dressing, eating, transferring (such as from the bed to a wheelchair), mobility, and toileting. Review of Resident #68's Care Guide, which was last reviewed on 9/30/18, revealed the listed interventions of aid of two people, feed resident, and encourage to call for assistance. An interview was conducted in conjunction with an observation of Resident #68 and Resident #68's call light was conducted on 10/15/18 at 12:20 PM. The observation revealed the resident's standard button call light was on the night stand and the resident was resting in the bed. The resident stated he could not use his hands, but he could move his hands. The resident stated he was unable to use the call light button. The resident further stated when he needed the nurse he would either wait for the nurse to come to the room or call out for the nurse. An observation of Resident #68 and Resident #68's call light was conducted on 10/15/18 at 3:50 PM. The observation revealed the resident's standard button call light was on the night stand and the resident was resting in the bed. The call light was observed to be out of reach of the resident. An observation of Resident #68's call light was conducted during a round on 10/16/18 at 3:16 PM. Resident #68's standard button call light was observed sitting on the resident's night stand out of the resident's reach.	F 558	have been affected by the deficient practice On 10/17/18, the maintenance director ordered a soft touch call pad for Resident #68's use. On 10/18/18, the maintenance director received the soft touch call pad and installed it in Resident #68's room. On 10/18/18, Resident #68 was able to demonstrate use of the soft touch call pad. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/9/18, the minimum data set (MDS) nurse and director of nursing (DON) reviewed resident care plans to identify residents requiring reasonable accommodations relating to call lights and the type of call light needed. On 11/9/18, the DON instructed the nurse unit manager and the maintenance director to audit the rooms of residents requiring alternative call lights and ensure: 1) the correct call light type was in the room and accessible and 2) the alternative style call light was in working order. The audit revealed residents identified as needing an alternate style call light had the preferred call light in place and it was in working order. On 11/9/18, the interdisciplinary team (IDT) began identifying other residents requiring reasonable accommodations of	

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F 558	Continued From page 2 An observation of Resident #68's call light was conducted during a round on 10/17/18 at 9:59 AM. Resident #68's standard button call light was observed sitting on the resident's night stand out of the resident's reach. An observation of Resident #68's call light was conducted in conjunction with an interview with Nursing Assistant (NA) #4 on 10/17/18 at 10:35 AM. Resident #68's standard button call light was observed sitting on the resident's night stand out of the resident's reach. The NA stated she had taken care of Resident #68 and was familiar with him. The NA stated the resident was able to turn on his call light and tell you what he needed. The NA then stated the resident did not use the call light button but used a manual countertop metal tap bell. The NA was observed to put the tap bell on the over the bed table and position the table and tap bell to the left of the resident. An interview was conducted with Nurse #1 on 10/17/18 at 10:38 AM. The nurse stated Resident #68 needed a padded call light, such as a soft touch call light. The nurse stated he thought he had had a soft touch call light in the past. The nurse stated she was going to see about getting the resident a soft touch call light for the resident to use. An interview was conducted with NA #6 on 10/17/18 at 10:41 AM. The NA stated Resident #68 had had a padded/soft touch call light in the past and he could use his are or elbow to ring the call light. An interview was conducted with the Director of Nursing (DON) on 10/17/18 at 10:44 AM. The DON stated Resident #68 normally would call out	F 558	needs for functional call lights by assessing new admissions/ re-admissions. The IDT consists of the administrator, DON, nursing unit manager, MDS nurse, social services director, activities worker, therapy representative, and/or admissions director. The completion of the Nursing Admission and Re-Entry Evaluation will be utilized to document identified reasonable accommodation of needs for newly admitted/ re-admitted residents, including use of an alternative call light. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 10/17/18, the administrator instructed the maintenance director to order additional soft touch call lights to ensure there are extra in stock to meet resident needs for reasonable accommodations. The administrator and maintenance director agreed there should be a back-up soft touch call light for residents using soft touch call lights and an extra soft touch call light in case there is a new need for use of a soft touch call light by another resident (current, new admission, or re-admission). On 11/9/18, the administrator, DON, nursing unit managers, social services director, admissions director, and/or weekend manager on duty began reporting to the IDT any resident unable to	

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F 558	Continued From page 3	F 558		

when he had wanted to let the facility staff know he needed something. The DON stated the resident had had a soft touch call light button. The DON explained the resident had been discharged to the hospital and while at the hospital another resident had been admitted who had also needed a soft touch call light button. The DON stated soft touch call light button had been removed from Resident #68's room and given to the new resident. The DON further explained when Resident #68 had returned from the hospital there were no more soft touch call lights for him to use. The DON stated it was her expectation for a resident to have a call light mechanism which would allow the resident to independently notify the nurse.

A round and observation was conducted in conjunction with an interview with the Maintenance Director (MD) on 10/17/18 at 4:18 PM. Resident #68 was observed to have had a standard button call light. The MD stated a soft touch call light button had been ordered for the resident and it was scheduled to arrive via overnight delivery on 10/18/18. The MD stated he was not aware Resident #68 had returned from the hospital and there were no more soft touch call lights available in the facility when he returned from the hospital.

An interview was conducted with the Administrator on 10/18/18 at 9:16 AM. The Administrator stated it was his expectation for an appropriate call light, such as a soft touch call light, to be available for resident use.

An observation and interview were conducted with the MD on 10/18/18 at 11:10 AM. The MD stated the soft touch call light had been delivered

use the standard call light button as noted during administrative rounds. Upon notification, the DON and/or MDS nurse will assess the resident, update the resident's care plan, and offer an alternative style call light to accommodate the individual resident's call light needs.

On 11/9/18, the admissions director, DON, nursing unit manager, and/or social services director will begin notification of the need for alternative style (other than standard push button) call lights to the maintenance director during the morning IDT meeting. The notification will include the specific alternate style required. The maintenance director will ensure alternative style call light is installed promptly and give report at the afternoon IDT meeting.

How the facility plans to monitor its performance to make sure that solutions are sustained

On 11/9/18, the nursing unit manager began weekly monitoring of the availability of extra call lights and alternative style call lights. The unit manager will report the monitoring results to the DON weekly. The DON will determine if current inventories are sufficient and if not, the DON will ensure additional call lights are ordered to meet the reasonable accommodations of resident needs.

On 11/9/18, the administrator and/or

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F 558	Continued From page 4 to the facility. The soft touch call light was observed in the MD's hands. The MD further stated he was going to install the soft touch call light for Resident #68 immediately.	F 558	social worker began weekly monitoring of resident grievances related to availability and proper working of call lights. The administrator will ensure any resident grievances related to the availability of properly working call lights is discussed at the IDT meeting; residents shall be provided a call light mechanism which would allow the resident to independently notify the nurse. On 11/9/18, the administrator and/or DON began weekly review of completed administrative rounds tools to identify any issues related to accommodating resident call light needs. The administrator/DON will immediately validate any identified issues related to resident call light needs are resolved through replacement or changing type of the call light. The DON and/or nursing unit manager will present IDT corrective actions and resident grievance corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Reasonable Accommodations Needs/Preferences related to call lights.	

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F 561	Continued From page 5	F 561		
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, observations, staff interviews, and resident interview, the facility failed to provide showers as scheduled for 1 of 2 residents reviewed for choices (Resident #54). Findings included:	F 561	F 561 Self-Determination How corrective action will be accomplished for those residents found to have been affected by the deficient practice	11/15/18

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F 561	Continued From page 6 Resident #54 was admitted on 11/19/15 with the diagnoses of urinary tract infection (UTI) and quadriplegia. The quarterly Minimum Data Set dated 9/12/18 revealed the resident had an intact cognition with other behavior which occurred 1 to 3 days in the week. The resident required extensive assistance of 2 staff for all activities of daily living (ADL) except locomotion was one staff. The active diagnoses were neurogenic bladder, UTI, and retention of urine. A review of the resident's shower sheets from 8/1/18 to date timeframe, which included two periods out of the facility in the hospital for approximately 8 days, revealed the resident received 5 showers and the remainder were full or partial bed baths on the scheduled shower day. The resident ' s shower was scheduled twice a week. A review of a grievance form dated 8/22/18 revealed the resident filed a concern that he wanted his shower. The resident was interviewed by the Director of Nursing (DON). Actions documented were the resident was showered (evening shift). A review of a documented facility concern form dated 8/23/18 by social work (SW) who was informed by the resident that he had not had a shower for 2 weeks. Nurses' note dated 8/31/18 resident requested a shower and was offered a shower after lunch; the resident was not happy with the delay.	F 561	On 10/16/18, the nursing assistants (NAs) interviewed Resident #54 regarding bathing preferences. On 10/16/18, the unit manager scheduled Resident # 54□s shower days for days chosen by the resident, Wednesdays and Fridays during first shift. On 10/16/18, the minimum data set (MDS) nurse verified Resident #54□s care plan reflected the resident□s bathing preferences in order to promote self-determination through choice of bathing preferences. On Tuesday 10/16/18 during first shift, the nursing assistant (NA) assisted Resident #54 with a shower, as requested by the resident that day. On Friday, 10/19/18, during first shift the NA assisted Resident #54 with a shower, according to the resident□s preferred bathing choices. How the facility will identify other residents having the potential to be affected by the same deficient practice By 11/12/18, the social worker, nurses, and unit managers completed interviews with all current residents with a BIMS (Brief Interview for Mental Status) of 9 or higher for shower preferences and scheduled the residents per their individual shower preferences. Beginning 11/14/18, the admissions	

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F 561	Continued From page 7 The care plan dated 9/13/18 revealed goals and interventions for ADLs, personal hygiene, (refused care/showers at times, intervention to encourage), toileting, behavior secondary to ineffective coping, urinary tract infections with urosepsis, chronic pain, and at risk for skin breakdown. On 10/15/18 at 12:48 pm an observation of the resident was done, and a sour odor was noted. The resident was in his bed semi-reclined. His hair appeared shiny. On 10/15/18 at 12:48 pm an interview was conducted with the resident who stated he had not received his showers as scheduled; he had received bed baths. The resident just returned from the hospital after being treated for a UTI and was still receiving antibiotics. The resident stated that he had a bed bath today. The resident's pain was under control with current pain medication. The resident stated that he preferred a shower and had made the staff aware of his preference for months. On 10/16/18 at 9:50 am an observation of the resident revealed he was sleeping and not ready for morning care which was accommodated. No strong or unusual odor at this time was identified. On 10/16/18 at 9:50 am an interview was conducted with the resident who stated he was not ready to get up and had informed the nursing assistant (NA). On 10/16/18 at 10:15 am an interview was conducted to check back with the resident ' s assigned Nurse #1 who stated NA #1 went in to check and see if the resident was ready to get	F 561	director, nursing unit manager, or social services director will interview new admission residents or the resident□s representative regarding bathing choices, including preferred bathing type, days, and times then ensure the resident is scheduled accordingly. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/7/18, the DON initiated a re-education for the NAs on: 1) the shower schedule, 2) documentation of completed showers and refusals, and 3) the process of reporting completion of showers to the nurse responsible for the resident prior to the end of the shift. After 11/14/18, no NA will work until the re-education is completed. After 11/14/18, newly hired NAs, nurses, and agency NAs and nurses will receive this education during orientation to the facility. On 11/14/18, the NAs will document showers provided and resident refusals. The NA will notify the nurse of completed showers, resident refusals, and showers needing completion on the next shift. If a resident refuses a shower, the nurse will confirm the refusal by interviewing the resident then document the resident□s refusal in the resident□s electronic health record.	

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F 561	Continued From page 8 washed and out of bed, but he declined and wanted to "sleep." Nurse #1 stated that she was getting ready to speak with the resident and see if he would allow personal care. Nurse #1 stated she asked the resident if he would allow care and he stated he was not feeling well that he had a lot of pain. Nurse #1 informed the resident it was not time for his next scheduled medication and that after the 11:00 am administration of pain medication the NA would return and ask if he would accept care. On 10/16/18 at 11:30 am the Director of Nursing (DON) was made aware of the resident's delay in accepting care due to uncontrolled pain and was waiting for the next scheduled dose time. On 10/16/18 at 12:00 an interview was conducted with Nurse #1 who stated the resident had his pain medication at 11:00 am, had pain relief, and agreed to and received a shower at 12:00 pm. On 10/17/18 at 10:30 am an interview was conducted with NA #1 who was assigned to the resident and stated the resident liked to have his scheduled shower and rarely refused his shower. NA #1 also commented that she was not aware that the resident did not receive his shower when scheduled. The NA was also aware that the resident sometimes postponed his shower to the afternoon when he had pain in the morning. On 10/17/18 at 12:00 pm an observation was done of the resident who received a full bed bath by NAs #1, #2, and #3. NAs #1 and #3 provided the turning and holding of the resident ' s stiff legs while NA #2 performed the bed bath. No concerns for the bed bath.	F 561	How the facility plans to monitor its performance to make sure that solutions are sustained Beginning 11/14/18, the nursing unit manager, wound nurse, MDS nurse, DON, weekend supervisor, and/or corporate consultant will begin daily monitoring of bathing. The monitoring will include: 1) review of documentation for the completion of showers, 2) documentation of resident refusals, and 3) interviews with residents/resident representatives. The nursing unit manager, wound nurse, MDS nurse, DON, and/or weekend supervisor will immediately address concerns if bathing is not documented or if a resident is refusing bathing. The monitoring process will continue for a minimum of 12 weeks. Beginning 11/14/18, the nursing unit manager, wound nurse, desk nurse, and/or staff nurse will begin audits of bathing documentation 3 times a week for 4 weeks, then weekly for 8 weeks. The nursing unit manager or desk nurse will communicate the results of the audit to the DON. The nursing unit manager and/or DON will present the findings of the audits to the interdisciplinary team (IDT) for recommendations and corrective actions. The nursing unit manager and/or DON will present IDT corrective actions and resident grievance corrective actions to the monthly quality improvement (QI) committee for review, identification of	

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F 561	Continued From page 9 On 10/18/18 at 2:30 pm an interview was conducted with the DON who stated she expected staff to provide scheduled showers unless refused. If a shower was refused, the NA was expected to inform the assigned nurse.	F 561	trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of self-Determination related to providing bathing assistance as preferred by the resident or resident representative.	
F 571 SS=B	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35.	F 571		11/15/18

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(B) Food and Nutrition services as required at §483.60.
(C) An activities program as required at §483.24(c).
(D) Room/bed maintenance services.
(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.
(F) Medically-related social services as required at §483.40(d).
(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
(A) Telephone, including a cellular phone.
(B) Television/radio, personal computer or other electronic device for personal use.
(C) Personal comfort items, including smoking

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materials, notions and novelties, and confections.
(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
(E) Personal clothing.
(F) Personal reading matter.
(F) Gifts purchased on behalf of a resident.
(H) Flowers and plants.
(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).
(J) Non-covered special care services such as privately hired nurses or aides.
(K) Private room, except when therapeutically required (for example, isolation for infection control).
(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.
(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.
(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.
(iii) Requests for items and services.
(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
(B) The facility must not require a resident to request any item or service as a condition of

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F 571	Continued From page 12 admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to ensure a Medicaid resident was not charged for routine hair trimming for 1 of 1 sampled residents (Resident #77). The findings included: Resident #77 was initially admitted to the facility on 9/19/12 and most recently readmitted on 10/5/18. Resident #77 ' s current payor source was Medicaid. The quarterly Minimum Data Set (MDS) assessment dated 8/13/18 indicated Resident #77 ' s cognition was fully intact. The Resident Council minutes dated 9/27/18 indicated under the "New Business" section that Resident #77 asked if one haircut per month was free for the residents. An interview was conducted with Resident #77 on 10/15/18 at 4:00 PM. She confirmed she had asked about haircuts at the September 2018 Resident Council meeting. She stated she brought this up at the meeting because a friend of hers had informed her that she gets one haircut per month free at her facility. Resident #77 stated that she had been residing at this facility for several years and that she was charged for	F 571	F 571 Limitations on Charges to Personal Funds How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 11/9/18, the administrator and director of nursing (DON) met with Resident # 77 to clarify the hair trimming services provided for Medicaid recipients and services provided in beauty shop by licensed beauticians. The Resident #77 chose to continue utilizing the services of the licensed beautician rather than nursing providing routine hair trimming. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/25/18, the DON in-serviced the nursing staff (licensed nurses, nursing assistants, geriatric care assistants, and agency staff) that nursing staff will provide hair trimming and hair care services free of charge. The staff facilitator will provide the education to newly hired nursing and	

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F 571	Continued From page 13 routine haircuts. An interview was conducted with the Social Worker (SW) on 10/16/18 at 2:28 PM. The Resident Council minutes dated 9/27/18 related to Resident #77 ' s inquiry about haircuts was reviewed with the SW. The SW stated she had spoken with Resident #77 and told her that the facility had not provided free haircuts. She then revealed she was unaware that routine hair trimming was considered a basic hygiene service that was covered by Medicaid with no charge to the resident. An interview was conducted with the Director of Nursing (DON) on 10/16/18 at 4:00 PM. The DON revealed she was unaware that routine hair trimming was considered a basic hygiene service that was covered by Medicaid with no charge to the resident. She confirmed that this service was not being provided to all Medicaid residents. She acknowledged that Resident #77 ' s payor source was Medicaid and that routine hair trimming was not being provided to her at no charge. The DON stated that she expected the regulation to be followed and that she was going to inform the residents and Responsible Parties of this information.	F 571	agency staff during orientation to the facility. On 11/6/18, the social services director mailed written notification to resident representatives. The written notifications informed the resident representatives that they can have nursing staff trim or do hair care for a resident without charge to the resident. On 11/14/18, the social services director provided information to the resident council. The social services director educated the residents that they can have nursing staff trim or do hair care, if requested, without charge to the resident. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/14/18, the social services director began informing newly admitted residents/resident representatives that nursing staff will, if requested, provide hair trimming and hair care services free of charge. The social services director will also inform new admissions of other routine hair services provided at the center. On 11/14/18, the social services director and/or administrator began monitoring resident grievances for issues related to Medicaid residents being charged for routine hair trimming or hair care services.	

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F 571	Continued From page 14	F 571	How the facility plans to monitor its performance to make sure that solutions are sustained On 11/14/18, the social services director began quarterly monitoring of Medicaid residents to ensure residents are not charged for routine hair trimming and newly admitted residents/resident representatives are aware that nursing staff will, if requested, provide hair trimming and hair care services free of charge. The social services director will complete the monitoring for 12 weeks. The social services director will report any identified issues to the DON and/or administrator. The social services director and/or DON will present any issues related to Medicaid residents being charged for routine hair trimming to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The social services director and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Limitations on Charges to Personal Funds related to routine hair trimming and hair care services.	

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F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		11/15/18

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F 584	Continued From page 16 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and functional environment as evidenced by failure to maintain resident cabinetry for five of ten rooms (Rooms 403, 405, 406, 407, and 408), maintain intact sheetrock for four of ten rooms (Rooms 212, 403, 405, and 407), cover fluorescent tube lighting in two of nine rooms (Rooms 406 and 421) and one of two medication rooms (dementia unit medication room), and keep bathroom exhaust vents free of dust build up in three of nine rooms (Rooms 302, 406, and 408) reviewed for environment. Findings included: 1. Observations conducted during a round on 10/15/18, which started at 10:24 AM, revealed the following rooms had peeling laminate from the resident closet cabinetry which exposed the wooden framework: 403, 405, 407, and 408. Observations conducted during a round on 10/16/18, which started at 3:16 PM, revealed the following rooms had peeling laminate from the resident closet cabinetry which exposed the wooden framework: 403, 405, 407, and 408. Observations conducted during a round on 10/17/18, which started at 9:59 AM, revealed the following rooms had peeling laminate from the resident closet cabinetry which exposed the wooden framework: 403, 405, 407, and 408. An interview was conducted with Nurse #1 on	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 11/9/18, the maintenance director repaired the cabinetry in rooms #403, #405, #406, #407, and #408. On 11/9/18, the maintenance director repaired the sheetrock in rooms #212, #403, #405, and #407. On 11/9/18, the maintenance director replaced the cover for the fluorescent tube lighting in rooms #406 and #421. On 11/9/18, the maintenance director repaired the light fixtures in the dementia unit medication room. On 11/9/18, the maintenance director cleaned the bathroom exhaust vents in rooms #302, #406, and #408. How the facility will identify other residents having the potential to be affected by the same deficient practice	

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F 584	Continued From page 17 10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders. A round was conducted in conjunction with an interview with the Maintenance Director (MD) along with observations of rooms 403, 405, 406, 407, and 408, on 10/17/18 at 4:18 PM. Observations were made of the resident cabinetry in the rooms revealed peeling laminate which exposed the wooden framework. The MD stated the cabinets were delaminating and the delaminating had needed to be addressed. He stated cabinets in some other resident rooms had been repaired/replaced but he did not have a schedule for repair/replacement of the cabinets in the rooms observed. At the completion of the round conducted on 10/17/18 at 4:18 PM the MD demonstrated how the work orders were categorized and documented in the work order software program. A review of recent work orders was completed, back to August 1, 2018. The review revealed no submitted work orders documenting the peeling laminate of the resident cabinetry. An interview was conducted with the administrator on 10/18/18 at 9:16 AM. The Administrator stated it was his expectation for the resident cabinetry to have been intact. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for	F 584	On 11/9/18, to protect other residents, the Maintenance Director performed an observation audit of the 55 remaining rooms for needed cabinetry repairs, sheetrock repairs, lighting repairs, and vent cleaning. The results of the audit revealed 13 rooms needing laminate repairs, 25 room needing minor sheetrock repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light cover repairs were completed on 11/15/18. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/1/18, the director of nursing initiated an in-service with licensed nurses, nursing assistants, geriatric care assistants, and agency staff. The in-service reviewed the process for completing and submitting work orders for repairs to include furniture, light fixtures, and vents. The in-service was completed 11/14/18. After 11/14/18, no licensed nurse, nursing assistant, geriatric care assistant, or agency staff will work until the re-education is completed. After 11/14/18, the staff facilitator will educate all newly hired licensed nurse, nursing assistant, geriatric care assistant, and agency staff on the work order process, during orientation to the facility. On 11/13/18 the maintenance director formulated a prioritized repair calendar. On 11/13/18, the maintenance director	

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F 584	Continued From page 18 the maintenance department would be completed. Upon maintenance being made aware of the identified maintenance issue through the work order, the maintenance department would be able to complete the necessary repairs. 2. Observations conducted during a round on 10/15/18, which started at 10:24 AM, revealed the following: Room 212 had an approximate 12 inch by 12 inch scuffed area on the wall to the left of the resident's bed where the sheetrock paper had been scraped off exposing unpainted sheetrock; Room 403 had sheetrock where the paper had bubbled and had come loose from the sheetrock above the television next to the resident cabinetry on the ceiling; Room 405 had peeling paint and exposed sheetrock paper on the wall behind the vanity sink; Room 407 had torn sheetrock paper and a hole in the ceiling, approximately the size of a nickel, above the television located between the resident cabinetry. Observations conducted during a round on 10/16/18, which started at 3:16 PM, revealed the following: Room 212 had an approximate 12 inch by 12 inch scuffed area on the wall to the left of the resident's bed where the sheetrock paper had been scraped off exposing unpainted sheetrock; Room 403 had sheetrock where the paper had bubbled and had come loose from the sheetrock above the television next to the resident cabinetry on the ceiling; Room 405 had peeling paint and exposed sheetrock paper on the wall behind the vanity sink; Room 407 had torn sheetrock paper and a hole in the ceiling above the television located between the resident cabinetry. Observations conducted during a round on 10/17/18, which started at 9:59 AM, revealed the	F 584	and maintenance assistants began completing the repairs and maintenance tasks in order of priority. The identified repairs were completed 11/14/18. How the facility plans to monitor its performance to make sure that solutions are sustained On 11/14/18, the department heads (administrator, director of nursing, unit managers, social services director, activities director, bookkeepers, payroll, maintenance, environmental services, and dietary manager) began weekly compliance monitoring rounds to ensure a clean and functional environment. The department heads will document findings on the Compliance Monitoring rounds tool for 12 weeks. Identified issues will be immediately addressed by the department head and reported to the administrator, maintenance director, and/or environmental services director. The maintenance director and environment services director will present any issues related to a safe, clean, comfortable, and homelike environment to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The maintenance director, environmental services director, and/or administrator will present trends and QI committee recommendations to the quarterly quality assurance and	

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following: Room 212 had an approximate 12 inch by 12 inch scuffed area on the wall to the left of the resident's bed where the sheetrock paper had been scraped off exposing unpainted sheetrock; Room 403 had sheetrock where the paper had bubbled and had come loose from the sheetrock above the television next to the resident cabinetry on the ceiling; Room 405 had peeling paint and exposed sheetrock paper on the wall behind the vanity sink; Room 407 had torn sheetrock paper and a hole in the ceiling above the television located between the resident cabinetry.

An interview was conducted with Nurse #1 on 10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders. The nurse stated the hole in the ceiling in room 407 had been there months and it was from the water leaks. The nurse stated she had not written a work order for the hole in the ceiling or the torn sheetrock in room 407.

A round was conducted in conjunction with an interview with the Maintenance Director (MD) along with observations of rooms 212, 403, 405, and 407 on 10/17/18 at 4:18 PM. The following was observed during the round: Room 212 had an approximate 12 inch by 12 inch scuffed area on the wall to the left of the resident's bed where the sheetrock paper had been scraped off exposing unpainted sheetrock; Room 403 had sheetrock where the paper had bubbled and had come loose from the sheetrock above the television next to the resident cabinetry on the ceiling; Room 405 had peeling paint and exposed sheetrock paper on the wall behind the vanity

performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of the facility maintaining a safe, clean, comfortable, and homelike environment for the residents.

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sink; Room 407 had torn sheetrock paper and a hole in the ceiling above the television located between the resident cabinetry. The MD stated the resident in room 212 often stayed in the bed and he had not been able to get into the room to repair the drywall when the resident was not in the room. The MD stated the damage to the sheetrock and the sheetrock paper had needed to be addressed.

At the completion of the round conducted on 10/17/18 at 4:18 PM the MD demonstrated how the work orders were categorized and documented in the work order software program. A review of recent work orders was completed, back to August 1, 2018. The review revealed no submitted work orders documenting the holes in sheetrock or damaged sheetrock.

An interview was conducted with the administrator on 10/18/18 at 9:16 AM. The Administrator stated it was his expectation for the sheetrock to have been intact. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for the maintenance department would be completed. Upon maintenance being made aware of the identified maintenance issue through the work order, the maintenance department would be able to complete the necessary repairs.

3. An observation conducted on 10/15/18 at 11:44 AM revealed exposed florescent tube lighting with no protective tubing or lens cover in the over the bed light in room 406 for the bed nearest the window. There were two residents who resided in room 406 at the time of the observation.

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Observations conducted during a round on 10/16/18, which started at 3:16 PM, revealed the following: Exposed florescent tube lighting with no protective tubing or lens cover in the over the bed light in room 406 for the bed nearest the window; exposed florescent tube lighting in the ceiling light over the bed closest to the door in room 421. There were two residents residing in room 421 at the time of the observation.

An observation conducted of the dementia unit medication room was conducted on 10/17/18 at 8:34 AM. The observation revealed three of the four florescent tubes were exposed and were not protected by a lens cover or plastic tubing.

Observations conducted during a round on 10/17/18, which started at 9:59 AM, revealed the following: Exposed florescent tube lighting with no protective tubing or lens cover in the over the bed light in room 406 for the bed nearest the window; exposed florescent tube lighting in the ceiling light over the bed closest to the door in room 421.

An interview was conducted with Nurse #1 on 10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.

A round was conducted in conjunction with an interview with the Maintenance Director (MD) along with observations of rooms 406 and 421 on 10/17/18 at 4:18 PM. Observations were made of the exposed florescent tube lighting with no protective tubing or lens cover in the over the bed

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light in room 406 for the bed nearest the window and the exposed florescent tube lighting in the ceiling light over the bed closest to the door in room 421. An additional observation was made of the ceiling lights in the medication of the dementia unit. The observation revealed three of the four florescent tubes did not have a lens cover or protective tubing. The MD stated florescent tube lights should have had a lens cover or plastic tubing over the florescent glass tubes.

At the completion of the round conducted on 10/17/18 at 4:18 PM the MD demonstrated how the work orders were categorized and documented in the work order software program. A review of recent work orders was completed, back to August 1, 2018. The review revealed no submitted work orders documenting the peeling laminate of the resident cabinetry.

An interview was conducted with the administrator on 10/18/18 at 9:16 AM. The Administrator stated it was his expectation for fluorescent glass tubing to be protected. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for the maintenance department would be completed. Upon maintenance being made aware of the identified maintenance issue through the work order, the maintenance department would be able to complete the necessary repairs.

4. An Observation conducted on 10/15/18 at 10:02 AM revealed a dust build up on the exhaust vent in the bathroom of room 302.

An Observation conducted on 10/15/18 at 11:44

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F 584	Continued From page 23 AM revealed a dust build up on the exhaust vent in the bathroom of room 406. An Observation conducted on 10/15/18 at 12:20 PM revealed a dust build up on the exhaust vent in the bathroom of room 408. Observations conducted during a round on 10/16/18, which started at 3:16 PM, revealed the following rooms had a dust build up on the exhaust vent in the resident bathrooms: 302, 406, and 408. Observations conducted during a round on 10/17/18, which started at 9:59 AM, revealed the following rooms had a dust build up on the exhaust vent in the resident bathrooms: 302, 406, and 408. A round was conducted in conjunction with an interview with the Maintenance Director (MD) along with an observation of the bathroom in room 406 on 10/17/18 at 4:18 PM. The observation revealed the bathroom exhaust vent had a dust build up. The MD stated it was the maintenance department's responsibility to ensure the bathroom exhaust vents were clean. The MD further stated the exhaust vent in the bathroom of room 406 needed to be cleaned so it would be free of a dust build up. An interview was conducted with the administrator on 10/18/18 at 9:16 AM. The Administrator stated it was his expectation for the resident bathroom exhaust vents to have been free of a dust build up.	F 584		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		11/15/18

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F 585	Continued From page 24 §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. §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	F 585		

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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 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

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F 585	Continued From page 26 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 a written grievance summary for one of one resident reviewed for grievances (Resident #4). Findings include: Resident #4 was originally admitted on 1/4/16 and was most recently readmitted on 5/23/18. The resident was discharged to the hospital on 10/10/18 and did not return to the facility. The resident's diagnoses included: Dementia, generalized weakness, and difficulty swallowing, difficulty speaking. Review of Resident #4's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 7/3/18. The resident was coded as having had severe cognitive impairment. The resident was coded as having required assistance of one to two people for all Activities of Daily Living (ADLs).	F 585	F 585 Grievances How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 11/9/18, the social services director mailed a written grievance summary to Resident #4□s resident representative. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/9-14/18, the administrator reviewed the grievance concern log for completion of the resolution process. The administrator audited grievances filed from 10/1/18 through 11/14/18. The audit revealed only one (1) grievance filed was	

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F 585	Continued From page 27 A review was completed of a Facility Concern/Grievance Form with a date received of 10/7/18 for Resident #4 which had been initiated by a family member. Review of the Concern/Grievance Form revealed the investigation findings were reported to the family member voicing the concern via phone. Further review revealed the Administrator had signed the Concern/Grievance Form as having been complete on 10/15/18. An interview was conducted with the Social Worker (SW) on 10/17/18 at 11:26 AM regarding the grievance filed by the family member of Resident #4. The SW stated the follow up for grievances, most of the time, was through verbal communication. The SW further stated follow up for grievances was often completed "just in passing" and asking the filing party if everything was OK. The SW stated the grievance filed by the family member of Resident #4 was related to a nursing matter and she had not provided follow up for the grievance filed by the family member of Resident #4 on 10/7/18. An interview was conducted with the Administrator and the Director of Nursing (DON) on 10/17/18 at 11:33 AM. During the interview the DON stated she had had phone conversations with the family member of Resident #4 including on 10/7/18. The DON stated she had verbal conversations with the family member who had filed the grievance and other family members between the date the grievance was filed, 10/7/18, and the date the resident was discharged to the hospital, 10/10/18. The DON stated a written response was not provided to the family of the resident regarding the grievance. The Administrator stated it was	F 585	closed with providing a written grievance summary follow-up to the resident/resident representative. To protect other residents having the potential to be affected, the facility will provide a written grievance summary for all residents. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On or before 11/14/18, the corporate consultant in-serviced the social services director, director of nursing and administrator on the Resident Concerns and Grievance Guidelines process. The in-service included the facility will provide written response to the resident/resident representative speaking on behalf of the resident who file a grievance; a request for a written response is not required. The written response will include the date the grievance was received, a brief description of the grievance, a brief description of findings of investigation and any corrective action. On 11/14/18, the social services director and/or the administrator began reviewing grievances during the morning interdisciplinary team (IDT) meeting to ensure resolutions and actions taken will be communicated to the resident, including a written grievance response. On 11/14/18, the administrator began	

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F 585	Continued From page 28 not the facility's policy to provide a written response to provide a written grievance decision regarding the filed grievance. During an interview conducted with the Administrator and DON on 10/17/18 at 5:55 PM, both the Administrator and the DON stated it was their expectation to follow the regulation for grievances.	F 585	reviewing the grievance concern log weekly and will ensure all grievances completed include written responses to the resident/resident representative. How the facility plans to monitor its performance to make sure that solutions are sustained Beginning on 11/14/18, the social services director and/or administrator will present any issues related resident grievances to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The social services director and/or administrator will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of the grievances.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		11/15/18

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F 600	Continued From page 29 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility neglected to provide supervision and to manage the physical behaviors of cognitively impaired residents for 2 of 2 residents (Residents #10 and #56) reviewed for neglect. This failure resulted in Resident #10 initiating physical altercations with 5 cognitively impaired residents (Residents #8, #18, #26, #74, and #329) and Resident #56 slapping a cognitively impaired resident (Resident #18) twice in a 40-minute time period. The findings included: 1. Resident #10 was admitted to facility on 12/21/17 with diagnoses that included dementia without behavioral disturbance, psychosis, mood disorder, and anxiety. The 14-day Minimum Data Set (MDS) assessment dated 4/17/18 indicated Resident #10 had short-term and long-term memory problems and severely impaired decision making. She had no behaviors during the MDS review period. Resident #10 required the extensive assistance of 1 for bed mobility. She required supervision of 1 for transfers, walking in room, walking in corridor, and locomotion on/off the unit. Resident #10 was not steady on her feet, but she was able to stabilize without staff assistance.	F 600	How corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident # 10 has had decreased episodes of agitation with increased supervision and continued routine psychiatric consults, most recently on 10/26/2018. The Resident #56 has had decreased episodes of agitation with increased supervision and continued routine psychiatric consults, most recently on 10/26/2018. How the facility will identify other residents having the potential to be affected by the same deficient practice Beginning 10/18 through 10/22/2018 Minimum Data Set (MDS) Nurse, Director of Nursing, Unit Managers and Desk Nurse audited 100% of current resident□s progress notes for unreported evidence of abuse or neglect for the previous 30 days without negative findings. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Nursing staff on the dementia unit were in-serviced by the DON on 10/18/18 on supervision of residents to prevent	

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F 600	Continued From page 30 She had no impairment with range of motion and she utilized a wheelchair. The plan of care for Resident #10 included the focus area, "Problematic manner in which resident acts characterized by ineffective coping; agitation/combativeness related to: dementia. Swings, hits at staff and has period of crying. Resident has a [history] of hitting others, grabbing others, and accusing others of ' running around ' with her husband." This focus area was initiated on 12/22/17. The interventions for Resident #10 included, in part, being careful not to invade her personal space (initiated on 12/22/17), behavior management/psychiatric consultation as needed (initiated on 12/22/17 and revised on 2/1/18), and to give resident an item or task in an attempt to distract (initiated on 4/27/18). The plan of care for Resident #10 also included the focus area, "Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression and combativeness related to: [history] of dementia. Resident has reports of being physically and verbally abusive to staff and other residents ...". This focus area was initiated on 12/27/17. The interventions for Resident #10 included, in part, allow resident to pace where she can be observed (initiated on 12/27/17 and revised on 1/25/18) and be cognizant of not invading her personal space (initiated on 2/1/18). a.) An incident report dated 4/29/18 completed by Nurse #2 indicated Nursing Assistant (NA) #6 reported that she heard residents arguing and upon entering the room she observed Resident #10 and Resident #74 hitting each other. Resident #10 was observed to slap Resident #74	F 600	reoccurrence, including non-pharmacological interventions for behavior management. The remaining Nursing staff will be re-educated by the DON or the Unit Managers by 11/15/18 on supervision of residents to prevent occurrences related to behaviors including non-pharmacological interventions. New hires and agency staff will receive this education during orientation to the facility. Facility staff will receive annual training on Abuse, Neglect, Misappropriation of Property that includes supervision of residents and management of physical behaviors of cognitively impaired residents. Training will be provided by the Staff Development Coordinator or the Director of Nursing. Residents exhibiting aggressive behaviors will be discussed in the next Interdisciplinary Team (IDT) meeting after the occurrence. Discussion will include notification of Medical Director, Resident Representative and whether interventions implemented are effective. How the facility plans to monitor its performance to make sure that solutions are sustained The DON will review the IDT form for behaviors for trending and tracking of residents repeat behaviors on a weekly basis for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions and reported abuse/neglect actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator	

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twice on the right side of her head. Resident #10 and Resident #74 were separated. Resident #10 was noted with a bruise on her right and left lower arms. Resident #74 had no injuries. (Resident #74's 4/1/18 annual MDS assessment indicated her cognition was severely impaired.)

A nursing note dated 4/29/18 completed by Nurse #2 indicated that Resident #10 and Resident #74 were separated and brought to the nurses' station after the physical altercation. Resident #10 was noted with purple colored bruises to her right and left forearm and a nail indentation on the left forearm.

A written statement dated 4/29/18 completed by NA #6 indicated she saw Resident #10 and Resident #74 grabbing each other's arms. Resident #10 stated, "she was going to beat [Resident #74's] ass" then Resident #10 slapped Resident #74 two times on the right side of her head. NA #6 indicated she then brought Resident #10 to Nurse #2 and explained the incident.

An interview was conducted with Nurse #2 on 10/17/18 at 11:00 AM. Nurse #2 stated she was familiar with Resident #10. She indicated Resident #10 had a history of behaviors that included physical behaviors directed at other residents. She reported Resident #10 was ambulatory and she walked up and down the hall of her unit, in the common areas, and in and out of resident rooms. She indicated that staff tried to prevent any physical altercations with Resident #10 and other residents by monitoring her whereabouts and redirecting her to the common areas or the nurses' station where she was easily observed. Nurse #2 confirmed she was working on 4/29/18 at the time of the physical altercation

and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Abuse/Neglect.

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between Resident #10 and Resident #74. She stated she was unable to recall any specific information about the incident.

An interview was conducted with NA #6 on 10/17/18 at 3:00 PM. NA #6 stated she was familiar with Resident #10. She stated that Resident #10 was ambulatory and spent most of the hours while she was awake walking up and down the hall and in the common areas. She confirmed she was working on 4/29/18 at the time of the physical altercation between Resident #10 and Resident #74. NA #6 revealed that 4/29/18 was the first time she had worked with Resident #10 and she was unaware of her history of physical behaviors at that time. She stated that she had been in another resident's room providing care when she heard two residents yelling at each other. She came out of the room and observed Resident #10 hit Resident #74 and then Resident #74 in turn hit Resident #10. She indicated the hitting occurred before she could get to the residents to separate them. She stated when she was able to separate the residents she informed Nurse #2 of the incident. NA #6 indicated she had only worked with Resident #10 a couple of times since then. She stated when she did work with Resident #10 she tried to keep her eyes on the resident and redirect her to areas where she was easily observed to prevent any physical altercations from occurring.

On 4/30/18 the care plan (initiated on 12/22/17) for Resident #10 related to agitation/combativeness was updated with the intervention, "Remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and

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provide diversional activity".

A Psychiatric Nurse Practitioner (PNP) note dated 5/1/18 indicated staff reported that Resident #10 continued to present with increased anxiety and agitation. Staff also noted that Resident #10 had become physically aggressive toward other residents.

A Nurse Practitioner (NP) note dated 5/3/18 indicated Resident #10 was involved in an altercation with another resident on her unit. Resident #10 was noted with agitation and combativeness toward others.

b.) An incident report dated 5/6/18 completed by Nurse #2 indicated NA #7 reported that Resident #10 hit Resident #18. (Resident #18's 4/12/18 significant change MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making.)

A nursing note dated 5/6/18 completed by Nurse #2 indicated Resident #10 hit another resident (Resident #18) on her forearm. The residents were separated, and no injuries were noted to either resident.

A written statement, undated, completed by Nurse #2 indicated NA #7 reported to her on 5/6/18 that Resident #10 hit Resident #18. The residents were separated, and Resident #10 was placed on 1 to 1 supervision until she went to bed. No injuries were observed to either resident.

A written statement dated 5/9/18 completed by NA #7 indicated she observed the incident on 5/6/18 between Resident #10 and Resident #18.

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NA #7 reported she walked up to the nurses' station and saw Resident #10 holding onto Resident #18's wheelchair. NA #7 asked Resident #10 to let go of the chair, but she wouldn't. NA #7 indicated that before she could go around the chair Resident #10 "popped" Resident #18 on her left hand. Resident #10 then walked off and went down the hall.

An interview was conducted with Nurse #2 on 10/17/18 at 11:00 AM. She confirmed she was working on 5/6/18 at the time of the physical altercation between Resident #10 and Resident #18. She stated she was unable to recall any specific information about the incident.

A phone interview was conducted with NA #7 on 10/17/18 at 4:55 PM. NA #7 indicated she currently worked at the facility infrequently on an as needed basis only. She stated she was familiar with Resident #10 and had worked with her a couple of times. She reported Resident #10 was ambulatory and she was normally walking about on her unit while she was awake. NA #7 confirmed she was working on 5/6/18 at the time of the physical altercation between Resident #10 and Resident #18. She reported she saw Resident #10 holding onto Resident #18's wheelchair and was trying to push her. She indicated she asked Resident #10 to let go of Resident #18's wheelchair, but she had not complied. She stated that she started to walk around to the front of Resident #10 to redirect her and get to her to release the wheelchair, but before she could do that Resident #10 hit Resident #18 on her hand. NA #7 reported that after that, Resident #10 walked away from Resident #18 on her own.

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c.) An incident report dated 5/13/18 completed by Nurse #3 indicated NA #8 informed her Resident #10 had been in a physical altercation with another resident (Resident #26). Resident #10 hit Resident #26 and then Resident #26 hit her back. (Resident #26 's 4/28/18 annual MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making).

A nursing note dated 5/13/18 completed by Nurse #3 indicated NA #8 reported Resident #10 slapped Resident #26 on the hand and Resident #26 then slapped her back on the hand. The residents were separated, and no injuries were observed.

A written statement dated 5/13/18 completed by NA #8 indicated she heard two residents (Resident #10 and Resident #26) arguing back and forth. She then looked for where the arguing was coming from and she observed Resident #10 hit Resident #26 on the hand. Resident #26 then hit Resident #10 back on the hand. NA #8 indicated she was able to separate the residents and reported to the nurse (Nurse #3).

A phone interview was conducted with Nurse #3 on 10/18/18 at 9:29 AM. Nurse #3 stated she had not worked with Resident #10 frequently, but she had on a few occasions. She indicated Resident #10 was ambulatory and could get up and down on her own. She stated Resident #10 could be lying in bed one minute and the next thing you knew she was up and walking about again. Nurse #3 confirmed she was working on 5/13/18 at the time of the physical altercation between Resident #10 and Resident #26. She stated that both residents were seated next to each other

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when NA #8 saw Resident #10 hit Resident #26. Resident #26 then in turn hit Resident #10 back before NA #8 could separate the residents.

An interview was conducted with NA #8 on 10/17/18 at 3:43 PM. NA #8 stated she was familiar with Resident #10. She reported Resident #10 had physical behaviors directed toward both staff and residents. She indicated Resident #10 was very active and she walked up and the hall and into other residents ' rooms almost the whole time she was awake. NA #8 confirmed she was working on 5/13/18 at the time of the physical altercation between Resident #10 and Resident #26. She indicated she heard Resident #10 and Resident #26 arguing so she started to walk over to them. She stated that before she could get to the residents to separate them, Resident #10 hit Resident #26 on her hand and Resident #26 hit her back on her hand. She indicated she then separated the residents and reported the incident to Nurse #3. NA #8 revealed it was very challenging at times to work with Resident #10 as you had to keep an eye on her at all times and needed to make sure she wasn't too close to any other residents to avoid any physical altercations.

On 5/14/18 the care plan (initiated on 12/27/17) for Resident #10 related to verbal/physical aggression was updated to include the intervention, "Remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity".

An NP note dated 5/15/18 indicated Resident #10 had been physically abusive to other residents on

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the unit. She was sent to the Emergency Department (ED) on 5/13/18 for psychiatric evaluation, but the ED provider had not felt Resident #10 would benefit from a psychiatric evaluation in the ED so she was transferred back to the facility.

A PNP note dated 5/15/18 indicated Resident #10 continued with increased anxiety and agitation. She was noted with physical aggression toward other residents. Medication adjustments were made by the PNP.

d.) An incident report dated 6/9/18 completed by Nurse #4 indicated NA # 9 informed her that Resident #10 walked up to another resident (Resident #8) and began to pull and hit him. No injuries were observed to either resident. (Resident #8 ' s 4/6/18 quarterly MDS assessment indicated he had short-term and long-term memory problems and severely impaired decision making.)

A written statement, undated, completed by NA #9 indicated Resident #8 was sitting in the hall when Resident #10 walked up to him and started to "pull and hit on him". Resident #8 started hit back.

A phone interview was attempted with Nurse #4 on 10/17/18 at 4:29 PM. Nurse #4 was unable to be reached. (Nurse #4 completed the incident report related to the 6/9/18 physical altercation between Resident #10 and Resident #8.)

A phone interview was attempted with NA # 9 on 10/17/18 at 4:30 PM. NA #9 was unable to be reached. (NA #4 completed the witness statement related to the 6/9/18 physical

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altercation between Resident #10 and Resident #8.)

A PNP note dated 6/13/18 indicated staff reported Resident #10 recently hit another resident. Staff also reported increased confusion, restlessness, and agitation. The PNP indicated Resident #10 was irritable and angry with staff. Medication adjustments were made by the PNP.

A PNP note dated 8/29/18 indicated Resident #10 had returned to her baseline following medication adjustments. She had intermittent crying spells, but no physical aggression or combative behaviors were reported by staff.

The annual MDS assessment dated 10/3/18 indicated Resident #10's cognition was severely impaired. She had other behavioral symptoms on 1 to 3 days during the MDS review period. Resident #10 required the extensive assistance of 1 for bed mobility and transfers. She required supervision of 1 for walking in room, walking in corridor, and locomotion on the unit. Resident #10 was not steady on her feet, but she was able to stabilize without staff assistance. She had no impairment with range of motion and she utilized a wheelchair.

e.) A nursing note dated 10/4/18 completed by Nurse #5 indicated NA #10 heard Resident #329 hollering "get out of my room". Resident #10 had entered Resident #329's room, grabbed her by the arm, and twisted her wrist backwards. Resident #10 was removed from Resident #329's room. Resident #329 had redness on her wrist and complained of mild pain when wrist was moved. An order was received for an x-ray of Resident #329's wrist.

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An incident witness statement dated 10/4/18 completed by NA #10 indicated she was setting up trays and heard Resident #329 hollering. Resident #10 had entered Resident #329's room and grabbed her hand and arm and started to twist.

A 24 hour and 5 working day report for an allegation of resident abuse related to the incident between Resident #10 and Resident #329 on 10/4/18 was reviewed. Resident #329 was in bed as NA # 10 provided care for her roommate. Resident #10 entered Resident #329's room and grabbed her on the wrist. NA #10 went over to intervene and tried to get Resident #10 to release Resident #329's wrist. Nurse #5 came into the room and assisted NA #10 with getting Resident #10 to release Resident #329's wrist. Resident #10 was then separated from Resident #329. A skin tear was noted to Resident #329's wrist. An x-ray was obtained of Resident #329's wrist and results were negative. Resident #329 was relocated to another hall way away from Resident #10. The allegation of resident abuse was substantiated.

An interview with the Social Worker on 10/18/18 at 10:15 AM indicated that she completed a Brief Interview of Mental Status (BIMS) for Resident #329 on 10/15/18 and her cognition was severely impaired.

A phone interview was conducted with Nurse #5 on 10/17/18 at 4:45 PM. Nurse #5 stated she was familiar with Resident #10. She indicated Resident #10 had physical behaviors directed toward other residents in the past. She reported that staff tried to make sure she wasn't too close

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to any other residents and for at least one staff member to keep their eye on her. She indicated that it could be difficult at times for staff to keep Resident #10 in their eyesight at all times because she moved about constantly. Nurse #5 confirmed she was working on 10/4/18 at the time of the physical altercation between Resident #10 and Resident #329. She stated she had heard yelling from Resident #329's room. She indicated she went to the room and she saw Resident #10 holding Resident #329's wrist. NA #10 was in the room and was trying to separate Resident #10 from Resident #329. Nurse #5 stated Resident #10 was able to be removed from Resident #329's room. She reported that Resident #329 had a skin tear on her wrist and an x-ray was ordered to ensure no further injury.

A phone interview was conducted with NA #10 on 4:15 PM. NA #10 indicated she was familiar with Resident #10. She stated Resident #10 was very active throughout the time she was awake. She reported Resident #10 walked around the common areas, the hall, and into resident rooms. She stated that Resident #10 had physical behaviors directed at other residents in the past. She indicated that staff tried to keep Resident #10 in their eyesight at all times to ensure no physical altercations occurred with any other resident. NA #10 explained that if she was providing care for one of her residents that the other NA on the unit or the nurse on the unit monitored Resident #10. She indicated there were always at least 2 NAs on the unit. She revealed it was sometimes difficult to monitor her at all times because she moved around constantly. NA #10 confirmed she as working on 10/4/18 at the time of the physical altercation between Resident #10 and Resident #329. She

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indicated she was in Resident #329's room setting up her meal tray when she heard yelling in the room. She stated she looked over and saw that Resident #10 had entered Resident #329 ' s room and grabbed her wrist and was twisting. She reported she went over to separate Resident #10 from Resident #329 and at that time Nurse #5 entered the room to assist her with separating the residents.

Resident #10 was observed on 10/15/18 at 12:30 PM ambulating with a shuffled gait a common room of the facility's memory care unit. Staff were present in the common room during this observation.

Resident #10 was observed on 10/17/18 at 2:00 PM ambulating with a shuffled gait in the hallway of the facility's memory care unit. She was within staffs' eyesight during this observation.

An interview was conducted with the Director Nursing (DON) on 10/18/18 at 3:35 PM. She stated that she expected residents to be protected from the physical behaviors of other residents. She also stated she expected staff to provide adequate supervision and for behaviors to be managed to prevent resident to resident physical altercations.

2. Resident #56 was admitted to the facility on 6/27/18 and most recently readmitted on 9/28/18 with diagnoses that included dementia with behavioral disturbance and schizophrenia.

The plan of care for Resident #56 included the focus area, "Problematic manner in which

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resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: cognitive impairment and recent placement to [nursing facility]. Resident has a reported [history] of hitting staff members and other residents." This focus area was initiated on 7/16/18. Interventions for Resident #56 included, in part, provide one on one sitter as needed, be sure you have the resident's attention before speaking or touching, and approach the resident slowly and from the front.

An initial psychiatric evaluation for Resident #56 was completed by the Psychiatric Nurse Practitioner (PNP) on 7/17/18. The PNP indicated that staff reported Resident #56 had been aggressive verbally and physically. He presented as angry, yelling out, demanding, and hitting staff.

The annual MDS assessment dated 9/6/18 indicated Resident #56's cognition was severely impaired. He had physical behaviors on 1 to 3 days, other behavioral symptoms on 4 to 6 days, and rejection of care on 1 to 3 days during the MDS review period. Resident #56 required the extensive assistance of 1 for bed mobility and locomotion on the unit. He required the extensive assistance of 2 or more staff with transfers. Resident #56 was not steady on his feet and he was only able to stabilize with staff assistance. He had no impairment with range of motion and he utilized a wheelchair.

An incident report dated 10/14/18 completed by Nurse #8 indicated Resident #56 was observed pushing Resident #18 in her wheelchair and he reached around her chair and slapped her "hard on the left cheek". The two residents were

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separated. Resident #18 was observed with redness to her left cheek. (Resident #18's 7/9/18 quarterly MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making.)

A nursing note dated 10/14/18 completed by Nurse #8 indicated at 3:00 PM Resident #56 was in the dining room when he stood up and started pushing Resident #18 in her wheelchair, he then reached around and slapped her "hard on the left side of her face". The residents were separated by staff and new orders were received from the Nurse Practitioner (NP) to send Resident #56 to the Emergency Department (ED) for evaluation.

A written statement dated 10/14/18 completed by NA #12 indicated Resident #56 and Resident #18 were in the dining room on 10/14/18 when she observed Resident #56 hit Resident #18 in the face.

An incident report dated 10/14/18 completed by Nurse #8 indicated at 3:40 PM Resident #56 was seated in his wheelchair. Resident #18 was self-propelling in her wheelchair and as she was passing Resident #56 he reached out and slapped the left side of her face. The residents were separated and assessed for injuries. Resident #18's left side of her face was red, and no injuries were noted to Resident #56. This incident was noted to occur while waiting for Emergency Medical Services (EMS) to transport Resident #56 to the ED as ordered for evaluation.

A nursing note dated 10/14/18 completed by Nurse #8 indicated at 3:40 PM Resident #56 "once again struck [Resident #18]" on the left side of her face as she was passing him in her

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wheelchair. Residents were separated by staff. EMS arrived at 4:00 PM to transport Resident #56 to the ED for evaluation.

An incident witness statement taken by Nurse #8 from NA #11 indicated on 10/14/18 Resident #56 was seated in his wheelchair. Resident #18 was self-propelling in her wheelchair and as she was passing Resident #56 he reached out and struck her on the left side of her face.

The ED evaluation dated 10/14/18 indicated Resident #56 was sent in for evaluation of aggressive behaviors and a medical screening. Resident #56 presented with normal vital signs, no concerns with his appearance, and an unremarkable medical exam. Resident #56 was noted to have been treated for a urinary tract infection (UTI) during his hospitalization on 9/22/18 through 9/28/18. Resident #56 had been discharged to the facility on 9/28/18 on an antibiotic ordered for 2 weeks. A urinalysis and culture was ordered for Resident #56 on 10/14/18 while at the ED. The ED physician indicated Resident #56 likely had chronic colonization and he recommended discharge back to the facility with an antibiotic ordered for one week. Resident #56 was discharged to the facility on 10/14/18.

An inservice sign in sheet, dated 10/15/18, indicated the subject covered was, "Immediate response to resident to resident abuse/altercation must include separation of residents to protect them from harm". The sign in sheet indicated 27 staff had received the inservice provided by the Director of Nursing (DON).

A review of the staffing sheets from the time period after Resident #56's return from the ED on

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10/14/18 through 10/18/18 indicated he was provided with one to one supervision.

An observation of Resident #56 was conducted on 10/15/18 at 12:30 PM. Resident #56 was self-propelling in his wheelchair up and down the hall of the facility's memory care unit. He had an assigned staff member providing one to one supervision.

A phone interview was conducted with Nurse #8 on 10/18/18 at 9:15 AM. Nurse #8 stated she was familiar with Resident #56. She indicated Resident #56 had periods of agitation as well as physical and verbal behaviors directed toward staff. Nurse #8 confirmed she was working on 10/14/18 when Resident #56 slapped Resident #18 on two separate occasions (3:00 PM and 3:40 PM). She stated that the first incident occurred when Resident #56 and Resident #18 were in the dining room. NA #12 reported to her that Resident #56 slapped Resident #18 in the face. Nurse #8 stated she notified the Responsible Parties (RPs) and the NP and she received an order to send Resident #56 to ED for evaluation. She reported she had exited Resident #56's unit to go to the front of the building to copy Resident #56's medical information to send with him to the ED. She explained that the copier on Resident #56's unit was broken. Nurse #8 revealed that while she was at the front of the building one of the NAs called her and said Resident #56 hit Resident #18 again. Nurse #8 stated that NA #11 and NA #12 had brought Resident #56 to the nurses' station to monitor him while waiting for EMS to arrive. She indicated that Resident #18 then self-propelled herself to the nurses' station and before the NAs could separate them, Resident

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#56 had slapped Resident #18 a second time. Nurse #8 reported that in hindsight she should've done things differently to ensure Resident #56 was kept separated from Resident #18 until he left for the ED. She stated that she could ' ve taken Resident #56 with her while she copied the documents, or she could've asked for another staff's assistance.

An interview was conducted with NA #12 on 10/17/18 at 3:50 PM. She stated she was familiar with Resident #56. She indicated Resident #56 had periods of agitation as well as physical and verbal behaviors directed toward staff. NA #12 confirmed she was working on 10/14/18 when Resident #56 slapped Resident #18 on two separate occasions (3:00 PM and 3:40 PM). She reported that after the first incident, Resident #56 and Resident #18 were separated and Resident #56 was brought to the nurses' station for monitoring until EMS arrived. She indicated that Resident #18 had self-propelled her wheelchair back to the nurses' station and near Resident #56. She revealed that before she or NA #11 could separate the two residents, Resident #56 slapped Resident #18 again. NA #12 indicated that Resident #56 was now on one to one supervision.

An interview was conducted with the DON on 10/18/18 at 3:35 PM. She stated that she expected residents to be protected from the physical behaviors of other residents. She also stated she expected staff to provide adequate supervision and for behaviors to be managed to prevent resident to resident physical altercations. The DON spoke about the two incidents that occurred on 10/14/18 in which Resident #56 slapped Resident #18 twice in a 40-minute time

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F 600	Continued From page 47 period. She stated that after the first incident occurred, staff should've immediately separated the two residents and kept them separated with a staff member staying with Resident #56 at all times until EMS arrived. She indicated she had initiated an inservice for staff related to these incidents. She reported the inservice was still in the process of being given to all nurses and NAs.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to implement its policy and procedure in the area of reporting for an allegation of Misappropriation of Property for 1 of 1 sampled resident (Resident #77). The findings included: The facility's policy titled, "Abuse, Neglect, or Misappropriation of Resident Property Policy", dated 1/2009 and last revised on 3/10/17, indicated that the Administrator was responsible to review the results of investigations of	F 607	F 607 Develop/Implement Abuse/ Neglect Policies How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #77 was reimbursed for the doll on 9/4/18. On 10/16/18, the administrator #2 notified the local law enforcement of the allegation of misappropriation of property. How the facility will identify other residents having the potential to be affected by the	11/15/18

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F 607	Continued From page 48 misappropriation of property and for reporting the alleged incident to the appropriate agencies in accordance with state and federal regulations. Resident #77 was initially admitted to the facility on 9/19/12 and most recently readmitted on 10/5/18. The quarterly Minimum Data Set (MDS) assessment dated 8/13/18 indicated Resident #77's cognition was fully intact. A facility concern/grievance form dated 8/21/18 indicated Resident #77 was missing a porcelain doll. The facility filed a 24-hour and 5-working-day report for an allegation of Misappropriation Property for Resident #77's missing porcelain doll. The allegation indicated Resident #77 reported that someone stole the doll she had bought for her granddaughter for Christmas. The investigation indicated the facility staff had searched Resident #77's room and were unable to locate the porcelain doll. The investigation was completed on 8/29/18 by the facility's former Administrator. The allegation of misappropriation of Resident #77's property was substantiated by the facility. The 5-working day report, completed 8/29/18, indicated reasonable suspicion of a crime had occurred, but that local law enforcement was not notified. An interview was conducted with Resident #77 on 10/15/18 at 4:00 PM. She confirmed she had a brand-new porcelain doll that went missing from her closet a couple of months ago and she believed that someone stole it. She reported staff had assisted her with searching for the doll	F 607	same deficient practice Other residents that allege misappropriation of property, allegations of abuse or neglect have the potential to be affected. Any allegations of abuse, will be reported to law enforcement if there is reasonable suspicion of a crime. Administrator #2 completed a 100% review of all allegations of abuse, neglect or misappropriation of property that were reported since 9/4/18 to determine notification of local law enforcement if reasonable suspicion of a crime was reported. The results of the audit determined that the center has not had any allegations with suspicion of a crime since 9/4/18. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The administrator, DON, Social Worker will be re-educated by the RN Facility Consultant regarding the responsibilities, process for allegations of misappropriation of property including notification to law enforcement and utilization of the Facility Investigative Checklist. Incidences are reviewed at morning stand-up meetings by the interdisciplinary team. Identification of neglect, abuse and misappropriation will be completed by the interdisciplinary team and the law enforcement contact will be initiated by the Director of Nursing or Administrator	

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F 607	Continued From page 49 to ensure it was not misplaced, but they were unable to locate it. She indicated the facility reimbursed her $39.99 for the cost of the porcelain doll plus an additional $7.99 for the cost of shipping the doll. The facility had offered to reorder the porcelain doll for Resident #77, but she declined and accepted the financial reimbursement. Resident #77 stated this was the only piece of personal property that had gone missing since she began residing at the facility several years ago. An interview was conducted with the Director of Nursing (DON) on 10/16/18 at 2:15 PM. She stated that the former Administrator had completed the investigation related to Resident #77's porcelain doll that went missing. She reported she was familiar with the incident and with the investigation. She confirmed the allegation was substantiated by the facility. The 5-working day report, completed 8/29/18, that indicated reasonable suspicion of a crime had occurred, but that local law enforcement was not notified was reviewed with the DON. She stated that her expectation was for the facility's policy related to misappropriation of property to be followed and for local law enforcement to have been notified. She explained that initially, Resident #77's porcelain doll was thought to be missing, but after the staff searched for it and had not located it, the allegation of misappropriation of property was investigated. She further explained that she thought this may have been why the allegation was not reported to local law enforcement. The DON indicated she was going to contact local law enforcement to verify that the allegation wasn't reported. A follow up interview was conducted with the	F 607	when there is a reasonable suspicion of a crime. The Administrator will utilize the Facility Investigative Checklist to assist in following regulatory guidelines. The Facility Investigative Checklist directs the administrator and or the Director of Nursing on tasks to be completed when allegations of abuse, neglect and misappropriation of property. The Administrator will share the results of any reportable incidents with the QI team monthly to include the results of the investigation and notification of law enforcement if there was a reasonable suspicion of a crime. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. How the facility plans to monitor its performance to make sure that solutions are sustained The facility Administrator will report to the Executive QI committee the investigation results of all allegations of abuse, neglect and misappropriation of property. The report will The Administrator will be responsible for the implementation of the acceptable plan of correction.	

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F 607	Continued From page 50 DON on 10/16/18 at 2:27 PM. She confirmed the allegation of misappropriation of property related to Resident #77's porcelain doll was not reported to local law enforcement.	F 607		
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 interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of hospice care (Resident #44), medications (Resident # 280), diagnoses (Residents #280 & #11) and nutrition (Resident #30) for 4 of 20 sampled residents whose MDS assessments were reviewed. Findings included: 1. Resident #44 was admitted to the facility on 12/21/15 with multiple diagnoses including Chronic Obstruction Pulmonary Disease (COPD). The quarterly MDS assessment dated 8/27/18 indicated that Resident #44 was not receiving hospice care. The care plan dated 8/27/18 indicated that Resident #44 was receiving hospice care due to terminal illness. The hospice notes dated 8/11/18 and 8/24/18 were reviewed and revealed that Resident #44 was under hospice care.	F 641	F641 Accuracy of Assessments How corrective action will be accomplished for those residents found to have been affected by the deficient practice The Minimum Data Set (MDS) for residents #44, #280, #11 and #30 were corrected by the MDS nurse and resubmitted on 10/19/18 by RN MDS nurse. How the facility will identify other residents having the potential to be affected by the same deficient practice Beginning on 11/7/18 the MDS (Minimum Data Set) License Nurses will conducted a 100% audit of the current residents' most recent Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) submitted for accuracy related to Diagnosis, Hospice, Nutrition and Medications. current residents. The audit was completed on 11/8/18 and revealed 9 (nine) Assessments that have discrepancies will be that were corrected and resubmitted per Resident Assessment Instrument (RAI) manual by	11/15/18

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F 641	Continued From page 51 On 10/16/18 at 4:05 PM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #44 was under hospice care since 2017 and she missed to code hospice care on the quarterly MDS assessment dated 8/27/18. On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately. 2. Resident #30 was admitted to the facility on 9/27/17 with multiple diagnoses including dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 8/2/18 indicated that Resident #30 was on therapeutic diet and was not on feeding tube. Resident #30 had a doctor's order to receive a tube feeding at 50 milliliter (ml) per hour - off at 7 AM and on at 11 AM. On 10/18/18 at 11:50 AM, the MDS Nurse was interviewed. She stated that the Dietary Manager (DM) was responsible for completing section K (nutritional status) on the MDS assessment. The MDS Nurse stated that Resident #30 was on tube feeding and nothing by mouth (NPO). On 10/18/18 at 11:52 AM, the DM was interviewed. The DM verified that Resident #30 was receiving tube feeding and was not on therapeutic diet. She confirmed that she coded the MDS assessment dated 8/2/18 incorrectly.	F 641	the MDS Coordinator. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Beginning on 11/7/18 and completed on 11/8/18, The MDS nurses and Interdisciplinary Team (IDT) will be were re-educated regarding the importance of accurate submission of MDS assessments by the MDS Consultant. How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing (DON) will perform a 10% audit for accuracy in the areas of Hospice Care, Medications, Diagnoses and Nutrition each week for 12 weeks; then quarterly thereafter on the accuracy of submitted assessments. The DON will share the results of MDS Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks. The DON and/or MDS RN will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of accuracy of assessments.	

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On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

3a. Resident # 280 was admitted to the facility on 5/21/108 with multiple diagnoses including major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 8/27/18 indicated that Resident # 280 had no diagnosis of depression.

Resident #280 had a doctor's order dated 8/20/18 for Zoloft (antidepressant drug) 75 milligrams (mgs) by mouth daily for major depressive disorder.

The Medication Administration Record (MAR) for August, 2018 revealed that Resident #280 had received Zoloft from 8/21/18 through 8/27/18.

On 10/17/18 at 4:05 PM, the MDS Nurse was interviewed. She verified that Resident #280 had received Zoloft for depression during the assessment period. The MDS Nurse stated that on the MDS assessment dated 8/27/18 she should have coded depression under the diagnoses but she did not.

On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

3b. Resident # 280 was admitted to the facility on 5/21/108 with multiple diagnoses including major depressive disorder. The quarterly Minimum

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Data Set (MDS) assessment dated 8/27/18 indicated that Resident # 280 did not receive antidepressant drug during the assessment period.

Resident #280 had a doctor's order dated 8/20/18 for Zoloft (antidepressant drug) 75 milligrams (mgs) by mouth daily for major depressive disorder.

The Medication Administration Record (MAR) for August, 2018 revealed that Resident #280 had received Zoloft from 8/21/18 through 8/27/18.

On 10/17/18 at 4:05 PM, the MDS Nurse was interviewed. She verified that Resident #280 had received Zoloft during the assessment period. The MDS Nurse stated that she failed to code the use of antidepressant drug on the MDS assessment dated 8/27/18.

On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

4. Resident #11 was admitted to the facility on 5/10/10 with multiple diagnoses including diabetes and end stage renal disease.

A review of the resident's quarterly Minimum Data Set (MDS) dated 10/2/18 revealed end stage renal disease was not coded.

A review of the resident's care plan dated 10/4/18 revealed goals and interventions for all diagnoses including deep vein thrombosis to left upper arm/shunt, diabetes, end stage renal disease,

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F 641	Continued From page 54 and hemodialysis. A review of the physician order dated 10/1/18 revealed the resident was sent for outpatient hemodialysis on Monday, Wednesday and Friday each week. The resident received a liberal renal diet and multivitamins and nutritional supplement for renal failure. On 10/16/18 at 4:05 PM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #11 was receiving hemodialysis during the assessment period and she missed to code end stage renal disease on the quarterly MDS dated 10/2/18. On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must 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	F 656		11/15/18

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F 656	Continued From page 55 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, resident interview, the facility failed to implement the resident ' s care plan for showers and urinary catheter care for 1 of 2 residents reviewed for care plan (Resident #54). Findings included: 1. Resident #54 was admitted on 11/19/15 with the diagnoses of urinary tract infection (UTI) and quadriplegia.	F 656	How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #54 was provided with a shower on 10/16/2018 and catheter care as directed in the plan of care on 10/17/2018. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents that have a catheter and expressed shower choices have the	

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F 656	Continued From page 56 The quarterly Minimum Data Set dated 9/12/18 revealed the resident had an intact cognition with other behavior which occurred 1 to 3 days in the week. The resident required extensive assistance of 2 staff for all activities of daily living (ADL) except locomotion was one staff. The active diagnoses were neurogenic bladder, UTI, and retention of urine. The care plan dated 9/13/18 revealed goals and interventions for ADLs, personal hygiene, (refused care/showers at times, intervention to encourage), urinary catheter management, behavior secondary to ineffective coping, urinary tract infections with urosepsis, chronic pain, and at risk for skin breakdown. a. A review of the resident ' s shower sheet documentation from 8/1/18 to present revealed the resident had 5 showers and the remaining documentation was partial or full bed bath. On 10/15/18 at 12:48 pm an interview was conducted with the resident who stated he had not received his showers as scheduled; he had received bed baths. The resident stated that he had a bed bath today. The resident stated that he preferred a shower and had made the staff aware of his preference for months. On 10/17/18 at 10:30 am an interview was conducted with NA #1 who was assigned to the resident and stated the resident liked to have his scheduled shower and rarely refused his shower. NA #1 also commented that she was not aware that the resident did not receive his shower when scheduled. The NA was also aware that the resident sometimes postponed his shower to the afternoon when he had pain in the morning.	F 656	potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Wound Nurse provided nursing staff re-education on the shower schedule and the Resident Care Guide to include providing urinary catheter care as indicated on 10/17/2018 to all CNA's to include fulltime, part time and agency staff. For staff not inserviced by 11/15/2018 they will be in-serviced prior to working on the floor. The education included the importance of following the Resident Care Guide to provide care. New hires and agency staff will receive this education during orientation to the facility. How the facility plans to monitor its performance to make sure that solutions are sustained The wound care nurse will perform observation and/or interview audits for residents that have urinary catheters and expressed preferences for showers. The audits will be performed 3 times a week for 4 weeks, then weekly for 2 months then quarterly hereafter. The results of the audits will be communicated to the DON. The DON will track and trend the results and re-educate or initiate counseling for nursing staff as indicated. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and	

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F 656	Continued From page 57 On 10/18/18 at 2:30 pm an interview was conducted with the Director of Nursing who stated she expected nursing staff to provide scheduled showers as planned. b. On 10/17/18 at 12:15 pm an observation was done of morning care for Resident #54. Nursing assistants (NAs) #1, 2, and #3 provided a completed bed bath. None of the three NAs present were observed to perform catheter care to clean the insertion site of the urinary catheter (meatus) and urinary catheter tubing. On 10/17/18 at 12:35 pm NA #2 was interviewed who stated that the treatment nurse (TN) provided the urinary catheter cleaning care each day which included changing the urinary catheter, cleaning the catheter and checking that the catheter was secured. On 10/17/18 at 12:40 pm an interview was conducted with the treatment nurse (TN) who stated the NA who provided morning care to bath/shower or personal care was to perform the urinary catheter care cleaning and to empty the urinary drainage bag. On 10/18/18 at 11:10 am an interview was conducted with NA #1 who stated when resident #54 received a bed bath yesterday she did not observe catheter care cleaning and did not perform catheter care. NA #1 commented that her role was to hold the resident ' s contracted legs and had not observed what was being cleaned. NA #1 stated that catheter care cleaning was expected to be done with morning	F 656	recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of developing and implementing comprehensive care plans.	

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F 656	Continued From page 58 care. On 10/18/18 at 2:30 pm an interview was conducted with the Director of Nursing who stated she expected nursing staff to provide catheter care every day with morning care. The Director of Nursing stated the staff should be following the resident ' s plan of care.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and Psychiatric Nurse Practitioner interview, the facility failed to administer antipsychotic medication as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #8). The findings included: Resident #8 was admitted to the facility on 2/1/16 and most recently readmitted on 6/26/17 with diagnoses that included psychotic disorder and dementia with behavioral disturbance. A physician ' s order dated 6/19/18 indicated Risperdal (antipsychotic medication) 0.5 milligrams (mg) 3 times daily for 3 days then Risperdal 1 mg once daily. The quarterly Minimum Data Set (MDS)	F 658	F 658 Service Provided Meet Professional Standards How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/18/18 the order for Risperdal 1mg by mouth every am was re-written to reflect the order that was written on 8/29/18. On 11/14/18, the director of nursing (DON) and nursing unit manager verified that the Monthly Physician orders, dated for 11/1/18 through 11/30/18, and the current November 2018 MAR (Medication Administration/ Record) were reflective of the order that was written for Risperdal 1 mg by mouth every am for resident #8 on 8/29/18. The Director of	11/15/18

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F 658	Continued From page 59 assessment dated 7/6/18 indicated Resident #8 had short-term and long-term memory problems and moderately impaired decision-making skills. He had no behaviors and no rejection of care. Resident #8 received antipsychotic medication on 7 of 7 days during the MDS review period. A Psychiatric Nurse Practitioner (PNP) note dated 8/22/18 indicated a recommendation to reduce Resident #8 ' s Risperdal 1 mg once daily to Risperdal 0.5 mg once daily. A physician ' s order dated 8/22/18 indicated a decrease in Resident #8 ' s Risperdal from 1 mg once daily to 0.5 mg once daily. A PNP note dated 8/29/18 indicated Resident #8 had an increase in behaviors and aggression with recent medications changes. The PNP indicated she instructed the nurse to give Resident #8 Risperdal 0.5 mg now for one dose due to aggressive behaviors/agitation and to increase Risperdal back to 1 mg once daily. A nursing note dated 8/29/18 indicated the PNP saw Resident #8 and new orders were given to change Risperdal to 1 mg once daily. A physician ' s order dated 8/29/18 indicated Risperdal 0.5 mg now one time and an increase in Resident #8 ' s Risperdal from 0.5 mg once daily to 1 mg once daily. A PNP note dated 9/5/18 indicated Resident #8 had a failed Gradual Dose Reduction (GDR) of Risperdal in August 2018. Medications were resumed as originally ordered and staff noted an improvement in mood and behaviors.	F 658	Nursing and Unit Manager visually observed the current MAR for documentation of the medication administration as ordered. The observation by the DON and nursing unit manager revealed that resident was receiving medication as ordered as evidence by the documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/7-8/18, the desk nurse completed a review of all residents with new antipsychotic orders for the previous 30 days. The review identified five resident orders requiring further investigation. The desk nurse and DON immediately obtained clarification and took necessary action, including notification of the physician and resident/resident representative as appropriate. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/14/18, the DON completed re-education of the nurse unit managers on reviewing all new physician orders for antipsychotics prior to the next morning interdisciplinary team (IDT) meeting. The review of the orders will include the complete processing of the order to include transcription to the medication administration record (MAR).	

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F 658	Continued From page 60 A review of the October 2018 hard copy MAR from 10/1/18 through 10/18/18 for Resident #8 had the 8/29/18 physician ' s order for Risperdal 1 mg once daily electronically printed on the MAR. This order for Risperdal 1 mg had the 1 mg crossed out and replaced with 0.5 mg handwritten on the MAR. This resulted in Resident #8 receiving Risperdal 0.5 mg once daily for 18 days rather than the ordered 1 mg once daily. An observation was conducted of Resident #8 in his room in his wheelchair on 10/15/18 at 12:15 PM. There were no behavioral issues observed. Resident #8 was alert and oriented to self only. An observation was conducted of Resident #8 in the hallway of his unit in his wheelchair on 10/17/18 at 11:05 AM. There were no behavioral issues observed. Resident #8 was alert and oriented to self only. An interview was conducted with the Director of Nursing (DON) on 10/18/18 at 11:30 AM. The DON was asked who was responsible for the changeover of MARs and for reviewing and/or monitoring MARs to ensure medications were administered as ordered. She reported the normal process was for the third shift nurses to review the next month ' s MARs for accuracy and prevention of transcription errors when they were printed out at the end of the previous month. She indicated the third shift nurses were also responsible for reviewing the completed MARs at the end of the month to ensure medications were administered as ordered. The DON stated her expectation was for medications to be administered as ordered. This interview with the DON continued. The	F 658	The nurse unit manager will report the finding of the review to the IDT team during the next morning IDT meeting. On 11/14/18, the DON implemented the practice that the end-of-month changeover of MARs will be reviewed by two licensed nurses. How the facility plans to monitor its performance to make sure that solutions are sustained On 11/14/18, the desk nurse will begin auditing 10% of the resident medication administration records MARs for changeover accuracy each month for 12 weeks, then quarterly for 12 months. The DON will share the results of the audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area meeting	

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F 658	Continued From page 61 physician ' s orders dated 8/22/18 and 8/29/18 related to Resident #8 ' s Risperdal were reviewed with the DON. The October 2018 MAR from 10/1/18 through 10/18/18 was reviewed with the DON. The DON reviewed this information, she observed the medication cart, and she then confirmed Resident #8 was administered 0.5 mg of Risperdal once daily rather than 1 mg once daily as ordered for a period of 18 days in October 2018. The DON was unable to explain why the hard copy MAR had been changed from Risperdal 1 mg once daily to 0.5 mg once daily and she was unsure who had completed the change. She stated that during the month of September the facility admitted a total of 49 residents who were evacuated from other facilities due to weather related emergencies. She revealed that this high number of new admissions disrupted the facility ' s normal processes and she felt this was why the error was not discovered as it should have been during the monthly changeover of MARs. A phone interview was conducted with the PNP on 10/18/18 at 2:32 PM. She confirmed that Resident #8 had failed the GDR of Risperdal in August 2018 and she changed his Risperdal order back to 1 mg once daily on 8/29/18. She was unaware Resident #8 had received 0.5 mg once daily of Risperdal rather than the ordered 1 mg once daily for 18 days in October 2018. The PNP indicated she expected her orders to be followed.	F 658	professional standards.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		11/15/18

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F 677	Continued From page 62 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide fingernail care for one of two dependent residents reviewed for Activities of Daily Living (ADLs) (Resident #5). The findings included: Resident #5 was admitted to the facility on 4/8/16. The resident's cumulative diagnoses included: Diabetes, dementia, generalized weakness, hemiplegia/hemiparesis (weakness of one side of the body), stroke, and multiple sclerosis (MS). A review was completed of Resident #5's most recent Minimum Data Set (MDS). The review revealed a quarterly assessment with an Assessment Reference Date (ARD) of 7/3/18. The resident was coded as having been cognitively intact. The resident was also coded as having required extensive assistance of one to two people for the following Activities of Daily Living (ADLs): bed mobility, transfer (such as from the bed to a wheelchair), dressing, toilet use, personal hygiene, and was totally dependent for bathing. A review of Resident #5's care plan which was most recently reviewed on 10/4/18. The review revealed the resident had a Focus area for requiring assistance for personal hygiene characterized by the daily maintaining of appearance related to: Stroke and generalized weakness. The goal listed was for the resident to be neat, clean, and odor free through next review. An intervention was: Hygiene/grooming: Provide	F 677	F 677 ADL Care Provided for Dependent Residents How corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident #5 was provided with nail care immediately on 10/15/18 by staff Certified Nursing Assistant (CNA). How the facility will identify other residents having the potential to be affected by the same deficient practice All residents that require assistance have the potential to be affected. The Unit Managers observe resident grooming and hygiene during the performance of the Compliance Monitoring rounds to include nails being clean. New Compliance Monitoring rounds were initiated on 11/8/2018 by the Unit Managers (UM) and any issues with resident nails are resolved immediately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All CNA's to include fulltime, part time and agency staff will be re-educated regarding following the Resident Care Guide to include nail care by the DON (Director of Nursing). For staff not inserviced by 11/15/2018 they will be in-serviced prior to working on the floor. New hires and agency staff will receive this education during orientation to the facility. The UM and assigned Department Heads	

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F 677	Continued From page 63 constant supervision with physical assistance as needed. The resident's care plan had several care plans addressing the resident's right-sided weakness including the Focus areas of: Eating, Transferring, Mobility, Toileting, Risk for falls, and Pain. In addition, the resident had a Focus area for MS. The goal listed for MS was the resident would remain free of complications or discomfort related to MS through next review. A listed intervention was: Monitor for signs/symptoms of damage to motor nerve tracts such as weakness, paralysis, spasticity, fatigue, and diploplia and notify MD as appropriate. Review of Resident #5's Care Guide, which was last reviewed on 10/4/18, revealed the listed interventions of Aid of one person and the resident had right-sided paralysis. An observation of Resident #5's fingers conducted on 10/15/18 at 11:28 AM revealed the fingernails on the left hand, the resident's non-affected side, had dark debris under the free edge of each nail for all five fingers. An observation of Resident #5's fingers conducted on 10/17/18 at 3:48 PM revealed the fingernails on the left hand, the resident's non-affected side, had dark debris under the free edge of each nail for all five fingers. An observation of Resident #5's fingers conducted on 10/18/18 at 11:14 AM revealed the fingernails on the left hand, the resident's non-affected side, had dark debris under the free edge of each nail for all five fingers. An interview and observation were conducted with Nursing Assistant (NA) #6 on 10/18/18 at	F 677	will continue to perform Compliance Monitoring Rounds 3 (three) times per week. The rounds will be performed at random times, and days including weekends. How the facility plans to monitor its performance to make sure that solutions are sustained The UM will perform observation of 5 residents with daily audits 5 times a week for 1 week, then 3 times a week for 3 weeks then weekly thereafter for Activities of Daily Living (ADL) care to include nail care. The results of the ADL observation audits will be shared with the DON. The Director of Nursing (DON) will track and trend the results and re-educated or initiate counseling for nursing staff as indicated. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present Interdisciplinary Team (IDT) corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of providing ADL care.	

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F 677	Continued From page 64 12:25 PM. The NA stated Resident #5 was on her assignment. The NA stated she provided nail care for her residents and she had provided nail care for the residents on her assignment last week. The NA stated she tried to check residents' nails daily, including Resident #5. The NA stated she had not checked residents' nails or Resident #5's nails yet that day. The NA stated yesterday, 10/17/18, she had Resident #5 on her assignment and had not provided nail care for him. The NA stated she had not provided nail care because she had been told there were two ladies doing nail care for all the residents and she was told they would nail care for all the residents on her hall. Resident #5 was observed to be in the dining room awaiting lunch. An observation of Resident #5's fingers was conducted by NA #6. The observation revealed the fingernails on the left hand, the resident's non-affected side, had dark debris under the free edge of each nail for all five fingers. NA #6 stated the resident's fingernails had debris under the nail free edge of the nail on the resident's left hand and the resident's nails needed to be trimmed and cleaned. An interview and observation were conducted with the Director of Nursing (DON) on 10/18/18 at 12:31 PM. The DON observed Resident #5's finger nails on his left hail and stated the resident's fingernails had dark debris under the free edge of the nail on all five fingers on the left hand and the nails needed to have been trimmed and cleaned. The DON further stated it was her expectation for residents to have clean and trimmed finger nails.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/15/18

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F 689	Continued From page 65 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to provide supervision of cognitively impaired residents with known histories of combative behaviors (Residents #10, #56, and #74) to prevent physical altercations with other cognitively impaired residents for 3 of 3 sampled residents reviewed for resident to resident incidents. The facility also failed to secure one of two medication storage rooms (memory care unit). The findings included: 1. Resident #10 was admitted to facility on 12/21/17 with diagnoses that included dementia without behavioral disturbance, psychosis, mood disorder, and anxiety. The 14-day Minimum Data Set (MDS) assessment dated 4/17/18 indicated Resident #10 had short-term and long-term memory problems and severely impaired decision making. She had no behaviors during the MDS review period. Resident #10 required the extensive assistance of 1 for bed mobility. She required supervision of 1 for transfers, walking in room, walking in corridor, and locomotion on/off the unit. Resident #10 was not steady on her feet, but she	F 689	F 689 Free of Accidents Hazards/Supervision/Devices How corrective action will be accomplished for those residents found to have been affected by the deficient practice As of 11/14/18, the DON verified through progress note review, nursing staff input, and direct observation Resident # 10 has had decreased episodes of agitation correlated to medication monitoring, increased supervision and continued routine psychiatric consults. As of 11/14/18, the DON verified through progress note review, nursing staff input, and direct observation Resident #56 has had decreased episodes of agitation correlated to medication monitoring, increased supervision and continued routine psychiatric consults. Resident # 74 was transferred to the hospital on 10/31/18 related to a change in condition. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/18/18, the DON immediately locked the medication storage room on the	

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F 689	Continued From page 66 was able to stabilize without staff assistance. She had no impairment with range of motion and she utilized a wheelchair. The plan of care for Resident #10 included the focus area, "Problematic manner in which resident acts characterized by ineffective coping; agitation/combativeness related to: dementia. Swings, hits at staff and has period of crying. Resident has a [history] of hitting others, grabbing others, and accusing others of ' running around ' with her husband." This focus area was initiated on 12/22/17. The interventions for Resident #10 included, in part, being careful not to invade her personal space (initiated on 12/22/17), behavior management/psychiatric consultation as needed (initiated on 12/22/17 and revised on 2/1/18), and to give resident an item or task in an attempt to distract (initiated on 4/27/18). The plan of care for Resident #10 also included the focus area, "Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression and combativeness related to: [history] of dementia. Resident has reports of being physically and verbally abusive to staff and other residents ...". This focus area was initiated on 12/27/17. The interventions for Resident #10 included, in part, allow resident to pace where she can be observed (initiated on 12/27/17 and revised on 1/25/18) and be cognizant of not invading her personal space (initiated on 2/1/18). a.) An incident report dated 4/29/18 completed by Nurse #2 indicated Nursing Assistant (NA) #6 reported that she heard residents arguing and upon entering the room she observed Resident #10 and Resident #74 hitting each other.	F 689	secured dementia unit. The DON also verbally reinforced with the dementia unit staff how important it is to provide constant supervision of the residents to ensure resident incidents/accidents. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 10/31/18, the DON and staff facilitator initiated in-servicing with licensed nurses, nursing assistants, and agency staff working on the dementia unit. The in-servicing included supervision of residents to prevent recurrence, including non-pharmacological interventions for behavior management and the locking of the medication rooms at all times, especially on the secured dementia unit. The in-servicing was completed on 11/14/18. Any nursing staff or agency staff working on the dementia unit who did not complete the in-service by 11/14/18, will not work on the unit until they have participated in the in-service provided by the staff facilitator and/or DON. Newly hired licensed nurses, nursing assistants, and agency staff will receive this education during orientation to the facility. On 11/14/18, the DON and/or nurse unit managers began discussing, in the next interdisciplinary team (IDT) team meeting, residents exhibiting aggressive behaviors. Discussion will include: 1) monitoring for notification of the attending physician, 2) notification of the resident representative, and 3) if immediate interventions are effective or additional action is necessary. How the facility plans to monitor its performance to make sure that solutions	

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F 689	Continued From page 67 Resident #10 was observed to slap Resident #74 twice on the right side of her head. Resident #10 and Resident #74 were separated. Resident #10 was noted with a bruise on her right and left lower arms. Resident #74 had no injuries. (Resident #74's 4/1/18 annual MDS assessment indicated her cognition was severely impaired.) A nursing note dated 4/29/18 completed by Nurse #2 indicated that Resident #10 and Resident #74 were separated and brought to the nurses' station after the physical altercation. Resident #10 was noted with purple colored bruises to her right and left forearm and a nail indentation on the left forearm. A written statement dated 4/29/18 completed by NA #6 indicated she saw Resident #10 and Resident #74 grabbing each other's arms. Resident #10 stated, "she was going to beat [Resident #74's] ass" then Resident #10 slapped Resident #74 two times on the right side of her head. NA #6 indicated she then brought Resident #10 to Nurse #2 and explained the incident. An interview was conducted with Nurse #2 on 10/17/18 at 11:00 AM. Nurse #2 stated she was familiar with Resident #10. She indicated Resident #10 had a history of behaviors that included physical behaviors directed at other residents. She reported Resident #10 was ambulatory and she walked up and down the hall of her unit, in the common areas, and in and out of resident rooms. She indicated that staff tried to prevent any physical altercations with Resident #10 and other residents by monitoring her whereabouts and redirecting her to the common areas or the nurses' station where she was easily observed. Nurse #2 confirmed she was working	F 689	are sustained On 11/14/18, the DON, quality improvement nurse, nurse unit manager, and corporate consultant began reviews of nurse progress notes, incident reports, assignment sheets, and/or nurse assistant behavior documentation to ensure adequate supervision is provided to meet resident needs on the dementia unit. Any identified issues will be immediately reported to the assigned nurse on that shift and the DON for prompt intervention and corrective action. The reviews will occur five times weekly for 12 weeks. On 11/14/18, the DON, nursing unit managers and other assigned Department Heads began Compliance Monitoring rounds in the dementia unit to ensure residents are adequately supervised, non-resident areas are secured, and residents are provided with diversional activities. The compliance rounds are performed 3 times weekly at various times, on various days to include the weekends. The results of the compliance rounds are reported to the DON and Administrator during morning IDT meeting. Beginning 11/14/18, the DON and or Unit Manager will share trending and tracking of the behaviors with the IDT on a weekly basis for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present	

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on 4/29/18 at the time of the physical altercation between Resident #10 and Resident #74. She stated she was unable to recall any specific information about the incident.

An interview was conducted with NA #6 on 10/17/18 at 3:00 PM. NA #6 stated she was familiar with Resident #10. She stated that Resident #10 was ambulatory and spent most of the hours while she was awake walking up and down the hall and in the common areas. She confirmed she was working on 4/29/18 at the time of the physical altercation between Resident #10 and Resident #74. NA #6 revealed that 4/29/18 was the first time she had worked with Resident #10 and she was unaware of her history of physical behaviors at that time. She stated that she had been in another resident's room providing care when she heard two residents yelling at each other. She came out of the room and observed Resident #10 hit Resident #74 and then Resident #74 in turn hit Resident #10. She indicated the hitting occurred before she could get to the residents to separate them. She stated when she was able to separate the residents she informed Nurse #2 of the incident. NA #6 indicated she had only worked with Resident #10 a couple of times since then. She stated when she did work with Resident #10 she tried to keep her eyes on the resident and redirect her to areas where she was easily observed to prevent any physical altercations from occurring.

On 4/30/18 the care plan (initiated on 12/22/17) for Resident #10 related to agitation/combativeness was updated with the intervention, "Remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to

trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance with ensuring the facility is free of accidents/hazards, provides supervision, and has safe devices to protect the residents.

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decrease/eliminate undesired behavior and provide diversional activity".

A Psychiatric Nurse Practitioner (PNP) note dated 5/1/18 indicated staff reported that Resident #10 continued to present with increased anxiety and agitation. Staff also noted that Resident #10 had become physically aggressive toward other residents.

A Nurse Practitioner (NP) note dated 5/3/18 indicated Resident #10 was involved in an altercation with another resident on her unit. Resident #10 was noted with agitation and combativeness toward others.

b.) An incident report dated 5/6/18 completed by Nurse #2 indicated NA #7 reported that Resident #10 hit Resident #18. (Resident #18's 4/12/18 significant change MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making.)

A nursing note dated 5/6/18 completed by Nurse #2 indicated Resident #10 hit another resident (Resident #18) on her forearm. The residents were separated, and no injuries were noted to either resident.

A written statement, undated, completed by Nurse #2 indicated NA #7 reported to her on 5/6/18 that Resident #10 hit Resident #18. The residents were separated, and Resident #10 was placed on 1 to 1 supervision until she went to bed. No injuries were observed to either resident.

A written statement dated 5/9/18 completed by NA #7 indicated she observed the incident on

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5/6/18 between Resident #10 and Resident #18. NA #7 reported she walked up to the nurses' station and saw Resident #10 holding onto Resident #18's wheelchair. NA #7 asked Resident #10 to let go of the chair, but she wouldn't. NA #7 indicated that before she could go around the chair Resident #10 "popped" Resident #18 on her left hand. Resident #10 then walked off and went down the hall.

An interview was conducted with Nurse #2 on 10/17/18 at 11:00 AM. She confirmed she was working on 5/6/18 at the time of the physical altercation between Resident #10 and Resident #18. She stated she was unable to recall any specific information about the incident.

A phone interview was conducted with NA #7 on 10/17/18 at 4:55 PM. NA #7 indicated she currently worked at the facility infrequently on an as needed basis only. She stated she was familiar with Resident #10 and had worked with her a couple of times. She reported Resident #10 was ambulatory and she was normally walking about on her unit while she was awake. NA #7 confirmed she was working on 5/6/18 at the time of the physical altercation between Resident #10 and Resident #18. She reported she saw Resident #10 holding onto Resident #18's wheelchair and was trying to push her. She indicated she asked Resident #10 to let go of Resident #18's wheelchair, but she had not complied. She stated that she started to walk around to the front of Resident #10 to redirect her and get to her to release the wheelchair, but before she could do that Resident #10 hit Resident #18 on her hand. NA #7 reported that after that, Resident #10 walked away from Resident #18 on her own.

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c.) An incident report dated 5/13/18 completed by Nurse #3 indicated NA #8 informed her Resident #10 had been in a physical altercation with another resident (Resident #26). Resident #10 hit Resident #26 and then Resident #26 hit her back. (Resident #26 's 4/28/18 annual MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making).

A nursing note dated 5/13/18 completed by Nurse #3 indicated NA #8 reported Resident #10 slapped Resident #26 on the hand and Resident #26 then slapped her back on the hand. The residents were separated, and no injuries were observed.

A written statement dated 5/13/18 completed by NA #8 indicated she heard two residents (Resident #10 and Resident #26) arguing back and forth. She then looked for where the arguing was coming from and she observed Resident #10 hit Resident #26 on the hand. Resident #26 then hit Resident #10 back on the hand. NA #8 indicated she was able to separate the residents and reported to the nurse (Nurse #3).

A phone interview was conducted with Nurse #3 on 10/18/18 at 9:29 AM. Nurse #3 stated she had not worked with Resident #10 frequently, but she had on a few occasions. She indicated Resident #10 was ambulatory and could get up and down on her own. She stated Resident #10 could be lying in bed one minute and the next thing you knew she was up and walking about again. Nurse #3 confirmed she was working on 5/13/18 at the time of the physical altercation between Resident #10 and Resident #26. She stated that

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both residents were seated next to each other when NA #8 saw Resident #10 hit Resident #26. Resident #26 then in turn hit Resident #10 back before NA #8 could separate the residents.

An interview was conducted with NA #8 on 10/17/18 at 3:43 PM. NA #8 stated she was familiar with Resident #10. She reported Resident #10 had physical behaviors directed toward both staff and residents. She indicated Resident #10 was very active and she walked up and the hall and into other residents' rooms almost the whole time she was awake. NA #8 confirmed she was working on 5/13/18 at the time of the physical altercation between Resident #10 and Resident #26. She indicated she heard Resident #10 and Resident #26 arguing so she started to walk over to them. She stated that before she could get to the residents to separate them, Resident #10 hit Resident #26 on her hand and Resident #26 hit her back on her hand. She indicated she then separated the residents and reported the incident to Nurse #3. NA #8 revealed it was very challenging at times to work with Resident #10 as you had to keep an eye on her at all times and needed to make sure she wasn't too close to any other residents to avoid any physical altercations.

On 5/14/18 the care plan (initiated on 12/27/17) for Resident #10 related to verbal/physical aggression was updated to include the intervention, "Remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity".

An NP note dated 5/15/18 indicated Resident #10

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had been physically abusive to other residents on the unit. She was sent to the Emergency Department (ED) on 5/13/18 for psychiatric evaluation, but the ED provider had not felt Resident #10 would benefit from a psychiatric evaluation in the ED so she was transferred back to the facility.

A PNP note dated 5/15/18 indicated Resident #10 continued with increased anxiety and agitation. She was noted with physical aggression toward other residents. Medication adjustments were made by the PNP.

d.) An incident report dated 6/9/18 completed by Nurse #4 indicated NA # 9 informed her that Resident #10 walked up to another resident (Resident #8) and began to pull and hit him. No injuries were observed to either resident. (Resident #8 ' s 4/6/18 quarterly MDS assessment indicated he had short-term and long-term memory problems and severely impaired decision making.)

A written statement, undated, completed by NA #9 indicated Resident #8 was sitting in the hall when Resident #10 walked up to him and started to "pull and hit on him". Resident #8 started hit back.

A phone interview was attempted with Nurse #4 on 10/17/18 at 4:29 PM. Nurse #4 was unable to be reached. (Nurse #4 completed the incident report related to the 6/9/18 physical altercation between Resident #10 and Resident #8.)

A phone interview was attempted with NA # 9 on 10/17/18 at 4:30 PM. NA #9 was unable to be reached. (NA #4 completed the witness

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statement related to the 6/9/18 physical altercation between Resident #10 and Resident #8.)

A PNP note dated 6/13/18 indicated staff reported Resident #10 recently hit another resident. Staff also reported increased confusion, restlessness, and agitation. The PNP indicated Resident #10 was irritable and angry with staff. Medication adjustments were made by the PNP.

A PNP note dated 8/29/18 indicated Resident #10 had returned to her baseline following medication adjustments. She had intermittent crying spells, but no physical aggression or combative behaviors were reported by staff.

The annual MDS assessment dated 10/3/18 indicated Resident #10's cognition was severely impaired. She had other behavioral symptoms on 1 to 3 days during the MDS review period. Resident #10 required the extensive assistance of 1 for bed mobility and transfers. She required supervision of 1 for walking in room, walking in corridor, and locomotion on the unit. Resident #10 was not steady on her feet, but she was able to stabilize without staff assistance. She had no impairment with range of motion and she utilized a wheelchair.

e.) A nursing note dated 10/4/18 completed by Nurse #5 indicated NA #10 heard Resident #329 hollering "get out of my room". Resident #10 had entered Resident #329's room, grabbed her by the arm, and twisted her wrist backwards. Resident #10 was removed from Resident #329's room. Resident #329 had redness on her wrist and complained of mild pain when wrist was moved. An order was received for an x-ray of

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Resident #329's wrist.

An incident witness statement dated 10/4/18 completed by NA #10 indicated she was setting up trays and heard Resident #329 hollering. Resident #10 had entered Resident #329's room and grabbed her hand and arm and started to twist.

A 24 hour and 5 working day report for an allegation of resident abuse related to the incident between Resident #10 and Resident #329 on 10/4/18 was reviewed. Resident #329 was in bed as NA # 10 provided care for her roommate. Resident #10 entered Resident #329's room and grabbed her on the wrist. NA #10 went over to intervene and tried to get Resident #10 to release Resident #329's wrist. Nurse #5 came into the room and assisted NA #10 with getting Resident #10 to release Resident #329's wrist. Resident #10 was then separated from Resident #329. A skin tear was noted to Resident #329's wrist. An x-ray was obtained of Resident #329's wrist and results were negative. Resident #329 was relocated to another hall way away from resident #10. The allegation of resident abuse was substantiated.

An interview with the Social Worker on 10/18/18 at 10:15 AM indicated that she completed a Brief Interview of Mental Status (BIMS) for Resident #329 on 10/15/18 and her cognition was severely impaired.

A phone interview was conducted with Nurse #5 on 10/17/18 at 4:45 PM. Nurse #5 stated she was familiar with Resident #10. She indicated Resident #10 had physical behaviors directed toward other residents in the past. She reported

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that staff tried to make sure she wasn't too close to any other residents and for at least one staff member to keep their eye on her. She indicated that it could be difficult at times for staff to keep Resident #10 in their eyesight at all times because she moved about constantly. Nurse #5 confirmed she was working on 10/4/18 at the time of the physical altercation between Resident #10 and Resident #329. She stated she had heard yelling from Resident #329's room. She indicated she went to the room and she saw Resident #10 holding Resident #329's wrist. NA #10 was in the room and was trying to separate Resident #10 from Resident #329. Nurse #5 stated Resident #10 was able to be removed from Resident #329's room. She reported that Resident #329 had a skin tear on her wrist and an x-ray was ordered to ensure no further injury.

A phone interview was conducted with NA #10 on 10/17/18 at 4:15 PM. NA #10 indicated she was familiar with Resident #10. She stated Resident #10 was very active throughout the time she was awake. She reported Resident #10 walked around the common areas, the hall, and into resident rooms. She stated that Resident #10 had physical behaviors directed at other residents in the past. She indicated that staff tried to keep Resident #10 in their eyesight at all times to ensure no physical altercations occurred with any other resident. NA #10 explained that if she was providing care for one of her residents that the other NA on the unit or the nurse on the unit monitored Resident #10. She indicated there were always at least 2 NAs on the unit. She revealed it was sometimes difficult to monitor her at all times because she moved around constantly. NA #10 confirmed she as working on 10/4/18 at the time of the physical altercation

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between Resident #10 and Resident #329. She indicated she was in Resident #329's room setting up her meal tray when she heard yelling in the room. She stated she looked over and saw that Resident #10 had entered Resident #329's room and grabbed her wrist and was twisting. She reported she went over to separate Resident #10 from Resident #329 and at that time Nurse #5 entered the room to assist her with separating the residents.

Resident #10 was observed on 10/15/18 at 12:30 PM ambulating with a shuffled gait a common room of the facility's memory care unit. Staff were present in the common room during this observation.

Resident #10 was observed on 10/17/18 at 2:00 PM ambulating with a shuffled gait in the hallway of the facility's memory care unit. She was within staffs' eyesight during this observation.

An interview was conducted with the Director Nursing (DON) on 10/18/18 at 3:35 PM. She stated that she expected residents to be protected from the physical behaviors of other residents. She also stated she expected staff to provide adequate supervision to prevent resident to resident physical altercations.

2. Resident #56 was admitted to the facility on 6/27/18 and most recently readmitted on 9/28/18 with diagnoses that included dementia with behavioral disturbance and schizophrenia.

The plan of care for Resident #56 included the focus area, "Problematic manner in which

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resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: cognitive impairment and recent placement to [nursing facility]. Resident has a reported [history] of hitting staff members and other residents." This focus area was initiated on 7/16/18. Interventions for Resident #56 included, in part, provide one on one sitter as needed, be sure you have the resident's attention before speaking or touching, and approach the resident slowly and from the front.

An initial psychiatric evaluation for Resident #56 was completed by the Psychiatric Nurse Practitioner (PNP) on 7/17/18. The PNP indicated that staff reported Resident #56 had been aggressive verbally and physically. He presented as angry, yelling out, demanding, and hitting staff.

The annual MDS assessment dated 9/6/18 indicated Resident #56's cognition was severely impaired. He had physical behaviors on 1 to 3 days, other behavioral symptoms on 4 to 6 days, and rejection of care on 1 to 3 days during the MDS review period. Resident #56 required the extensive assistance of 1 for bed mobility and locomotion on the unit. He required the extensive assistance of 2 or more staff with transfers. Resident #56 was not steady on his feet and he was only able to stabilize with staff assistance. He had no impairment with range of motion and he utilized a wheelchair.

An incident report dated 10/14/18 completed by Nurse #8 indicated Resident #56 was observed pushing Resident #18 in her wheelchair and he reached around her chair and slapped her "hard on the left cheek". The two residents were

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separated. Resident #18 was observed with redness to her left cheek. (Resident #18's 7/9/18 quarterly MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making.)

A nursing note dated 10/14/18 completed by Nurse #8 indicated at 3:00 PM Resident #56 was in the dining room when he stood up and started pushing Resident #18 in her wheelchair, he then reached around and slapped her "hard on the left side of her face". The residents were separated by staff and new orders were received from the Nurse Practitioner (NP) to send Resident #56 to the Emergency Department (ED) for evaluation.

A written statement dated 10/14/18 completed by NA #12 indicated Resident #56 and Resident #18 were in the dining room on 10/14/18 when she observed Resident #56 hit Resident #18 in the face.

An incident report dated 10/14/18 completed by Nurse #8 indicated at 3:40 PM Resident #56 was seated in his wheelchair. Resident #18 was self-propelling in her wheelchair and as she was passing Resident #56 he reached out and slapped the left side of her face. The residents were separated and assessed for injuries. Resident #18's left side of her face was red, and no injuries were noted to Resident #56. This incident was noted to occur while waiting for Emergency Medical Services (EMS) to transport Resident #56 to the ED as ordered for evaluation.

A nursing note dated 10/14/18 completed by Nurse #8 indicated at 3:40 PM Resident #56 "once again struck [Resident #18]" on the left side of her face as she was passing him in her

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wheelchair. Residents were separated by staff. EMS arrived at 4:00 PM to transport Resident #56 to the ED for evaluation.

An incident witness statement taken by Nurse #8 from NA #11 indicated on 10/14/18 Resident #56 was seated in his wheelchair. Resident #18 was self-propelling in her wheelchair and as she was passing Resident #56 he reached out and struck her on the left side of her face.

The ED evaluation dated 10/14/18 indicated Resident #56 was sent in for evaluation of aggressive behaviors and a medical screening. Resident #56 presented with normal vital signs, no concerns with his appearance, and an unremarkable medical exam. Resident #56 was noted to have been treated for a urinary tract infection (UTI) during his hospitalization on 9/22/18 through 9/28/18. Resident #56 had been discharged to the facility on 9/28/18 on an antibiotic ordered for 2 weeks. A urinalysis and culture was ordered for Resident #56 on 10/14/18 while at the ED. The ED physician indicated Resident #56 likely had chronic colonization and he recommended discharge back to the facility with an antibiotic ordered for one week. Resident #56 was discharged to the facility on 10/14/18.

An inservice sign in sheet, dated 10/15/18, indicated the subject covered was, "Immediate response to resident to resident abuse/altercation must include separation of residents to protect them from harm". The sign in sheet indicated 27 staff had received the inservice provided by the Director of Nursing (DON).

A review of the staffing sheets from the time period after Resident #56's return from the ED on

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10/14/18 through 10/18/18 indicated he was provided with one to one supervision.

An observation of Resident #56 was conducted on 10/15/18 at 12:30 PM. Resident #56 was self-propelling in his wheelchair up and down the hall of the facility's memory care unit. He had an assigned staff member providing one to one supervision.

A phone interview was conducted with Nurse #8 on 10/18/18 at 9:15 AM. Nurse #8 stated she was familiar with Resident #56. She indicated Resident #56 had periods of agitation as well as physical and verbal behaviors directed toward staff. Nurse #8 confirmed she was working on 10/14/18 when Resident #56 slapped Resident #18 on two separate occasions (3:00 PM and 3:40 PM). She stated that the first incident occurred when Resident #56 and Resident #18 were in the dining room. NA #12 reported to her that Resident #56 slapped Resident #18 in the face. Nurse #8 stated she notified the Responsible Parties (RPs) and the NP and she received an order to send Resident #56 to ED for evaluation. She reported she had exited Resident #56's unit to go to the front of the building to copy Resident #56's medical information to send with him to the ED. She explained that the copier on Resident #56's unit was broken. Nurse #8 revealed that while she was at the front of the building one of the NAs called her and said Resident #56 hit Resident #18 again. Nurse #8 stated that NA #11 and NA #12 had brought Resident #56 to the nurses' station to monitor him while waiting for EMS to arrive. She indicated that Resident #18 then self-propelled herself to the nurses' station and before the NAs could separate them, Resident #56 had slapped

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Resident #18 a second time. Nurse #8 reported that in hindsight she should've done things differently to ensure Resident #56 was kept separated from Resident #18 until he left for the ED. She stated that she could've taken Resident #56 with her while she copied the documents, or she could've asked for another staff's assistance.

An interview was conducted with NA #12 on 10/17/18 at 3:50 PM. She stated she was familiar with Resident #56. She indicated Resident #56 had periods of agitation as well as physical and verbal behaviors directed toward staff. NA #12 confirmed she was working on 10/14/18 when Resident #56 slapped Resident #18 on two separate occasions (3:00 PM and 3:40 PM). She reported that after the first incident, Resident #56 and Resident #18 were separated and Resident #56 was brought to the nurses' station for monitoring until EMS arrived. She indicated that Resident #18 had self-propelled her wheelchair back to the nurses' station and near Resident #56. She revealed that before she or NA #11 could separate the two residents, Resident #56 slapped Resident #18 again. NA #12 indicated that Resident #56 was now on one to one supervision.

An interview was conducted with the DON on 10/18/18 at 3:35 PM. She stated that she expected residents to be protected from the physical behaviors of other residents. She also stated she expected staff to provide adequate supervision to prevent resident to resident physical altercations. The DON spoke about the two incidents that occurred on 10/14/18 in which Resident #56 slapped Resident #18 twice in a 40-minute time period. She stated that after the first incident occurred, staff should've immediately

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separated the two residents and kept them separated with a staff member staying with Resident #56 at all times until EMS arrived. She indicated she had initiated an inservice for staff related to these incidents. She reported the inservice was still in the process of being given to all nurses and NAs.

3. Resident #74 was admitted to the facility on 2/1/16 and most recently readmitted on 6/26/17 with diagnoses that included schizophrenia, dementia, psychotic disorder with delusions, and schizoaffective disorder.

The quarterly Minimum Data Set (MDS) assessment dated 7/1/18 indicated Resident #74'scognition was severely impaired. She had other behavioral symptoms on 1 to 3 days during the MDS review period. Resident #74 required the extensive assistance of 1 with bed mobility, the limited assistance of 1 with transfers, and the supervision of 1 with locomotion on/off the unit. She was assessed as not steady on her feet and was only able to stabilize with staff assistance. Resident #74 had no impairment with range of motion and she utilized a wheelchair.

The plan of care for Resident #74 included the focus area, "Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression and combativeness related to: cognitive impairment. Resident hits/strikes at staff and others. Report episodes of breaking/busting windows. Resident calls staff members inappropriate names. Resident strikes, pinches, and slaps staff at times. Resident attempted to strike other residents at times." This

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focus area was initiated on 6/8/17 and most recently revised on 4/27/18. Interventions for Resident #74 included, in part, approach the resident slowly and from the front, be cognizant of not invading resident's personal space, be sure you have resident's attention before speaking or touching, provide 15 minute checks and one on one sitter as needed, remove resident from public area when behavior is disruptive/unacceptable, and talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior, and provide diversional activity.

An incident report dated 7/17/18 completed by Nurse #8 indicated she was called to Resident #74 ' s room by Nursing Assistant (NA) #8. NA #8 reported she witnessed Resident #74 "striking" Resident #23. No injuries were observed. (Resident #23's 6/16/18 annual MDS assessment indicated her cognition was moderately impaired.)

A nursing note dated 7/17/18 completed by Nurse #8 indicated NA #8 had witnessed Resident #74 self-propel her wheelchair from the hallway, into the room, and over to Resident #23's bed. Resident #74 then struck Resident #23 on the left forearm. Resident #74 would not answer why she had done this. Residents #74 and #23 were separated and Resident #74 was moved to different room with one on one monitoring.

A review of Resident #74's medical record indicated one on one monitoring continued through 8/1/18.

An observation of Resident #74 was conducted on 10/15/18 at 12:30 PM. She was in her wheelchair in a common area of the facility's memory care unit. There were no physical

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behavior issues observed.

A phone interview was conducted with Nurse #8 on 10/18/18 at 9:15 AM. Nurse #8 stated she was familiar with Resident #74. Nurse #8 confirmed she was working on 7/17/18 when Resident #74 struck Resident #23 on her arm. She stated that had not observed this incident, but that NA #8 had witnessed it and reported it to her. Nurse #8 was asked if Resident #74 had any previous physical altercations with other residents. She indicated she believed Resident #74 had physical behaviors in the past, but she was unsure if she was involved in any previous resident to resident altercations.

An interview was conducted with NA #8 on 10/17/18 at 3:43 PM. NA #8 stated she was familiar with Resident #10. NA #8 confirmed she was working on 7/17/18 when Resident #74 struck Resident #23 on her arm. She stated she observed Resident #74 self-propel her wheelchair over to Resident #23's bed and slap her on the arm. She indicated the slap made an audible noise, but that no injuries or redness were noted to Resident #23. NA #8 reported the residents were separated and she informed Nurse #8 of the incident. NA #8 was asked if Resident #74 had any previous physical altercations with other residents. She indicated she believed Resident #74 had physical behaviors in the past, but she was unsure if she was involved in any previous resident to resident altercations.

An interview was conducted with the Director Nursing (DON) on 10/18/18 at 3:35 PM. She stated that she expected residents to be protected from the physical behaviors of other residents. She also stated she expected staff to

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provide adequate supervision to prevent resident to resident physical altercations.
4. An observation conducted on 10/17/18 at 8:34 AM revealed the medication room in the secured dementia unit was unlocked and was in a resident accessible area. The medication room was at the rear of the nurses' station which was accessible to residents via a swinging half door which when closed, was only secured with a slide latch. There were no staff members within the medication room nor were there any staff members monitoring the medication room door at the time of the observation. Upon entering the unlocked medication room several 10 dispensing boxes of resident medication were observed on the counter. Further observation revealed accessible syringes, injectable medications, over the counter stock medications, and other various medical supplies. Upon exiting the medication room multiple residents were observed to be ambulating or had congregated near the nurses' station where the medication room was located.

An observation conducted on 10/17/18 at 10:51 AM revealed the medication room in the secured dementia unit was unlocked in a resident accessible area. There were no staff members within the medication room nor were there any staff members monitoring the medication room door at the time of the observation. Upon exiting the medication room multiple residents were observed to be ambulating or had congregated near the nurses' station where the medication room was located.

An observation conducted on 10/18/18 at 8:19 AM revealed the medication room in the secured dementia unit was unlocked in a resident accessible area. There were no staff members

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F 689	Continued From page 87 within the medication room nor were there any staff members monitoring the medication room door at the time of the observation. Upon exiting the medication room multiple residents were observed to be ambulating or had congregated near the nurses' station where the medication room was located. An observation was conducted in conjunction with an interview with the Director of Nursing (DON) on 10/18/18 at 9:07 AM. The observation revealed the medication room in the secured dementia unit was unlocked in a resident accessible area. There were no staff members within the medication room nor were there any staff members monitoring the medication room door at the time of the observation. The DON stated it was her expectation for all medication rooms in the facility to be locked. During an interview conducted with the DON on 10/18/18 at 3:35 PM the DON stated it was her expectation for all medication rooms to be locked. The DON further stated it was her expectation for medications, sharps, and other hazardous supplies to be secured and out of potential contact from residents.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		11/15/18

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F 690	Continued From page 88 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to provide urinary catheter care (Resident #54) for 1 of 5 sampled residents reviewed for urinary catheter. Findings included: Resident #54 was admitted on 11/19/15 with the diagnoses of urinary tract infection (UTI) and quadriplegia.	F 690	F 690 Bowel / Bladder Incontinence Catheter How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident # 54 was provided with catheter care as directed in the plan of care on 10/17/18 by Certified Nursing Assistants (CNA). How the facility will identify other residents	

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F 690	Continued From page 89 The quarterly Minimum Data Set dated 9/12/18 revealed the resident had an intact cognition with other behavior which occurred 1 to 3 days in the week. The resident required extensive assistance of 2 staff for all activities of daily living (ADL) except locomotion was one staff and meals were set up. The active diagnoses were neurogenic bladder, UTI, and retention of urine. The care plan dated 9/13/18 revealed goals and interventions for ADLs, personal hygiene, toileting, and urinary tract infections with urosepsis. On 10/17/18 at 12:15 pm an observation was done of morning care for Resident #54. Nursing assistants (NAs) #1, 2, and #3 provided a complete bed bath and no issues were noted for the bath. NA #2 provided the washing. There were no signs or symptoms of pain during care. None of the three NAs present were observed to perform catheter care to clean the insertion site of the urinary catheter (meatus) and urinary catheter tubing. On 10/17/18 at 12:35 pm NA #2 was interviewed who stated that the treatment nurse (TN) provided the urinary catheter cleaning care each day which included changing the urinary catheter, cleaning the catheter and checking that the catheter was secured. On 10/17/18 at 12:40 pm an interview was conducted with the treatment nurse (TN) who stated that she changed the urinary catheter when needed and made sure the leg strap secured the urinary catheter each day. The TN stated that the NA who provided morning care to bath/shower or personal care was to perform the	F 690	having the potential to be affected by the same deficient practice Residents that have urinary catheters have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Wound Nurse provided nursing staff re-education on the Resident Care Guide to include providing urinary catheter care as indicated on 10/17/2018 to all CNAs to include fulltime, part time and agency staff. For staff not inserviced by 11/15/2018 they will be in-serviced prior to working on the floor. The UM will perform observation and/or interview audits for residents that have urinary catheters. The audits will be performed 3 times a week for 4 weeks, then weekly for 2 months then quarterly thereafter. The audits will be performed at random times on random days including the weekend. How the facility plans to monitor its performance to make sure that solutions are sustained The audits will be performed 3 times a week for 4 weeks, then weekly for 2 months then quarterly thereafter. The results of the audits will be communicated to the DON. The DON will track and trend the results and re-educate or initiate counseling for nursing staff as indicated. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI)	

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F 690	Continued From page 90 urinary catheter care cleaning and to empty the urinary drainage bag. On 10/18/18 at 11:10 am an interview was conducted with NA #1 who stated when Resident #54 received a bed bath yesterday she did not observe catheter care cleaning and did not perform catheter care. NA #1 commented that her role was to hold the resident's contracted legs and had not observed what was being cleaned. NA #1 stated that catheter care cleaning was expected to be done with morning care. On 10/17/18 at 1:15 pm an interview was conducted with the Director of Nursing DON who stated she expected the nursing assistant to provide urinary catheter care cleaning with morning care.	F 690	committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		11/15/18

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F 692	Continued From page 91 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Registered Dietician (RD) interview, the facility failed to implement the interventions as ordered to prevent further weight loss for 1 of 3 sampled residents reviewed for nutrition (Resident # 75). Findings included: Resident #75 was admitted to the facility on 5/5/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/2/18 indicated that Resident #75 had moderate cognitive impairment, was totally dependent for eating and had a significant weight loss. The assessment further indicated that Resident #75 was on a therapeutic and mechanically altered diet. The care plan for Resident #75 dated 10/3/18 was reviewed. One of the care plan problems was state of nourishment, less than body requirement characterized by weight loss, inadequate intake and decreased appetite. The goal was resident would not experience significant weight loss through next review. The approaches included alternate food bites with liquids, use teaspoon when feeding resident, if meals refused, provide extra nourishment and nectar thickening consistency. Resident #75 weights were reviewed. On 5/2/18, he weighed 140 pounds (lbs.), on 6/16/18, he	F 692	F 692 Nutrition Hydration Status Maintenance How corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident #75 is receiving the supplement recommended by the Registered Dietitian (RD) and as ordered by the physician. The order for restorative dining was discontinued as resident is currently receiving Speech Therapy. How the facility will identify other residents having the potential to be affected by the same deficient practice The Certified Dietary Manager (CDM) performed a 100% review of residents' with new dietary supplement orders for the previous 30 days. The results of the audit revealed 1 (one) negative finding which was immediately addressed by the CDM. The MDS (Minimum Data Set) Licensed Nurse performed an audit on 11/20/18 on the November 2018 physician orders for any active restorative dining orders. The audit revealed that currently the center does not have any residents with current orders for restorative dining. Facility Registered Nurse (RN) performed an observation audit of the tray delivery of supplements on 11/8/18 during the lunch meal pass. The audit revealed that of the 33 residents with supplement orders, 6	

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F 692	Continued From page 92 weighed 137 lbs., on 7/2/18, he weighed 138 lbs., on 8/28/18, he weighed 130 lbs., on 9/12/18 he weighed 123 lbs. and on 10/10/18, he weighed 121 lbs. He lost 19 lbs. in 5 months (which equates into a 13.57 percent significant weight loss). On 6/25/18, there was a doctor's order for a dietary supplement to be given 2 times a day at lunch and dinner. The resident's dietary notes were reviewed. On 8/29/18, the notes revealed that Resident #75 had 10 pounds (lbs.) weight loss in 3 months. His meal intake was 50-100 percent (%) for breakfast and lunch and variable intake for dinner 0-100 %. Recommendation was to increase the dietary supplement to 3 times a day and to be served with meals. On 9/24/18, the notes revealed Resident #75's weight on 3/8/18 was 141 lbs. His current weight was 124 lbs. He continued to have a significant weight loss. Recommended to refer Resident #75 to a restorative feeding program. On 10/10/18, the notes revealed that Resident #75 continued to trigger for significant weight loss. His current weight was 123 lbs. Resident was on multiple therapeutic supplements in place to aid with needs including dietary supplement 3 times a day with meals. On 8/29/18, there was a doctor's order to increase the dietary supplement to 3 times a day at breakfast, lunch and dinner and to document percent of intake on the Medication Administration Record (MAR). On 9/24/18, there was a doctor's order for restorative feeding program for significant trending weight loss and dysphagia.	F 692	areas of concern that were addressed immediately by the RN's and the CDM. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/7/18 The Unit Managers (UM) were re-educated by the RD (Registered Dietitian) and the Director of Nursing (DON) on reviewing RD recommendations, including recommendations for restorative dining, processing the recommendations restorative dining, and all new physician orders for dietary supplements prior to the next morning Interdisciplinary Team (IDT) meeting. The review of the orders will include the complete processing of the order to verify transcription to the Medication Administration Record (MAR) or notification to CDM. On 11/9/18 the dietary staff were re-educated on the process of delivery of supplements as ordered and reflected on the individual resident's tray card by the CDM. How the facility plans to monitor its performance to make sure that solutions are sustained The UM will report the findings of the review to the IDT during the next IDT meeting. The end of the month changeover of MAR's will be reviewed by 2 licensed nurses. The CDM will perform an observation audit 3 times a week for 1 week, then weekly for 1 month for the provision of Restorative Dining, dietary supplements	

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F 692	Continued From page 93 On 10/10/18, there was a clarification order for the dietary supplement to be given 3 times a day on meals trays, and to document percent of intake of supplement consumed. The Medication Administration Records (MARs) for August through October 2018 were reviewed and revealed that the dietary supplement was provided twice a day and not 3 times a day as ordered. On 10/15/18 during lunch observation, Resident #75 was observed in bed. A staff member was feeding him. On 10/16/18 and 10/17/18 during breakfast observation, Resident #75 was in his bed. A staff member was observed feeding him. There was no dietary supplement observed on his meal tray. On 10/17/18 at 10:40 AM, the Director of Nursing (DON) was interviewed. She stated that they had 2 restorative aides. Their duties were splinting, restorative ambulation, toileting, restorative feeding and weights. The DON stated that nobody was on restorative feeding/dining program at this time. On 10/17/18 at 11:05 AM, Nurse Aide (NA) #2 was interviewed. NA #2 stated that she was one of the Restorative Aides. She stated that they had 1 resident on restorative feeding/dining at this time but not Resident #75. She indicated that they were not informed that Resident #75 had to be on restorative feeding/dining program. NA #2 further indicated that when a resident was on a restorative feeding program, they should be in the restorative dining room every meal. The	F 692	as recommended by the RD and ordered by the physician. The CDM will share the results of the audits with the DON. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance.	

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F 692	Continued From page 94	F 692		

Restorative Aides had to assist and encouraged them to eat.

On 10/17/18 at 12:45 PM, the RD was interviewed. She verified that Resident #75 had been trending for significant weight loss. She stated that the facility had a weight committee consisting of the department heads and they had a meeting weekly. The RD indicated that Resident #75's weight loss had been discussed during the meeting and the interventions including the restorative feeding program and the increase of the supplement. She also indicated that she had written the orders for the restorative feeding program and the increase of the supplement. The RD further stated that she had identified issues recently that the dietary orders were not communicated to nursing and dietary staff by the staff member who signed off the orders and therefore were not implemented. The RD stated that on 10/10/18, she had to write a clarification order for the supplement because the order dated 8/29/18 to increase the supplement to 3 times a day was not followed and even with the clarification order on 10/10/18, the supplement was still administered twice a day instead of 3 times a day. The RD also indicated that Resident #75 would benefit from the restorative feeding program as the RA would take time in assisting the resident to eat. She further stated that she expected her recommendations to be implemented to prevent further weight loss.

On 10/17/18 at 12:59 PM, the Staff Development Coordinator (SDC) was interviewed. The SDC indicated that he signed off the doctor's order for the restorative feeding program on 9/24/18 but he could not remember if he had informed the restorative aides about it or not.

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F 692	Continued From page 95 On 10/17/18 at 1:10 PM, Nurse #10 was interviewed. Nurse #10 was the nurse who signed off the order dated 10/10/18 to increase the supplement to 3 times a day. She stated that she didn't transcribe the order to the MAR nor sent a diet slip to dietary department but she made a copy of the order and gave it to the nurse to transcribe and to inform the dietary department. Nurse #10 was unable to remember the name of the nurse she had given the copy of the order. On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the interventions for weight loss to be implemented as ordered.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		11/15/18

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F 693	Continued From page 96 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow doctor's order for tube feeding for 2 of 3 sampled residents reviewed for tube feeding (Residents #20 & # 30). Findings included: 1. Resident # 20 was admitted to the facility on 2/28/17 with multiple diagnoses including dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 8/22/18 indicated that Resident #20 was on feeding tube and on therapeutic and mechanically altered diet. The assessment indicated that Resident #20 was not assessed for cognitive status. Resident #20 had a current doctor's order which was initiated on 4/26/17 for tube feeding formula to infuse at 40 milliliter (ml) per hour from 7 PM to 7 AM. On 10/17/18 at 9 AM, Resident #20 was observed in bed with the tube feeding infusing at 40 ml per hour. On 10/17/18 at 11:05 AM, Resident #20 was observed in bed with the tube feeding infusing at 40 ml per hour. On 10/17/18 at 11:06 AM, Nurse #6 was interviewed. She stated that she was assigned to work on different halls and she didn't know that Resident #20's tube feeding had to be turned off	F 693	F 693 Tube Feeding Management/Restore Eating Skills How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #20 and #30 are currently receiving tube feedings as ordered by the physician was verified by visual observation of the tube feeding pumps, review of documentation on the MAR (Medication Administration Record) and current physician orders by the DON (Director of Nursing) and UM (Unit Manager) on 10/18/18. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents with tube feeding orders have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/7/18 The Unit Manager (UM)were re-educated by the Director of Nursing on reviewing all new physician orders for tube feeding orders prior to the next morning Interdisciplinary Team (IDT) meeting including start and stop times. UM will observe that residents are receiving enteral tube feedings as ordered 3 times weekly on random days at	

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F 693	Continued From page 97 at 7 AM. Nurse #6 was observed to turn off the resident's feeding tube at 11:06 AM. On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the order for tube feeding to be followed as ordered. 2. Resident #30 was admitted to the facility on 9/27/18 with multiple diagnoses including dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 8/2/18 indicated that Resident #30 had long and short term memory problems. The assessment did not indicate that the resident was on feeding tube. Resident #30 had a current doctor's order which was initiated on 9/27/17 for tube feeding to infuse at 50 milliliter (ml) per hour and to be off at 7 AM and on at 11 AM. On 10/17/18 at 9:00 AM, Resident #30 was observed in bed with tube feeding infusing at 50 ml per hour. On 10/17/18 at 9:10 AM, Nurse #6 was interviewed. She stated that she was assigned to work on different halls and she didn't know that Resident #30's tube feeding had to be turned off at 7 AM. Nurse #6 was observed to turn off the resident's the feeding tube at 9:10 AM. On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the order for tube feeding to be followed as ordered.	F 693	random times including the weekends for compliance with physician orders. How the facility plans to monitor its performance to make sure that solutions are sustained The UM will report the finding of the review to the IDT during the next IDT meeting. On 11/7/2018, Director of Nursing (DON) initiated re-education of the licensed nurses on tube feeding orders and administration of tube feedings including MAR review. For licensed nurses not inserviced by 11/15/2018 they will be inserviced prior to working in the facility. New hires and agency staff will receive this education during orientation to the facility. The UM will perform an observation audit 3 times a week for 1 week, then weekly for 1 month for the provision of tube feedings as recommended by the RD and ordered by the physician. The UM will share the results of the audits with the (DON). The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the	

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F 693	Continued From page 98	F 693	need for continued monitoring to ensure continued compliance in the area of tube feeding management.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to monitor and to draw the laboratory test as ordered for 2 of 5 sampled residents reviewed for unnecessary medications (Residents #279 & # 280). Findings included:	F 757	F 757 Drug Regimen is Free from Unnecessary Drugs How corrective action will be accomplished for those residents found to have been affected by the deficient practice Laboratory tests for residents #279 and #280 were obtained on 10/18/18. The	11/15/18

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F 757	Continued From page 99 1. Resident #279 was admitted to the facility on 9/28/18 with multiple diagnoses including septicemia, stage 4 sacral pressure ulcer and osteomyelitis. The admission Minimum Data Set (MDS) assessment dated 10/5/18 indicated that Resident # 279 had moderate cognitive impairment and was admitted with unstageable and deep tissue injury (DTI) pressure ulcers. The assessment also indicated that the resident had a diagnosis of septicemia. The hospital discharge summary dated 9/27/18 indicated that Resident #279 had osteomyelitis and required 6 weeks of antibiotics. The notes indicated to continue with ceftriaxone (antibiotic) (IV) 2 grams daily and doxycycline (antibiotic) 100 mgs (by mouth) twice a day until 10/31/18. The notes further indicated that while on antibiotics, the resident should have a CBC and renal panel weekly and a hepatic function panel every 2 weeks. Resident #279 had doctor's orders dated 9/28/18 for ceftriaxone 2 grams (GM) intravenous (IV) daily and doxycycline 100 milligrams (mgs) by mouth twice a day for septicemia/osteomyelitis and a complete blood count (CBC) and chemistry 7 to be drawn on 10/1/18. Resident #279's medical records were reviewed and there were no laboratory tests results noted including the CBC and chemistry 7 in the hard copy chart and electronic records. On 10/18/18 at 9:10 AM, interview with Nurse # 6, assigned to Resident #279, was conducted. She stated that she could not find laboratory tests	F 757	results for resident # 279 were abnormal but not critical labs, the physician was made aware of the results of the labs on 10/18/18 by the licensed nurse assigned to the resident. The results for resident #280 revealed abnormal but not critical labs, the resident's physician was made aware of the results on 10/18/18 by the licensed nurse assigned to the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/7/2018, the Unit Manager (UM) was re-educated on reviewing all new physician orders for lab orders prior to the next morning Interdisciplinary Team (IDT) meeting by the Director of Nursing (DON). The review of the orders will include the complete processing of the order to include transcription to the Lab Sheet/Program. How the facility plans to monitor its performance to make sure that solutions are sustained The UM will report the findings of the review to the IDT during the next IDT meeting. The end of the month changeover of physician's orders will be reviewed by 2 licensed nurses. The UM will perform an lab audit weekly of newly ordered labs for obtaining specimen for labs, results received and physician notified for 1 month then monthly thereafter for obtaining and receiving results of the laboratory orders by the physician. The UM will share the results of the audits with Director of Nursing (DON).	

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F 757	Continued From page 100 dated 10/1/18 for CBC and chemistry 7 for Resident #279. On 10/18/18 at 10:44 AM, the Director of Nursing (DON) was interviewed. The DON stated that the laboratory tests (CBC and chemistry 7) ordered for 10/1/18 were not drawn. She stated that once the laboratory test was ordered and entered into their system, the phlebotomist could see the order and draw the blood. If the laboratory test was ordered stat, the facility staff had to draw the blood and sent the specimen to the hospital. The DON indicated that the ordered laboratory tests (CBC and chemistry 7) for Resident #279 were not entered into the system and therefore the blood was not drawn. On 10/18/18 at 3:40 PM, the DON was again interviewed. She stated that she expected the admitting nurse to read the hospital discharge summary and to write orders for the laboratory tests written in the hospital discharge instruction. The DON also stated that she expected the laboratory test to be followed as ordered and as recommended per hospital discharge summary. 2. Resident #280 was admitted to the facility on 5/21/08 and was re-admitted on 8/20/18 with multiple diagnoses including hyperlipidemia, atrial fibrillation and ventricular tachycardia. The quarterly Minimum Data Set (MDS) assessment dated 8/27/18 indicated that Resident #280 had severe cognitive impairment. The hospital discharge summary dated 8/20/18 revealed that Resident #280 was started on digoxin 125 microgram on 8/16/18 due to atrial fibrillation versus flutter.	F 757	The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance.	

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F 757	Continued From page 101 Resident #280 had admitting doctor's orders dated 8/20/18 for Lipitor (used to treat hyperlipidemia) 20 milligrams (mgs) at bedtime for hyperlipidemia and digoxin (anti-arrhythmic drug) 125 mcg daily for atrial fibrillation/ventricular tachycardia. On 9/18/18, the notes from the drug regimen review revealed the need for digoxin level and lipid panel. On 10/17/18 at 4:15 PM, the Quality Assurance (QI) Nurse was interviewed. She stated that she could not find lipid panel and digoxin level results for Resident #280. On 10/18/18 at 10:44 AM, the Director of Nursing (DON) was interviewed. She stated that the digoxin level and the lipid panel should have been drawn on admission but they were not. She also stated that she didn't get into the September 2018 pharmacy recommendations for Resident #280 and therefore the digoxin level and the lipid panel were not drawn. On 10/18/18 at 3:40 PM, the DON was again interviewed. She stated that she expected that digoxin level and lipid panel obtained on admission and when requested by the Pharmacy Consultant.	F 757		
F 758 SS=E	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,	F 758		11/15/18

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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 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

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F 758	Continued From page 103 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 observation, record review, staff interview, and Psychiatric Nurse Practitioner interview, the facility failed to administer antipsychotic medication as ordered for 1 of 5 residents reviewed for unnecessary psychotropic medications. Resident #8 received an additional 0.5 milligrams of Risperdal (antipsychotic medication) for a period of 30 days. The findings included: Resident #8 was admitted to the facility on 2/1/16 and most recently readmitted on 6/26/17 with diagnoses that included psychotic disorder and dementia with behavioral disturbance. A physician's order dated 6/19/18 indicated Risperdal (antipsychotic medication) 0.5 milligrams (mg) 3 times daily for 3 days then Risperdal 1 mg once daily. The quarterly Minimum Data Set (MDS) assessment dated 7/6/18 indicated Resident #8 had short-term and long-term memory problems and moderately impaired decision-making skills. He had no behaviors and no rejection of care. Resident #8 received antipsychotic medication on 7 of 7 days during the MDS review period. A Psychiatric Nurse Practitioner (PNP) note dated 8/22/18 indicated a recommendation to reduce Resident #8 ' s Risperdal 1 mg once daily to Risperdal 0.5 mg once daily.	F 758	F 758 Free from Unnecessary Psychotropic Meds/ PRN use How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/18/18 the order for Risperdal 1mg by mouth every am was re-written to reflect the order that was written on 8/29/18. On 11/14/18, the Director of Nursing (DON) and nursing Unit Manager (UM) verified that the Monthly Physician orders, dated for 11/1/18 through 11/30/18, and the current November 2018 MAR (Medication Administration/ Record) were reflective of the order that was written for Risperdal 1 mg by mouth every am for resident #8 on 8/29/18. The Director of Nursing and Unit Manager visually observed the current MAR for documentation of the medication administration as ordered. The observation by the DON and nursing unit manager revealed that resident was receiving medication as ordered as evidence by the documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/7-8/18, the desk nurse completed a review of all residents with new antipsychotic orders for the previous 30 days. The review identified five resident	

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F 758	Continued From page 104 A physician's order dated 8/22/18 indicated a decrease in Resident #8 ' s Risperdal from 1 mg once daily to 0.5 mg once daily. A PNP note dated 8/29/18 indicated Resident #8 had an increase in behaviors and aggression with recent medications changes. The PNP indicated she instructed the nurse to give Resident #8 Risperdal 0.5 mg now for one dose due to aggressive behaviors/agitation and to increase Risperdal back to 1 mg once daily. A nursing note dated 8/29/18 indicated the PNP saw Resident #8 and new orders were given to change Risperdal to 1 mg once daily. A physician's order dated 8/29/18 indicated Risperdal 0.5 mg now one time and an increase in Resident #8's Risperdal from 0.5 mg once daily to 1 mg once daily. A review of the August 2018's hard copy Medication Administration Record (MAR) indicated Risperdal was administered as ordered to Resident #8. A PNP note dated 9/5/18 indicated Resident #8 had a failed Gradual Dose Reduction (GDR) of Risperdal in August 2018. Medications were resumed as originally ordered and staff noted an improvement in mood and behaviors. A review of the September 2018 hard copy MAR for Resident #8 revealed two physician's orders for Risperdal. The first order, dated 8/22/18, was electronically printed on the hard copy MAR and indicated Risperdal 0.5 mg once daily for Resident #8. The second order, dated 8/29/18,	F 758	orders requiring further investigation. The desk nurse and DON immediately obtained clarification and took necessary action, including notification of the physician and resident/resident representative as appropriate. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/14/18, the DON completed re-education of the nurse unit managers on reviewing all new physician orders for antipsychotics prior to the next morning interdisciplinary team (IDT) meeting. The review of the orders will include the complete processing of the order to include transcription to the medication administration record (MAR). The nurse unit manager will report the finding of the review to the IDT team during the next morning IDT meeting. On 11/14/18, the DON implemented the practice that the end-of-month changeover of MARs will be reviewed by two licensed nurses. How the facility plans to monitor its performance to make sure that solutions are sustained On 11/14/18, the desk nurse will begin auditing 10% of the resident medication administration records MARs for changeover accuracy each month for 12 weeks, then quarterly for 12 months. The DON will share the results of the audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI)	

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F 758	Continued From page 105 was handwritten on the hard copy MAR and indicated Risperdal 1 mg once daily for Resident #8. Both orders, Risperdal 0.5 mg and Risperdal 1.0 mg, were administered once daily from 9/1/18 through 9/30/18. The 8/22/18 order for Risperdal 0.5 mg once daily had been discontinued by the physician on 8/29/18, but had not been discontinued on the September 2018 MAR. This resulted in the administration of an additional 0.5 mg of Risperdal once daily for 30 days for Resident #8. An observation was conducted of Resident #8 in his room in his wheelchair on 10/15/18 at 12:15 PM. There were no behavioral issues observed. Resident #8 was alert and oriented to self only. An observation was conducted of Resident #8 in the hallway of his unit in his wheelchair on 10/17/18 at 11:05 AM. There were no behavioral issues observed. Resident #8 was alert and oriented to self only. An interview was conducted with the Director of Nursing (DON) on 10/18/18 at 11:30 AM. The DON was asked who was responsible for the changeover of MARs and for reviewing and/or monitoring MARs to ensure medications were administered as ordered. She reported the normal process was for the third shift nurses to review the next month ' s MARs for accuracy and prevention of transcription errors when they were printed out at the end of the previous month. She indicated the third shift nurses were also responsible for reviewing the MARs at the end of the month to ensure medications were administered as ordered. The DON stated her expectation was for medications to be administered as ordered.	F 758	committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance.	

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F 758	Continued From page 106	F 758		

This interview with the DON continued. The physician's orders dated 8/22/18 and 8/29/18 related to Resident #8's Risperdal were reviewed with the DON. The September 2018 MARs for Resident #8 were reviewed with the DON. The DON confirmed Resident #8 was administered an additional 0.5 mg of Risperdal once daily for 30 days in September 2018. She stated that the hard copy MARs were printed on 8/29/18 and had included the 8/22/18 physician's order for Risperdal 0.5 mg once daily for Resident #8. She reported the 8/29/18 physician's order for Risperdal 1 mg once daily for Resident #8 was handwritten onto the MAR. She revealed that when the handwritten order for Risperdal 1 mg was added onto the September 2018 MAR on 8/29/18, that the 8/22/18 order for Risperdal 0.5 mg should have been discontinued. The DON explained that since the 8/29/18 order came after the hard copy MARs were printed (8/29/18), the error was not caught during the MAR review at the end of August. She additionally explained that during the month of September the facility admitted a total of 49 residents who were evacuated from other facilities due to weather related emergencies. She revealed that this high number of new admissions disrupted the facility's normal processes and she felt this was why the error was not discovered at the end of month MAR review.

A phone interview was conducted with the PNP on 10/18/18 at 2:32 PM. She confirmed that Resident #8 had failed the GDR of Risperdal in August 2018 and she changed his Risperdal order back to 1 mg once daily on 8/29/18. She was unaware Resident #8 had received an additional 0.5 mg of Risperdal once daily for 30

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F 758	Continued From page 107 days in September 2018. The PNP indicated she expected her orders to be followed.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interview, the facility failed to prevent a significant medication error when prescribed antibiotics were not administered as ordered for 1 of 1 sampled resident reviewed with infection (Resident # 279). Findings included: Resident #279 was admitted to the facility on 9/28/18 with multiple diagnoses including septicemia and osteomyelitis. The admission Minimum Data Set (MDS) assessment dated 10/5/18 indicated that Resident # 279 had moderate cognitive impairment, had a stage 4 sacral pressure ulcer and had diagnoses of septicemia and osteomyelitis. The hospital discharge summary dated 9/27/18 indicated that Resident #279 had osteomyelitis and required 6 weeks of antibiotics. The notes indicated to continue with ceftriaxone (antibiotic) intravenous (IV) 2 grams daily and doxycycline (antibiotic) 100 milligrams (mgs) by mouth twice a day until 10/31/18. Resident #279 had doctor's orders dated 9/28/18	F 760	F 760 Residents are Free of Significant Med Errors How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #279 is receiving medication as ordered by the physician. On 11/14/18, the Director of Nursing (DON) and nursing unit manager verified that the Monthly Physician orders, dated for 11/1/18 through 11/30/18, and the current November 2018 MAR (Medication Administration/ Record) were reflective of the orders for resident #279. How the facility will identify other residents having the potential to be affected by the same deficient practice The desk nurse performed a review of residents' with new antibiotic orders for the previous 30 days. The Desk Nurse review included availability of medication to administer as ordered. Any negative findings were addressed/investigated immediately by the auditor, including notification of the physician as appropriate. What measures will be put into place or	11/15/18

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F 760	Continued From page 108 for ceftriaxone 2 grams (GM) intravenous (IV) daily and doxycycline 100 milligrams (mgs) by mouth twice a day for septicemia/osteomyelitis. The order for the 2 antibiotics did not have a stop date. The September 2018 Medication Administration Records (MARs) for Resident #279 were reviewed. On September 29 and 30, the boxes on the MAR did not have nurse's initials to indicate that ceftriaxone 2 grams IV and the AM dose of doxycycline were administered. Resident #279 had 2 missed doses of ceftriaxone (9/29 and 9/30) and 2 doses of doxycycline (AM dose). The October 2018 MARs were reviewed. On October 14 through 18 (except on the 15), the boxes on the MAR for ceftriaxone and doxycycline (AM and PM dose) had circled initials indicating that the medications were not administered. Resident #279 had 5 missed doses of ceftriaxone IV and 9 doses of doxycycline. On 10/18/18 at 9:05 AM, Nurse #9 was interviewed. Nurse #9 stated that she was assigned to Resident #279 on October 14 and 16. She stated that she did not administer the ceftriaxone and the doxycycline on October 14 and 16 because they were not available. She also stated that she had faxed a request form for refill to pharmacy. On 10/18/18 at 9:15 AM, the Pharmacist from the facility's pharmacy was interviewed. She stated that the orders for the ceftriaxone and the doxycycline had no stop date and the pharmacy had automatic stop date of 10 days. The Pharmacist stated that according to the pharmacy records, they had sent a total of 13 bags of	F 760	systemic changes made to ensure that the deficient practice will not recur On 11/8/2018, Unit Managers (UM) were re-educated by the DON on reviewing all new physician orders for antibiotics prior to the next morning interdisciplinary team (IDT) meeting. The review of the orders will include the complete processing of the order to include transcription to the medication administration record (MAR) as well as the availability of the newly ordered medication. The UM will report the finding of the review to the IDT team during the next IDT meeting. The end of the month changeover of MARs will be reviewed by 2 licensed nurses. How the facility plans to monitor its performance to make sure that solutions are sustained The desk nurse will audit 10% of the MARs for changeover accuracy each month for 12 weeks, then quarterly thereafter. The UM will share the results of the audits with Director of Nursing (DON). The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the	

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F 760	Continued From page 109 ceftriaxone to the facility (3 bags on 9/28, 7 bags on 10/1 and 3 bags on 10/8) and 20 capsules of doxycycline on 9/28/18 and they had not receive any more refill request from the facility. The Pharmacist stated that they had a backup pharmacy but the ceftriaxone IV had to come from their pharmacy. On 10/18/18 at 10:10 AM, Nurse #11 was interviewed. She stated that she worked at the other nursing facility and she came at this facility to help. She remembered that she had worked either 9/29/18 or 9/30/18 and had administered the antibiotics but she forgot to initial the MAR. On 10/18/19 at 11:30 AM, Nurse # 6 was interviewed. She stated that she was assigned to Resident #279 on October 17 and 18. She stated that she didn't administer the ceftriaxone and the doxycycline on both dates because they were not available. She stated that she had faxed a refill request form to the pharmacy on 10/17/18 but the medications did not come. On 10/18/18 at 3:40 PM, the Director of Nursing (DON) was interviewed. She stated she expected the nurses to fax the request form to the pharmacy in advance and to call when the medication did not come during the night delivery. She also stated that she expected that medications were administered as ordered.	F 760	need for continued monitoring to ensure continued compliance.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		11/15/18

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F 761	Continued From page 110 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 2 of 2 medications rooms observed (main medication room and dementia care unit). Findings included: 1. On 10/17/18 at 11:45 AM, the main medication room was observed. The following were observed: Three (3) - 118 milliliter (ml) bottles of Loperamide Hydrochloride (anti diarrhea drug) with expiration date of 6/2018.	F 761	F 761 Label /Store Drugs and Biologicals How corrective action will be accomplished for those residents found to have been affected by the deficient practice The expired medications and undated multi dose medications were discarded on 10/17/18 by the Director of Nursing (DON). How the facility will identify other residents having the potential to be affected by the same deficient practice All resident have the potential to be affected. What measures will be put into place or	

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F 761	Continued From page 111 One bottle of opened Purified Protein Derivatives (PPD) (used to diagnose tuberculosis) that was undated. On 10/17/18 at 11:59 AM, Nurse # 1 was interviewed. Nurse #1 verified that the 3 bottles of Loperamide HCL had expiration date on 6/2018 and were expired. She also verified the opened bottle of PPD had no date of opening. Nurse #1 stated that PPD should have been dated when opened and it was good for 30 days after opening. On 10/17/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. She stated that nurses were responsible for checking the medication rooms monthly for expired medications. On 10/18/18 at 3:40 PM, the DON was again interviewed. She stated that she expected nursing staff to discard expired medications and to date multi dose medications including PPD and to discard it per the manufacturer's specification. 2. An observation was conducted on 10/17/18 at 8:34 AM of the dementia unit medication storage room. The observation revealed an opened, undated, 10 milliliter (ml) glass vial (bottle) of injectable lidocaine 10milligrams (mg)/ml. The vial was marked as having been a multi-dose vial. The vial was not marked with an opened date or a dispose by date. Further observation of the refrigerator revealed an opened and undated bottle of Tuberculin (TB) Purified Protein Derivative (PPD) (Mantoux) solution. The bottle of PPD solution was observed to have been neither dated with an opened date or a dispose by date. The bottle appeared to have been used	F 761	systemic changes made to ensure that the deficient practice will not recur All licensed nurses will be re-educated by the Director of Nursing or the Unit Manager (UM) regarding the daily checking of medication carts for expired medications and dating of multi-dose medications by 11/15/2018. New hires and agency staff will receive this education during orientation to the facility. How the facility plans to monitor its performance to make sure that solutions are sustained The UM's will perform observation audits for expired meds and undated multi-dose medications weekly. The UM will ensure all medication carts and medication rooms are audited monthly. The results of the audits will be communicated to the DON. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 112 due to the cap having been removed and was observed to have been less than full. Review of the package insert with the PPD solution discovered in the box with the PPD solution revealed the manufacturer's recommendations were if the vial were opened and entered (a needle inserted into the rubber top) and in use for 30 days, the bottle should be discarded. An observation and interview with the Director of Nursing (DON) was conducted on 10/18/18 at 9:07 AM of the dementia unit medication storage room. The observation revealed an opened, undated, 10 milliliter (ml) glass vial (bottle) of injectable lidocaine 10milligrams (mg)/ml. The vial was marked as having been a multi-dose vial. The vial was not marked with an opened date or a dispose by date. Further observation of the refrigerator revealed an opened and undated bottle of Tuberculin (TB) Purified Protein Derivative (PPD) (Mantoux) solution. The bottle of PPD solution was observed to have been neither dated with an opened date or a dispose by date. The bottle appeared to have been used due to the cap having been removed and was observed to have been less than full. The DON stated it was her expectation for multi-dose vials of injectable medications to have been dated when opened. During a second interview conducted with the DON on 10/18/18 at 3:35 PM the DON stated it was her expectation for multi-dose vials of injectable medications to be dated when opened and discarded 28 days after having been opened.	F 761		
F 842	Resident Records - Identifiable Information	F 842		11/15/18

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F 842 SS=E	Continued From page 113 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 114 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records regarding code status for 6 of 25 sampled residents reviewed regarding code status (Residents #8, #11, #29, #73, #74, and #280). Findings included: 1. Resident #11 was admitted to the facility on 5/10/10 with multiple diagnoses to include	F 842	F 842 Resident Records – Identifiable Information How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/18/18 through 11/14/18, the social services director, medical records director, minimum data set (MDS) nurse and/or Director of Nursing (DON)	

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F 842	Continued From page 115 diabetes, end stage renal disease, and Parkinson's disease. The quarterly Minimum Data Set dated 10/2/18 revealed the resident had an intact cognition. The resident required extensive assistance of two staff for all transfers and dressing, and set up for meals. Active diagnoses were heart failure, Parkinson's disease, peripheral vascular disease, and diabetes. A review of the resident's electronic physician order dated 5/10/10 documented full code status. A review of the resident's physician progress note dated 10/8/18 documented do not resuscitate (DNR) and noted that the resident's advance care directive and healthcare proxy were documented in the chart. A review of the resident's medical record revealed there was no physician signed DNR determination and no DNR red sticker on the binder of the record as was observed with other resident charts with DNR advance directive. On 10/17/18 at 11:30 am an interview was conducted with the resident ' s attending physician who stated he would review the medical record and correct the advanced directive when in the facility on Monday. On 10/17/18 at 5:30 pm an interview was conducted with the Social Worker (SW) who observed the hard copy and electronic documentation of the resident ' s medical record for the physician order and progress notes. SW commented that the physician order and progress note did not match. SW stated she would call the	F 842	contacted the resident/resident representative and updated the code status for Resident #8, #11, #29, #73, #74, and #280 to ensure the facility had accurate medical records regarding code status for all current residents. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/18/18 through 11/14/18, the social services director completed an audit of the current code status documented in the medical record of all current residents for accuracy. The audit revealed 58 out of 101 multiple residents did not have an updated code status documented in the medical record or the medical record contained conflicting documentation regarding the preferred code status. This audit of 101 residents includes 49 evacuees that were sent to the facility as a result of Hurricane Florence from evacuation shelters. On 10/18/18 through 11/14/18, the social services director, medical records director, minimum data set (MDS) nurse, nursing unit manager, and/or DON contacted the resident/resident representative and updated the code status for residents identified during the audit. The Social Services Director will discuss the advance directive status with the resident or the resident’s representative at annually, at significant change, readmission from hospital and at any change in advance directives or resident’s request.	

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F 842	Continued From page 116 physician to determine where the DNR status in the progress note was obtained. On 10/17/18 at 5:45 pm an interview was conducted with SW who stated after speaking with the physician who felt the order was correct would correct his progress note on Monday. The SW stated the physician informed her to follow the order. On 10/18/18 at 4:30 pm an interview was conducted with the Director of Nursing who stated she expected the resident's record to be accurate. 2. Resident #29 was admitted to the facility on 12/7/17 with multiple diagnoses which included altered mental status, peripheral vascular disease, chronic kidney disease stage 3, unspecified dementia without behavioral disturbance, encephalopathy, CKD stage 3, and epilepsy. A review of the resident's quarterly Minimum Data Set dated 8/2/18 revealed the resident was severely cognitively impaired. The resident required extensive assistance of two staff for all transfers, one person for all remaining activities of daily living (ADL) except meals were set up and supervision. A review of the resident's physician order dated 1/10/18 revealed a full code status. A review of the resident's medical record was a signed advanced directive DNR form and DNR red sticker on the record's binder edge.	F 842	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 10/18/18, the DON communicated with the medical director on the inaccuracy of the code status in the medical record; the DON/medical director also informed the nurse practitioner. On 11/14/18, the medical director/nurse practitioner completed documentation of the applicable code status of residents that reside in the facility. On 11/14/18, the facility was maintaining a current list of residents with a “do not resuscitate (DNR)” order to have available for the medical director and nurse practitioner during their visits to the center. On 11/14/18, the social services director, nurse unit manager, weekend nurse manager, admissions director, and/or DON began discussing advanced directives with residents and/or residents’ representatives upon admission, re-admission and annually. How the facility plans to monitor its performance to make sure that solutions are sustained On 11/14/18, the social services director began auditing 10% of current residents each quarter to ensure accuracy of medical records regarding code status. On 11/14/18, the social services director began sharing the results of audits with the interdisciplinary team (IDT) quarterly for six months. The IDT will make recommendations and take corrective action based on audit outcomes. The social services director and/or medical records director will present IDT	

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F 842	Continued From page 117 On 10/17/18 at 11:30 am an interview was conducted with the resident ' s attending physician who stated he would review the medical record and correct the advanced directive when in the facility on Monday. On 10/17/18 at 5:30 pm an interview was conducted with the Social Worker (SW) who observed the hard copy and electronic documentation of the resident's medical record for the physician order of full code status, advanced directive DNR determination signed by the physician and red DNR sticker on the record's binder. SW commented that the physician order and advance directive did not match. SW stated she would call the physician to determine the correct status. On 10/17/18 at 5:45 pm an interview was conducted with SW who stated after speaking with the physician who would review the record on Monday and correct the status. The SW stated the physician informed her to follow the order. On 10/18/18 at 4:30 pm an interview was conducted with the Director of Nursing who stated she expected the resident's record to be accurate. 3. Resident #8 was admitted to the facility on 2/1/16 and most recently readmitted on 6/26/17 with diagnoses that included psychotic disorder and dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 7/6/18 indicated Resident #8 had short-term and long-term memory problems and moderately impaired decision-making skills. A Nurse Practitioner (NP) note dated 9/11/18	F 842	corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance.	

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indicated Resident #8's code status was Do Not Resuscitate (DNR) with comfort measures only.

A physician note dated 10/8/18 indicated Resident #8's code status was DNR with comfort measures only.

Resident #8's hard copy physician's order summary for October 2018 indicated his code status was full code.

A review of the Resident #8's medical record on 10/17/18 revealed there was no physician signed DNR determination and no DNR red sticker on the binder of the record as was observed with other resident charts with DNR advance directive.

An interview was conducted with the Social Worker (SW) on 10/18/18 at 11:20 AM. The physician's progress note (dated 10/8/18) and NP progress note (dated 9/11/18) that indicated Resident #8's code status was DNR with comfort measures only was reviewed with the SW. The October 2018 physician's order summary that indicated Resident #8's code status was full code as well as the medical record that contained no physician signed DNR determination was reviewed with the SW. The SW confirmed the code status documentation for Resident #8 had not matched. She revealed she spoke with the physician regarding this issue related to another resident on 10/17/18 and he indicated he was going to review the code status documentation this upcoming Monday (10/22/18) when he returned to the facility. She reported the physician stated that if there was no physician signed DNR determination that the resident was a full code. The SW indicated after this issue was brought to her attention on 10/17/18 she began

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completing an audit on each current facility residents' medical records to ensure all the documentation related to code status matched.

A phone interview was conducted with the NP on 10/18/18 at 4:00 PM. The NP stated that when a resident was discharged to the hospital and readmitted to the facility that the resident's code status sometimes changed while in the hospital and was then not reflected in her progress notes or in the physician's progress notes. She stated she would review the resident records on her next visit to the facility to ensure the appropriate code status was documented in her progress notes. The NP confirmed the physician's statement that if there was no physician signed DNR determination that the resident was a full code

An interview was conducted with the Director of Nursing on 10/18/18 at 3:35 PM. She stated she expected the residents' medical records to be accurate and for documentation related to code status to be up to date.

4. Resident #74 was admitted to the facility on 2/1/16 and most recently readmitted on 6/26/17 with diagnoses that included schizophrenia and dementia.

The quarterly Minimum Data Set (MDS) assessment dated 10/1/18 indicated Resident #74's cognition was severely impaired.

A physician note dated 8/6/18 indicated Resident #8's code status was Do Not Resuscitate (DNR).

A Nurse Practitioner (NP) note dated 9/11/18 indicated Resident #74's code status was DNR.

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Resident #74's electronic physician's orders were reviewed on 10/18/18. An active physician's order dated 6/15/16 indicated Resident #74's code status was full code.

A review of the Resident #74's medical record on 10/18/18 revealed there was no physician signed DNR determination and no DNR red sticker on the binder of the record as was observed with other resident charts with DNR advance directive.

An interview was conducted with the Social Worker (SW) on 10/18/18 at 11:20 AM. The physician's progress note (dated 8/6/18) and NP progress note (dated 9/11/18) that indicated Resident #74's code status was DNR was reviewed with the SW. The electronic physician's order dated 6/15/16 that indicated Resident #74's code status was full code as well as the medical record that contained no physician signed DNR determination was reviewed with the SW. The SW confirmed the code status documentation for Resident #74 had not matched. She revealed she spoke with the physician regarding this issue related to another resident on 10/17/18 and he indicated he was going to review the code status documentation this upcoming Monday (10/22/18) when he returned to the facility. She reported the physician stated that if there was no physician signed DNR determination that the resident was a full code. The SW indicated after this issue was brought to her attention on 10/17/18 she began completing an audit on each current facility residents' medical records to ensure all the documentation related to code status matched.

A phone interview was conducted with the NP on 10/18/18 at 4:00 PM. The NP stated that when a

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resident was discharged to the hospital and readmitted to the facility that the resident's code status sometimes changed while in the hospital and was then not reflected in her progress notes or in the physician's progress notes. She stated she would review the resident records on her next visit to the facility to ensure the appropriate code status was documented in her progress notes. The NP confirmed the physician's statement that if there was no physician signed DNR determination that the resident was a full code

An interview was conducted with the Director of Nursing on 10/18/18 at 3:35 PM. She stated she expected the residents' medical records to be accurate and for documentation related to code status to be up to date.

5. Resident # 280 was admitted to the facility on 5/21/08 with multiple diagnoses including schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated 8/27/18 indicated that Resident #280 had severe cognitive impairment.

Review of the Physician's orders for September and October 2018 revealed that Resident #280 was a Full Code.

The Physician's progress notes dated 9/18/18 (written by the Nurse Practitioner) and 10/3/18 (written by the physician) indicated that Resident #280's code status was "do not resuscitate" (DNR).

On 10/17/18 at 5:10 PM, the Social Worker (SW) was interviewed. She stated that she was responsible for the resident's code status. The SW had verified that Resident #280 was a Full code and she didn't know why the doctor's progress notes indicated that he was a DNR. At

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5:30 PM, the SW stated that she had called the physician of Resident #280 who stated that it might be an error on his part.

On 10/18/18 at 4:00 PM, interview with the Nurse Practitioner was conducted. She stated that the code status written on her progress notes might not be accurate. The code status written on the physician's order in the hard copy or electronic records was the correct code status for the resident.

On 10/18/18 at 4:30 pm an interview was conducted with the Director of Nursing who stated she expected the resident's record to be accurate.

6. Resident #73 was admitted to the facility on 8/29/16. The resident's cumulative diagnoses included: Diabetes, chronic obstructive pulmonary disease (COPD), dementia, and arthritis.

Review of Resident #73's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/1/18. The resident was coded as having been cognitively intact and as having required supervision with little or no assistance for all Activities of Daily Living (ADLs) including bed mobility, transfer (such as from a bed to a wheelchair), eating, and toileting.

A review was completed of Resident #73's physician progress note, completed by the Nurse Practitioner (NP), dated 5/22/18. The documentation next to Code Status in the note was "Do Not Resuscitate (DNR/no Cardio Pulmonary Resuscitation (CPR))."

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A review was completed of Resident #73's physician progress note, completed by the resident's physician, dated 9/10/18. The documentation next to Code Status in the note was "Do Not Resuscitate (DNR/no Cardio Pulmonary Resuscitation (CPR))."

A review completed on 10/16/18 at 9:12 AM of Resident 73's Electronic Medical Record (EMR) revealed a physician's order for the resident to be a full code.

An observation was conducted in conjunction with an interview with the Medical Records Director (MRD) on 10/17/18 at 12:07 PM. The observation revealed a drop-down menu in Resident #73's EMR providing the information Resident #73 was a full code. The MRD stated the drop-down menu was available for staff who had access to the resident's EMR. The MRD further stated when a resident was a full code there would not be a golden rod sheet or stop sign document, indicating the resident was a Do Not Resuscitate (DNR), in the resident's hard copy of chart under the Advance Directives tab. An observation of Resident #73's hard copy of the chart revealed no golden rod sheet or stop sign document under the Advance Directives tab. The MRD stated Resident #73 was a full code.

A phone interview was conducted with the NP on 10/18/18 at 4:00 PM. The NP stated the code status written in her progress notes may not be accurate. The NP further stated the code status written on the physician's order in the hard copy of the chart or the EMR would have been the correct code status for the resident.

During an interview conducted with the Director of

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F 842	Continued From page 124 Nursing (DON) on 10/18/18 at 4:30 PM she stated it was her expectation for the resident's record to be accurate.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 4/26/18 recertification survey in the areas of Self Determination (F561), Abuse and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessary Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). These 8 deficiencies were cited again on the current recertification survey of 10/18/18. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to:	F 867	F867 QAPI /QAA Improvement Activities The facility's quality assurance and performance improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the 4/26/18 recertification survey in the areas of: Self Determination (F561), Abuse and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessary Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). These eight (8) deficiencies were cited again on the current recertification survey completed on 10/18/18. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance (QAA) program.	11/15/18

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	345293	A. BUILDING _____ B. WING _____	C 10/18/2018

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F 867	Continued From page 125 1a. F561 Self Determination: Based on record review, observations, staff interviews, and resident interview, the facility failed to provide showers as scheduled for 1 of 2 residents reviewed for choices (Resident #54). During the recertification survey of 4/26/18 the facility was cited at F561 Self Determination for failing to honor a resident ' s choice to receive showers over bed baths. b. F600 Abuse and Neglect: Based on record review, observation, and staff interview, the facility neglected to provide supervision and to manage the physical behaviors of cognitively impaired residents for 2 of 2 residents (Residents #10 and #56) reviewed for neglect. This failure resulted in Resident #10 initiating physical altercations with 5 cognitively impaired residents (Residents #8, #18, #26, #74, and #329) and Resident #56 slapping a cognitively impaired resident (Resident #18) twice in a 40-minute time period. During the recertification survey of 4/26/18 the facility was cited at F600 Abuse and Neglect for neglecting to provide adequate supervision of cognitively impaired residents. c. F641 Assessment Accuracy: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of hospice care (Resident #44), medications (Resident # 280), diagnoses (Residents #280 & #11) and nutrition (Resident #30) for 4 of 20 sampled residents whose MDS assessments were reviewed. During the recertification survey of 4/26/18 the	F 867	On 11/12/18, the corporate facility consultant in-serviced the facility administrator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of Self Determination (F561), Abuse and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessary Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). The facility QAPI Committee is comprised of the: medical director, administrator, director of nursing, minimum data set (MDS) nurses, quality improvement/infection control nurse, admissions director, wound nurse, nursing unit managers, social services director, activities director, dietary manager, environmental services director, maintenance director, payroll, bookkeeping, a staff nurse, nursing assistant, pharmacy consultant. On 11/12/18, the corporate facility consultant in-serviced the QAPI committee and reviewed the purpose and function of QAA/QAPI committee and reviewed on-going compliance issues. The quarterly QAPI committee will hold a meeting in December 2018 to review the deficiencies from the 10/18/18 survey and go over the approved plan of correction	

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F 867	Continued From page 126 facility was cited at F641 Assessment Accuracy for failing to code the MDS accurately in the areas of medications, physical restraints, and Activities of Daily Living. d. F677 Activities of Daily Living Care: Based on observations, record review, and staff interviews the facility failed to provide fingernail care for one of two dependent residents reviewed for Activities of Daily Living (ADLs) (Resident #5). During the recertification survey of 4/26/18 the facility was cited at F677 ADL Assist Care for failing to provide incontinent care and nail care. e. F689 Accidents: Based on record review, observation, and staff interview, the facility failed to provide supervision of cognitively impaired residents with known histories of combative behaviors (Residents #10, #56, and #74) to prevent physical altercations with other cognitively impaired residents for 3 of 3 residents reviewed for resident to resident incidents. The facility also failed to secure one of two medication storage rooms (memory care unit). During the recertification survey of 4/26/18 the facility was cited at F689 Accidents for failing to implement fall risk interventions, failing to provide adequate supervision for cognitively impaired residents, failing to monitor a resident ' s wanderguard, and failing to thoroughly analyze falls to determine causative factors and implement appropriate interventions to prevent further falls. f. F757 Unnecessary Medications: Based on record review, and staff interview, the facility	F 867	(PoC) with the medical director and pharmacy consultant. On 11/14/18, the administrator completed in-servicing with the department heads on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies in the areas of Self Determination (F561), Abuse and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessary Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). After the facility consultant in-service on 11/12/18, the facility QAPI Committee began identifying other areas of quality concern through the quality improvement (QI) review process during the daily interdisciplinary team (IDT) meetings and monthly QI committee meetings, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations. The QI committee will meet at a minimum of monthly and QAPI committee meets a minimum of quarterly to identify issues related to quality assessment and assurance activities and will develop and implement appropriate plans of action for	

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F 867	Continued From page 127 failed to monitor and to draw the laboratory test as ordered for 2 of 5 sampled residents reviewed for unnecessary medications (Residents #279 & # 280). During the recertification survey of 4/26/18 the facility was cited at F757 Unnecessary Medications for failing to monitor a resident ' s blood glucose level as ordered. g. F758 Unnecessary Psychotropic Medications: Based on observation, record review, staff interview, and Psychiatric Nurse Practitioner interview, the facility failed to administer antipsychotic medication as ordered for 1 of 5 residents reviewed for unnecessary medications. Resident #8 received an additional 0.5 milligrams of Risperdal (antipsychotic medication) for a period of 30 days. During the recertification survey of 4/26/18 the facility was cited at F758 Unnecessary Psychotropic Medications for administering an antipsychotic medication to a resident without a physician ' s order and failing to ensure that as needed (PRN) psychotropic medications were time limited in duration. h. F760 Significant Medication Errors: Based on record review and staff and pharmacist interview, the facility failed to prevent a significant medication error when prescribed antibiotics were not administered as ordered for 1 of 1 sampled resident reviewed for infection (Resident #279). During the recertification survey of 4/26/18 the facility was cited at F760 Significant Medication Errors for failing to prevent a significant medication error by administering an	F 867	identified facility concerns. Corrective action has been taken for the identified concerns in the areas of: Self Determination (F561), Abuse and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessary Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). The facility administrator is responsible for implementing an effective QAPI/QAA program.	

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F 867	Continued From page 128	F 867		

antipsychotic medication to a resident for almost 3 months without a physician ' s order.

An interview was conducted with the Administrator and the Director of Nursing (DON) on 10/18/18 at 4:10 PM. The Administrator indicated he was the head of the facility ' s QAA Committee. He stated he was not the Administrator during the previous recertification survey of 4/26/18 as he just began his role at this facility on 9/4/18. The Administrator and DON reported they were aware of the citations from the previous recertification survey. They both shared that the facility had admitted a total of 49 new residents during September 2018 due to a neighboring facility ' s evacuation caused by a weather-related emergency. They indicated this influx of new residents disrupted the normal flow of the facility processes which they believed contributed to the citations at F561 Self Determination, F677 ADL Care, F757 Unnecessary Medications, F758 Unnecessary Psychotropic Medications, and F760 Significant Medication Errors. The Administrator reported that he believed the repeat citation at F641 Assessment Accuracy was due to the facility operating with only one MDS Nurse since 9/12/18 when their second MDS Nurse left her full-time position. He stated that they were in the process of hiring an additional MDS Nurse and in the meantime a corporate MDS Consultant had been assisting with the assessments. The DON spoke about the citations at F600 Abuse and Neglect and F689 Accidents. She stated that the residents these citations involved had very challenging behaviors. She reported that the facility had plans to begin working with a behavioral health provider who offered services to

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F 867	Continued From page 129 residents as well as education and training to staff members on managing high acuity residents with challenging behaviors. She was hopeful this additional education would assist staff in developing the skillsets to better manage resident behaviors.	F 867		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a safe environment as evidenced by one of two over the bed lights had unprotected electrical wires and an exposed filament extending from a socket which were not protected or contained within the over the bed light in one of nine rooms reviewed for environment (Room #406). The findings included: An observation of the over the bed light on the window side of room 406, which was occupied by two residents, was conducted on 10/15/18 at 11:44 AM. The observation revealed a visible black wire extending above the over the bed light on the left side of the light. Further observation revealed the black wire was connected to a light bulb socket which contained what appeared to have been a light bulb filament due to several exposed wires protruding from the socket. There was no observed glass at or near the socket. In addition, there was a white wire connected to the	F 921	F 921 Safe /Functional/ Sanitary/Comfortable Environment How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/17/18, the maintenance director repaired the electrical wires in room #406. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/9/18, the maintenance director completed an observation audit of over-the-bed lights. The audit revealed no over-the-bed lights in disrepair as of 11/9/18.	11/15/18

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F 921	Continued From page 130 socket which returned into the over the bed light frame. During a round conducted on 10/16/18 at 3:16 PM an observation of room 406 was conducted. An observation of the over the bed light on the window side of the room revealed a visible black wire extending above the over the bed light on the left side of the light. Further observation revealed the black wire was connected to a light bulb socket which contained what appeared to have been a light bulb filament due to several exposed wires protruding from the socket. There was no observed glass at or near the socket. In addition, there was a white wire connected to the socket which returned into the over the bed light frame. During a round conducted on 10/17/18 at 9:59 AM an observation of room 406 was conducted. An observation of the over the bed light on the window side of the room revealed a visible black wire extending above the over the bed light on the left side of the light. Further observation revealed the black wire was connected to a light bulb socket which contained what appeared to have been a light bulb filament due to several exposed wires protruding from the socket. There was no observed glass at or near the socket. In addition, there was a white wire connected to the socket which returned into the over the bed light frame. An interview was conducted with Nurse #1 on 10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which	F 921	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/10/18, the maintenance director and/or maintenance worker began a schedule to complete an audit of over-the-bed lights on a quarterly basis for one year. On 11/14/18, the unit manager or interdisciplinary team (IDT) member began monitoring over-the-bed lights weekly during compliance rounds. How the facility plans to monitor its performance to make sure that solutions are sustained The maintenance director or unit manager will share the results of the compliance rounds with the administrator. The maintenance director and/or unit manager will share the results of the compliance rounds with the safety committee and the quality improvement (QI) committee on a monthly basis for 12 weeks. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The maintenance director or unit manager will present the	

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F 921	Continued From page 131 managed work orders. A round was conducted in conjunction with an interview with the Maintenance Director (MD) along with an observation of room 406 on 10/17/18 at 4:18 PM. An observation of the over the bed light on the window side of the room revealed a visible black wire extending above the over the bed light on the left side of the light. Further observation revealed the black wire was connected to a light bulb socket which contained what appeared to have been a light bulb filament due to several exposed wires protruding from the socket. There was no observed glass at or near the socket. In addition, there was a white wire connected to the socket which returned into the over the bed light frame. The MD stated he was unaware of the exposed electrical wires, loose socket, and exposure of the possible filament. The MD stated the wires, socket, and possible filament should have been contained within the over the bed light, needed to be repaired, and he would have liked to have had it brought to his attention sooner. The MD stated the needed repair of the electrical wire, socket, and possible filament was an important matter and he would address it promptly. At the completion of the round conducted on 10/17/18 at 4:18 PM the MD demonstrated how the work orders were categorized and documented in the work order software program. A review of recent work orders was completed, back to August 1, 2018. The review revealed no submitted work orders documenting the exposed electrical wire, socket, or possible filament. An interview was conducted with the administrator on 10/18/18 at 9:16 AM. The	F 921	findings and recommendations of the monthly QI committee to the quarterly quality assurance and performance improvement (QAPI) committee for further recommendations and oversight.	

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F 921	Continued From page 132 Administrator stated it was his expectation for the over the bed lights to be intact. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for the maintenance department would be completed. Upon maintenance being made aware of the identified maintenance issue through the work order, the maintenance department would be able to complete the necessary repairs.	F 921		