STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 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 observation, record review, resident and staff interviews, the facility failed to report a lock box that was not functioning properly and failed to report complaints from a resident that money had been stolen from her to the administrator for 1 of 1 resident (Resident #11) reviewed for misappropriation of private property. The findings included: Review of a Policy and Procedure entitled Abuse and Neglect Prohibition dated revision date 08/17 revealed the policy read in part: "Reporting and Responses" "1. State Reporting Obligations: The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, protective services (where state law	F 607	Please accept this Plan of Correction (POC) as Surry Community Health and Rehabilitation Center□s credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of noncompliance. The POC is being provided pursuant to Federal and State requirements which require an acceptable Plan of Correction as a condition of continued certification. Date of Alleged compliance December 07, 2018 F607 Develop/Implement Abuse/Neglect Policies 1. The facility failed to report a lock box that was not functioning properly and failed to report complaints from Resident #11 that money had been stolen from her to the administrator. Lock box was assessed by maintenance on 11/10/2018 and found to be functioning properly. Facility	12/7/18

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

Electronically Signed | 12/07/2018

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F 607	Continued From page 1 provides for jurisdiction in long term care facilities) in accordance with Federal and State law through established procedures. Timeline for reporting is as follows: b. If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, a report is made not later than 24 hours after the management staff becomes aware of the allegation;" Resident #11 was admitted to the facility on 11/11/17 with diagnoses which included chronic obstructive pulmonary disease (COPD), heart failure, anxiety disorder, and others. Review of Resident #11's quarterly Minimum Data Set (MDS) dated 10/17/18, revealed she was assessed by the facility as cognitively intact for daily decision making and required limited to extensive assistance of 1-2 staff for most activities of daily living (ADL). An interview on 11/06/18 at 9:03 AM with Resident #11 revealed about a week or so ago she had $80.00 stolen and had told staff (could not remember names) and it had not been recovered. Resident #11 stated one family member had given her $60.00 and another family member had given her $20.00. The resident stated it had been in her wallet inside her purse but had been moved inside her lock box in her top drawer in her bedside table. Resident #11 stated her lock box had not been working when a staff member (could not remember which staff member) had tried to lock up her wallet but maintenance had since checked it and told her it was working. The resident stated the lock box	F 607	Administrator initiated a 24 hour report regarding misappropriation of property on 11/10/2018. 2. Residents with lock boxes have the potential to be affected by this alleged deficient practice. Audit of all current lock boxes performed and no issues were noted on 11/10/2018 by Maintenance Director. Random audit performed with other residents by Director of Nursing on 11/10/2018 and no issues were reported. 3. Director of Nursing or Nurse Management to re-educate staff by 12/07/18 on notifying supervisor immediately if lock box not functioning properly and to secure any resident property kept in box. New Hires will be educated on this process during orientation by Director of Nursing/Nurse Management. Director of Nursing or Nurse Management to re-educate staff regarding receiving concerns; they should acknowledge receipt of concern and immediately notify grievance official. New will be educated on this process during orientation. Maintenance will check all lock boxes weekly x 12 weeks to ensure functioning properly. Administrator or Administrative Staff will interview 5 random residents weekly x 12 weeks to ensure any concerns been reported. Administrator or Administrative Staff will interview 5 random staff members weekly x 12 weeks to ensure all concerns voiced to them have been reported. 4. The Administrator will report findings of the audits to QAPI committee monthly x	

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F 607	Continued From page 2 was working and the lock box was observed to be in the top drawer with the key in it. A phone interview on 11/08/18 at 9:44 AM with the SW and Resident #11's family member revealed the family member had brought the resident $60.00 and put it in her wallet. The family member could not remember the exact day she brought the money to Resident #11 but stated it was within the last 2-3 weeks. The family member stated she had given her the money for her to get a perm at the facility An interview on 11/08/18 at 11:13 AM with Resident Assistant (RA) #1 revealed on Friday, 10/26/18 at approximately 3:00 or 3:30 PM Bingo had finished up in the dining room and Resident #11 asked RA #1 to assist her back to her room. RA #1 stated the resident asked her to put her $1.00 and 25 cents she had from Bingo in her wallet. RA #1 said as she was putting the money in her wallet some other money fell out and Resident #11 asked her to count the money. RA #1 stated it was four 20 dollar bills and three 1 dollar bills for a total of $83.00 and stated there was some additional change in the wallet that she did not count. RA #1 stated she put the money in her brown wallet that had a design on it and put the wallet in her lock box that was mounted in her top drawer beside her bed. RA #1 stated she attempted several times to close the lock box but stated she could not get it to close. RA #1 asked Resident #11 what she wanted her to do about the lock box and the resident told her just to leave the wallet in the box but asked her to get the $3.00 so she could go get her a drink and snack. RA #1 stated she handed Resident #11 her $3.00 and	F 607	3 months to evaluate the effectiveness and amend as needed.	

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assisted her to the vending machine where the resident purchased a drink and a snack and then assisted her back to her room. RA #1 stated again that she had not told anyone about not being able to close the lock box that contained Resident #11's wallet and money. RA #1 stated she had not heard anything about missing money until today when NA #3 and NA #4 asked her if she knew anything about missing money in Resident #11's room. RA #1 stated she told them she did not know anything about missing money but knew the resident had had $80.00 dollars in her wallet 2 weeks ago. RA #1 stated she had given the resident the key to the lock box when she could not get it to close and stated the resident had it around her neck when she left the room.

An interview on 11/08/18 at 09:13 AM with NA #3 who typically worked on the hall on which Resident #11 resided stated the resident was always complaining about missing money and had complained just this past week. NA #3 stated she thought the resident forgot what she had and how much she had. NA #3 stated she had been through her socks and there was no money in them so she did not report the resident's complaint to anyone.

An interview was conducted on 11/08/18 at 9:32 AM with Nurse #1 who usually worked the 100 hall. Nurse #1 stated Resident #11 was always complaining about her money missing and stated she had complained just this past week about missing money. Nurse #1 stated typically the resident did not have that much money. Nurse #1 stated Resident #11 sometimes had a small amount of money from Bingo but stated she had

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never known the resident to have a lot of money and stated she had a lock box to keep her money in. Nurse #1 stated she had not reported the resident's complaint to anyone.

An interview on 11/08/18 at 9:38 AM with NA #4 who typically worked on the 100 hall revealed Resident #11 was always complaining about money missing and stated she typically did not have that much money. NA #4 stated she had heard Resident #11 complaining just this past week about her money missing but did not recall how much but just that she was missing some money. NA #4 stated she had not reported the resident's complaint to anyone.

An interview on 11/08/18 at 9:39 AM with the Social Worker (SW) revealed she was Resident #11's ambassador and checked on her frequently. The SW stated Resident #11 always complained about missing money and stated she often was confused about her money. The SW stated she had not heard anything about the missing $80.00.

A review of a SW note on 11/09/18 at 10:00 AM written on 11/08/18 at 6:44 PM revealed the SW with the permission of Resident #11 had searched her room for the missing money. According to the note after a total search of the room $20.00 and 83 cents was found.

An interview on 11/09/18 at 3:33 PM with the Unit Manager revealed it was her expectation that missing money be reported immediately after Resident #11 told someone about it but stated she was not aware of the missing money.

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F 607	Continued From page 5 An interview on 11/09/18 at 3:38 PM with the Director of Nursing (DON) revealed it was her expectation that missing money reported by a resident be reported and investigated immediately after report from residents. An interview on 11/09/18 at 3:51 PM with the Administrator revealed she was not aware of the stolen money until reported yesterday at 10:00 AM and stated it was her expectation for all employees to report to someone in administration when a resident stated they have had money stolen from them. The Administrator further stated it was her expectation that it be reported immediately.	F 607		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to accurately code broken dentures for 1 of 1 resident (Resident #11) reviewed for dental services, code Hospice services for 1 of 1 resident (Resident #110) reviewed as closed record for death and code correct discharge location for 1 of 1 resident (Resident #112) reviewed as closed record for discharge to the community. The findings included: 1. Resident #11 was admitted to the facility on 11/11/17 with diagnoses which included type two diabetes mellitus, sleep apnea, chronic obstructive	F 641	F641 Accuracy of Assessments 1. The facility did not accurately code broken dentures for Resident #11, code Hospice services for Resident #110, and code correct discharge for Resident #112. MDS for resident # 112 was corrected to reflect correct discharge location by Resident Care Management Director on 11/8/2018. MDS for resident # 11 was corrected to reflect broken dentures, by Resident Care Management Director on 11/13/2018. MDS for resident # 110 was corrected to reflect hospice services by Resident Care Management Director on 12/5/2018.	12/7/18

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F 641	Continued From page 6 pulmonary disease (COPD), heart failure, anxiety disorder, history of falling and others. Review of an Incident/Accident Report dated 07/28/18 revealed on that evening, Resident #11 was trying to pull herself up in bed, her skin was stuck to the mattress because there was no sheet on it, her hand slipped and she hit her face on the side rail breaking her upper denture in half. The broken denture was placed in the denture cup and the cup placed in her top bedside table drawer. A review of Resident #11's annual comprehensive Minimum Data Set (MDS) dated 09/03/18 revealed the resident was cognitively intact for daily decision making and required limited to extensive assistance with activities of daily living. The MDS further indicated Resident #11 had no broken or loosely fitting full or partial denture. A review of Resident #11's quarterly MDS dated 10/17/18 again revealed the resident had no broken or loosely fitting full or partial denture. An interview with Resident #11 on 11/06/18 at 9:09 AM revealed she had broken her upper denture when she had accidentally hit her face on the side rail. Resident #11 stated she heard a pop when her face hit and stated her upper denture came out of her mouth and was broken in half. The denture was observed in a blue denture cup in her top bedside drawer and it was broken into two pieces. An interview was conducted with the MDS nurse on 11/08/18 at 10:37 AM. The MDS Nurse confirmed she had completed the comprehensive assessment dated 09/03/18, and the quarterly	F 641	2. Residents that receive hospice services, who have dentures, and residents discharged have the potential to be affected by this alleged deficient practice. Resident Care Management Director completed an audit of all OBRA assessments completed in the last 30 days for correct coding for broken dentures, hospice services and correct discharge location. Any issues found were corrected by Resident Care Management Director on 12/7/2018. 3. District Care Management Director will provide education to MDS staff on accurate coding of sections A, L and O on 12/5/2018. Director of Nursing or Nurse Management will audit 5 MDS weekly x 12 weeks to monitor for accurate coding for sections A, L and O. 4. The Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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assessment dated 10/17/18 for Resident #11. The MDS Nurse stated she had coded the dental status incorrectly on both assessments and would correct the mistakes immediately.

An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON stated that she expected each MDS assessment to be completed accurately because the staff were signing each assessment indicating they were accurate.

2. Resident #110 was admitted to the facility on 01/07/16 and expired in the facility on 09/26/18. Resident #110's diagnoses included: non-Alzheimer's dementia, anxiety, depression, atrial fibrillation, hypertension, diabetes, and deep vein thrombosis.

Review of a physician order dated 11/22/17 read: Full Hospice services.

Review of the comprehensive minimum data set (MDS) dated 11/30/17 indicated that Resident #110 was moderately impaired for daily decision making and had long/short term memory problem. The MDS further indicated that Resident #110 required extensive assistance with activities of daily living and had less than 6 months to live. Hospice services were not identified on the MDS.

An interview was conducted with the MDS Nurse on 11/08/18 at 10:37 AM. The MDS Nurse confirmed that she had completed the comprehensive assessment for Resident #110 dated 11/30/17. The MDS Nurse stated that she overlooked hospice on that assessment in error and she would correct the mistake immediately.

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An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON stated that she expected each MDS assessment to be completed accurately because the staff were signing each assessment indicating that they were accurate.

3. Review of Resident #112's medical record revealed he was admitted to the facility on 08/07/18 with diagnoses that included hemiplegia and hemiparesis following a stroke, aphasia and chronic pain among others. Resident #112 was discharged from the facility on 08/20/18.

According to Resident #112's discharge Minimum Data Set (MDS) Assessment dated 08/20/18, Resident #112 was discharged to an acute hospital. Resident #112 was coded as being cognitively intact and required limited assistance with bed mobility, dressing, toilet use and personal hygiene.

A review or Resident #112's progress notes revealed a progress note dated 08/20/18 that stated Resident #112 was discharged from the facility to his home. Further review of the progress note revealed Resident #112 was picked up and transferred home by his mother. Additional progress notes reviewed revealed another note dated 08/20/18 by the facility's Social Worker that indicated she had completed the discharge planning for Resident #112 and had scheduled a follow up physician appointment for Resident #112 with his primary care physician.

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F 641	Continued From page 9 An interview with the facility's Social Services Director on 11/06/18 at 4:36 PM revealed she was responsible for all discharge planning for residents in the facility. She reported Resident #112 was a planned discharge from the facility with his discharge location being his home. She reported Resident #112 discharged home on 08/20/18 with his mother. She reported Resident #112 was discharged with all necessary referrals and a follow up appointment with his primary care physician two weeks after discharge home. During an interview with MDS Nurse on 11/08/18 at 3:46 PM it was revealed she had coded Resident #112's discharge MDS Assessment incorrectly when she coded that he had discharged to an acute hospital instead of to the community. She reported it was a coding error and she would need to correct it. An interview with the Director of Nursing on 11/08/18 at 3:52 PM revealed that Resident #112's Discharge MDS Assessment should have reflected that he had been discharged to the community instead of to an acute hospital. She reported it was her expectation that MDS Assessments were to be completed accurately. During an interview with the Administrator on 11/08/18 at 3:59 PM it was revealed it was her expectation that MDS Assessments be completed 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	F 656		12/7/18

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implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the 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

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F 656	Continued From page 11 section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to implement care plan interventions for Geri gloves (Resident #69) and administration of oxygen (Resident #40) as stated in the care plan for 2 of 4 residents sampled for supervision to prevent accidents. The findings included: 1.Resident #69 readmitted to the facility on 04/25/18 with diagnoses that included: heart failure, diabetes mellitus, hypertension, depression, and dementia. Review of an Activity of Daily Living (ADL) care plan dated 04/25/18 read in part, Resident #69 has an ADL self-care performance deficit related to confusion and pain all over. The goal of the care plan read, Resident #69 will maintain current level of function in dressing, bathing, toileting through the review period. The interventions included: encourage resident to wear protective gloves while in wheelchair for skin integrity protection. Review of the comprehensive minimum data set (MDS) dated 09/21/18 revealed that Resident #69 was moderately impaired for daily decision making and had long/short term memory problems. The MDS further indicated that Resident #69 required extensive assistance with ADLs and no rejection of care was noted. Review of a physician's order dated 10/23/18 read, Geri Sleeves/Long sleeves to both arms every day and night shift.	F 656	F656 Develop/Implement Comprehensive Care Plan 1. The facility did not implement care plan interventions for Geri sleeves for Resident #69 (11/5, 11/6, and 11/7) and administration of oxygen for Resident #40 (11/5, 11/6, and 11/7) as stated on care plan. Resident # 69 Geri sleeves/long sleeves were put into place 11/8/2018 by resident care specialist. Resident #40 was assessed for need for continuous oxygen and per the medical director the order was changed to PRN on 11/7/2018. 2. Residents who are care planned for Geri sleeves and oxygen have the potential to be affected by this alleged deficient practice. Audit completed of all current residents with orders for Geri sleeves/long sleeves on 11/8/2018 by the unit manager, any issues were corrected. Audit completed of current residents with orders for oxygen by unit manager on 11/7/2018. Any issues were corrected. 3. Nurse Management or Unit Manager provided re-education to resident care specialist on 11/8/2018 regarding use of Kardex for implementation of Geri sleeves and oxygen interventions. This education will be completed in orientation for new hires. Director of Nursing or Nurse Management to audit 5 residents weekly x 12 weeks with Geri sleeves and oxygen orders to ensure proper implementation. 4. The Director of Nursing will report	

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F 656	Continued From page 12 Review of Resident #69's care Kardex read in part, Geri sleeves. An observation of Resident #69 was made on 11/05/18 at 11:06 AM. Resident #69 was noted to be resting in bed with eyes closed and was covered with a sheet. She appeared comfortable and was dressed in a black and white stripped short sleeve shirt. There were no Geri sleeves in place at this time. An observation of Resident #69 was made on 11/05/18 at 12:29 PM. Resident #69 was observed to be sitting upright in bed and had her lunch tray in front of her. She was dressed in a black and white short sleeve shirt and no Geri gloves were in place. An observation of Resident #69 was made on 11/05/18 at 4:38 PM. Resident #69 was resting in bed with eyes open she smiled and stated she was doing well. She was dressed in a black and white short sleeve shirt and no Geri gloves were in place. An observation of Resident #69 was made on 11/06/18 at 2:25 PM. Resident #69 was resting in bed with her eyes open. She was alert and verbal. She was dressed in a purple short sleeve shirt and no Geri gloves were in place. An observation of Resident #69 was made on 11/06/18 at 4:35 PM. Resident #69 was resting in bed with her eyes closed. She was dressed in a purple short sleeve shirt and no Geri gloves were in place.	F 656	findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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An observation of Resident #69 was made on 11/07/18 at 12:29 PM. Resident #69 was up in wheelchair propelling herself down the hallway. She was dressed in a red colored short sleeve shirt and no Geri gloves were in place.

An interview was conducted with Nursing Assistant (NA) #1 on 11/07/18 at 2:45 PM. NA #1 confirmed that she routinely cared for and was familiar with Resident #69. She stated that Resident #69 was usually up to her wheelchair during the day for at least a few hours. She added that she usually let Resident #69 pick out which clothes she was going to wear for the day including long/short sleeve, but she did assist her with dressing. NA #1 stated that Resident #69 used to wear the Geri gloves a while ago but she believed they had been discontinued so she had not placed them on her.

An interview was conducted with NA #2 on 11/07/18 at 3:15 PM. NA #2 confirmed that she routinely cared for Resident #69 and was familiar with her. NA #2 confirmed that Resident #69 needed assistance with getting dressed and added that she was not aware that Resident #69 was supposed to wear the Geri sleeves each day and that is why she did not have them on. NA #2 stated that the care Kardex for each resident was in the electronic system that they used for documentation and they could refer to as often as they needed.

An observation of Resident #69 was made on 11/07/18 at 3:25 PM. Resident #69 was observed to be resting in bed with her eyes closed. She was dressed in the same red colored shirt she was in

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earlier in the day and no Geri sleeves were in place.

An interview with the Long-Term Care Unit Manager was conducted on 11/09/18 at 10:22 AM. She stated that the NAs were expected to follow the care Kardex guide for each resident and if the resident refused something it should be documented in the medical record.

An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON explained that the care Kardex's were in the electronic system and most of the staff had been in at facility for a long time and were familiar with the residents. She added that the newer staff utilized the Kardex much more often than the staff that had worked at the facility for longer period. The DON stated that acute changes with the residents were communicated verbally but she expected the Geri sleeves to be in place as ordered and instructed by the plan of care and Kardex.

2. Resident #40 was admitted to the facility on 04/20/18 with diagnoses that included: chronic obstructive pulmonary disease (COPD), dementia, anxiety, and others.

Review of a physician's order dated 08/01/18 read, oxygen at 3 liters per minute via nasal cannula continuously. Monitor oxygen saturation every day and night shift.

Review of a care plan dated 08/02/18 read in part, Resident #40 had COPD and required oxygen use. The goal of the care plan read, Resident #40 will

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be free of signs and symptoms of respiratory infections through the review period. The interventions included: oxygen via nasal cannula as ordered.

Review of the quarterly minimum data set (MDS) dated 08/14/18 revealed that Resident #40 was severely cognitively impaired for daily decision making and required assistance with activities of daily living. The MDS further indicated that Resident #40 required oxygen during the assessment reference period.

An observation of Resident #40 was made on 11/05/18 at 11:08 AM. Resident #40 was sitting in her wheelchair in no acute distress. There was an oxygen concentrator sitting by her bed and was turned to 3.5 liters of oxygen. The oxygen tubing was on Resident #40's face but was not in place for inhaling the oxygen it was on her cheek.

An observation of Resident #40 was made on 11/06/18 at 10:14 AM. Resident #40 was sitting up in her wheelchair next to her bed in no acute distress. There was an oxygen concentrator sitting next to her wheelchair that was turned off and oxygen tubing was rolled up in a plastic bag.

An interview was conducted with the Hospice Nurse (HN) on 11/07/18 at 2:14 PM. The HN confirmed that Resident #40 was oxygen dependent at 3 liters per minute and she expected the staff to make sure she had her oxygen in place as directed in her plan of care.

An observation of Resident #40 was made on 11/07/18 at 3:27 PM. Resident #40 was observed

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in an activity in the dining room and was observed to have no oxygen in place.

An interview was conducted with Nursing Assistant (NA) #1 on 11/07/18 at 3:01 PM. NA #1 confirmed that she routinely cared for and was familiar with Resident #40. NA #1 stated that Resident #40 wore oxygen, but she would remove it at times and she would have to replace it.

An interview was conducted with NA #2 on 11/07/18 at 3:09 PM. NA #2 confirmed that she was familiar with Resident #40. NA #2 stated that Resident #40 wore oxygen always and the only time she had seen her without the oxygen was during her showers. NA #2 stated if she saw Resident #40 without her oxygen she would replace the oxygen and alert the nurse.

An interview was conducted with Nurse #7 on 11/08/18 at 5:55 PM. Nurse #7 confirmed that she routinely cared and was familiar with Resident #40. Nurse #7 also confirmed that Resident #40 had an order for oxygen at 3 liters per minute via nasal cannula continuously. She stated that she expected the staff to ensure Resident #40 had her oxygen in place as directed by her plan of care.

An interview with the Long-Term Care Unit Manager was conducted on 11/09/18 at 10:22 AM. She stated that the NAs were expected to follow the care Kardex guide for each resident and if the resident refused something it should be documented in the medical record.

An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON

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F 656	Continued From page 17 explained that the care Kardex's were in the electronic system and most of the staff had been in at facility for a long time and were familiar with the residents. She added that the newer staff utilized the Kardex much more often than the staff that had worked at the facility for longer period. The DON stated that acute changes with the residents were communicated verbally but she expected Resident #40 to have her oxygen in place as directed by her plan of care.	F 656		
F 658 SS=D	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 record reviews and staff interviews the facility failed to initiate a bowel protocol for 2 residents who had not had a bowel movement in 5 and 7 days for 2 of 5 residents sampled for unnecessary medications (Resident #100 and #40). Findings included: A review of a facility document titled in part Routine Standing Orders dated 01/19/17 revealed in part: Constipation (no Bowel Movement for 3 days): Assess for normal active bowel sounds. A. Give 4 ounces warm prune juice as needed B. Give Milk of Magnesia 30 cubic centimeters by mouth x 1 dose C. If no results in 8 hours give Dulcolax suppository x 1	F 658	F 658 Services Provided Meet Professional Standards 1. The facility did not initiate a bowel protocol for resident #100 and resident #40. Bowel protocol was immediately initiated for resident # 100 and Resident # 40 on 11/5/2018. 2. Current residents have the potential to be affected by this alleged deficient practice. Audit of all current residents for bowel movement status was performed by Director of Nursing/Assistant Director of Nursing on 11/8/2018 any issues were addressed when identified. 3. Director of Nursing/Assistant Director of Nursing will re-educate licensed nurses by 12/07/18 on activation of bowel protocol if no bowel movement has been documented in last 9 shifts. New hires will	12/7/18

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F 658	Continued From page 18 D. If no results, notify physician for further orders. 1. Resident #100 was re-admitted to the facility on 12/31/12 with diagnoses which included Parkinson's disease, high blood pressure, heart disease, diabetes, chronic lung disease, gastro-esophageal reflux, constipation and anxiety. A review of a physician's order dated 04/19/17 indicated Senna give 1 tablet by mouth 2 times a day for constipation. A review of the most recent quarterly Minimum Data Set (MDS) dated 10/10/18 revealed Resident #100 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #100 required extensive assistance with toileting and hygiene and was frequently incontinent with bladder and bowel. A review of facility documents revealed there were no bowel movements recorded on 10/17/18, 10/18/18, 10/19/18, 10/20/18 or 10/21/18. A review of a nurse's note dated 10/21/18 at 11:28 AM revealed in part Resident #100 was continent with incontinent episodes of bowel and bladder. The notes indicated bowel sounds were present in x 4. A review of the monthly medication administration record (MAR) dated 10/01/18 through 10/31/18 indicated there were no medications listed on the bowel protocol that had been given to Resident #100.	F 658	be educated by the DON/Nurse Management on the activation of bowel protocol if no bowel movement in the last 9 shifts during the orientation process. During Clinical Morning Meeting the Director of Nursing and Nursing Management will review bowel report 3 x a week for 12 weeks for residents having no bowel movement in 9 shifts and ensure bowel protocol is initiated. 4. The Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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A review of a care plan with a last reviewed date of 10/25/18 revealed in part Resident #100 had constipation related to decreased mobility and the goal indicated Resident #100 would pass formed bowel movements at the preferred frequency of every 3 days through the next review date. The interventions were listed to encourage Resident #100 to sit on the toilet to evacuate bowels if possible, follow facility bowel protocol for bowel management, notify physician as indicated, observe for bowel pattern to ensure adequate bowel elimination, observe medications for side effects of constipation and keep physician informed of any problems.

A review of a Kardex revealed Resident #100 required stand by assistance, check resident frequently and assist with toileting as needed and encourage resident to ask for assistance with toileting.

A review of facility documents revealed there were no bowel movements recorded for Resident #100 on 10/31/18, 11/01/18, 11/02/18, 11/03/18, 11/04/18, 11/05/18 or 11/06/18.

A review of the monthly medication administration record (MAR) dated 11/01/18 through 11/06/18 indicated there were no medications listed on the bowel protocol that had been given to Resident #100.

During an interview on 11/08/18 at 2:59 PM, Nurse #6 who was assigned to provide care to Resident #100 explained if a resident had not had a bowel movement for 9 shifts a list was printed out and was given to the nurse with the resident's name on

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it and the nurse was supposed to address it and give the resident something. He further explained they were supposed to follow standing orders and he usually gave Milk of Magnesia unless the resident had a medication ordered for constipation on an as needed basis. He stated Resident #100 had never been on the bowel lists that had been given to him.

During an interview on 11/08/18 at 4:55 PM, Nurse Aide (NA) #6 explained if a resident had a bowel movement she documented it in the electronic documentation system. She further explained if the resident did not have a bowel movement on her shift she did not document it in the electronic documentation system.

During an interview on 11/08/18 at 5:26 PM, the Assistant Director of Nursing (ADON) explained she ran a report daily for residents who had gone 9 shifts and had not had a bowel movement. She stated she gave the reports to the hall nurses and they were expected to initiate the bowel protocol or if the resident had something ordered for constipation they were expected to give that to them.

During a telephone interview on 11/09/18 at 11:49 AM, NA#7 explained she had provided care to Resident #100. She stated if a resident had a bowel movement she documented it in the electronic documentation system. She stated if a resident did not have a bowel movement she would not document it. She further stated she did not recall a time when Resident #100 went for days without having a bowel movement.

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During an interview on 11/09/18 at 2:58 PM, the Director of Nursing explained the ADON was responsible to run a daily report of residents who had not had a bowel movement after 9 shifts. She further explained the list came from documentation the Nurse Aides entered in the electronic documentation system. She stated after 9 shifts she expected for staff to start with the prune juice. She stated if the resident still had not had a bowel movement they would show up again on the list to be given to the nurse. She further stated it was her expectation for nurses to follow up and initiate the bowel protocol if they had not had a bowel movement. She explained after review of the standing orders she was not sure if the current Medical Director had reviewed or approved the bowel protocol. She stated she was not aware of any abdominal discomfort or abdominal blockages related to Resident #100.

2.Resident #40 was admitted to the facility on 04/20/18 with diagnoses that included: constipation, chronic obstructive pulmonary disease, dementia, anxiety, and others.

Review of a physician order dated 08/01/18 read in part, Senokot (stool softener) 8.6 milligrams (mg) give 1 tablet by mouth two times a day.

Review of the quarterly minimum data set (MDS) dated 08/14/18 revealed that Resident #40 was severely cognitively impaired for daily decision making and required extensive assistance with toileting. The MDS further revealed that Resident #40 was always continent of bowel and no constipation was noted during the assessment reference period.

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Review of facility documents revealed that Resident #40 had no bowel movements on 11/01/18, 11/02/18, 11/03/18, 11/04/18, or 11/05/18.

Review of the medication administration record (MAR) dated 11/01/18 through 11/30/18 revealed that no medications listed on the bowel protocol had been given to Resident #40.

A review of Kardex (care plan) for Resident #40 read in part, check resident frequently an assist with toileting as needed. Provide pericare after each incontinent episode.

An interview was conducted with Nursing Assistant (NA) #6 on 11/08/18 at 4:48 PM. NA #6 confirmed that she had cared for Resident #4 on 11/01/18, 11/02/18, 11/03/18, 11/04/18, and 11/05/18. She stated that at times Resident #40 would use the call bell to alert the staff of her toileting needs and at time she would not and was incontinent. NA #6 stated that if Resident #40 had a bowel movement she would have recorded it in the electronic medical record and if she did not have a bowel movement she would recorded no bowel movements.

An interview was conducted with the Assistant Director of Nursing (ADON) on 11/08/18 at 5:26 PM. The ADON stated that each day she ran a report that listed the residents who had not had a bowel movement in 3 days or 9 shifts. The ADON stated she would give the report to each nurse and they were expected to start the bowel protocol on their residents listed on the report.

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An interview was conducted with NA #8 on 11/08/18 at 5:41 PM. NA #8 confirmed that she had cared for Resident #40 on 11/03/18 and 11/04/18. NA #8 stated that Resident #8 was mostly incontinent of bowel and if she had a bowel movement she would record it in the electronic medical record. NA #8 stated that to her recollection Resident #40 had never had a bowel movement while she was on duty.

An interview was conducted with Nurse #7 on 11/08/18 at 5:55 PM. Nurse #7 confirmed that she routinely cared and was familiar with Resident #40. She stated that the NAs record bowel movements in the electronic medical record and each day the ADON ran a report that listed the residents that had no bowel movement in 3 days or 9 shifts. Nurse #7 stated that the ADON gave the report to each nurse and if we had resident on the list we were expected to initiate the bowel protocol.

An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON stated that the ADON ran a daily report of residents who had not had a bowel movement in 3 days or 9 shifts and gave it to each hall nurse. She further explained that the list came from documentation the NAs entered in the electronic documentation system. The DON stated that after 3 days or 9 shift she expected the hall nurse to initiate the bowel protocol for their residents listed on the report. The DON stated that after she reviewed the bowel protocol she was not sure if the current medical director had reviewed or approved the bowel protocol but stated she was not aware of any abdominal pain, discomfort, or distention that

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F 658	Continued From page 24 Resident #40 had experienced.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to keep a dependent residents fingernail clean for 1 of 4 sampled residents (Resident #69). The findings included: Resident #69 readmitted to the facility on 04/25/18 with diagnoses that included: heart failure, diabetes mellitus, hypertension, depression, and dementia. Review of the comprehensive minimum data set (MDS) dated 09/21/18 revealed that Resident #69 was moderately impaired for daily decision making and had long/short term memory problems. The MDS further indicated that Resident #69 required extensive assistance with personal hygiene and no rejection of care was noted. An observation of Resident #69 was made on 11/05/18 at 11:06 AM. Resident #69 was noted to be resting in bed with eyes closed and was covered with a sheet. She appeared comfortable. Her fingernails were approximately ½ inch long and contained dark brown/black dried substance under each of the nails.	F 677	F677 ADL Care Provided for Dependent Residents 1. Resident #69 was observed on 11/5/18, 11/6/18, and 11/7/18 with dirty finger nails. Resident # 69 nails were cleaned, filed and painted by unit manager on 11/8/2018. 2. Dependent residents have the potential to be affected by this alleged deficient practice. Audit was performed of all current dependent residents on 11/8/2018 by the unit manager and nail care was performed as needed. 3. Director of Nursing and Assistant Director of Nursing will re-educate licensed nurses and nursing assistants to identify and provide nail care as needed to dependent residents by 12/07/18. New hires will be educated by the DON/Nurse Management to identify and provide nail care as needed to dependent residents during the orientation process. Random audits on nail care will be performed on 5 residents weekly x 12 weeks. 4. The Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	12/7/18

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An observation of Resident #69 was made on 11/05/18 at 12:29 PM. Resident #69 was observed to be sitting upright in bed and had her lunch tray in front of her. She was using a spoon to feed herself the puree meal. Her fingernails remained approximately ½ inch long and contained brown/black dried substance under each of the nails.

An observation of Resident #69 was made on 11/05/18 at 4:38 PM. Resident #69 was resting in bed with eyes open she smiled and stated she was doing well. Her fingernails remained approximately ½ inch long and contained dark brown/black dried substance under each nail.

An observation of Resident #69 was made on 11/06/18 at 2:25 PM. Resident #69 was resting in bed with her eyes open. She was alert and verbal. Her fingernails were observed to be approximately ½ inch long with dried brown/black substance under each nail.

An observation of Resident #69 was made on 11/06/18 at 4:35 PM. Resident #69 was resting in bed with her eyes closed. Her fingernails remain approximately ½ inch long with dried brown/black substance under each nail.

An observation of Resident #69 was made on 11/07/18 at 10:00 AM. Resident #69 was resting in bed with eyes open. Her fingernails remain approximately ½ inch long with dried brown/black substance under each nail.

An interview was conducted with Nursing Assistant (NA) #1 on 11/07/18 at 2:45 PM. NA #1 confirmed

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that she routinely cared for and was familiar with Resident #69. NA #1 indicated that nail care was completed during the resident's shower by the shower team who completed the shower and anytime that the nails were dirty or long.

An observation of Resident #69 was made on 11/07/18 at 3:25 PM. Resident #69 was observed to be resting in bed with her eyes closed. Her fingernails remain approximately ½ long and dried brown/black substance remain under each nail.

An interview was conducted with the Rehab Unit Manager (RUM) on 11/08/18 at 11:48 AM. The RUM stated that she had painted Resident #69's fingernails and cleaned from under the nails. She confirmed that there was dried brown/black substance under each nail and it should have been cleaned out during her shower or when the staff noted it during care. The RUM also indicated that Resident #69 preferred to keep her nails long, so she did not want them trimmed.

A follow up interview was conducted with NA #1 on 11/09/18 at 9:23 AM. NA #1 stated that she had not taken Resident #69 to the shower on Wednesday as scheduled but she did give her a good bed bath and had cleaned out from under her nails. She stated that Resident #69 "does not take long to get them dirty again."

An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON stated that Resident #69 enjoyed having her nails painted and preferred to keep them long. She stated that the staff needed to be checking and cleaning Resident #69's nails daily because

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F 677	Continued From page 27 Resident #69 would not clean the food from underneath her nails.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and medical doctor interviews the facility failed to prevent an open wound from being contaminated with urine that contained extended spectrum beta-lactamase (ESBL) (type of microorganism) which resulted in the wound becoming infected for 1 of 1 residents sampled with diabetic foot ulcers (Resident #69). The findings included: Resident #69 readmitted to the facility on 04/25/18 with diagnoses that included: heart failure, diabetes mellitus, hypertension, depression, and dementia. Review of Resident #69's readmission assessment	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers 1. The facility did not prevent Resident #69□s open wound from being contaminated with urine that contained ESBL which resulted in the wound becoming infected. Resident # 69 has no open wound and no active infection of the urinary tract. 2. Residents with open wounds and active urinary tract infection have the potential to be affected by this alleged deficient practice. An Audit of residents with wounds and active urinary tract infection was performed by DON on 11/12/2018 to ensure urine was contained. 3. Education will be provided to licensed	12/7/18

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F 686	Continued From page 28 revealed that she had a wound to her left heel that measured 3.0 centimeters (CM) x 2.0 CM. Review of a weekly skin report dated 05/18/18 revealed that on 05/18/18 the wound to her left foot opened up and became an open wound. Review of a weekly skin report dated 05/25/18 indicated that Resident #69 was observed to drag her left foot on the floor. Review of a physician's order dated 05/25/18 read, Urinalysis with culture and sensitivity due to altered mental status and bladder tenderness. Review of laboratory report dated 05/26/18 read in part, Result: greater than 100,000 colony forming units per milliliter (CFU/ML) lactose fermenting gram negative results (microorganism). Review of a physician's order dated 05/27/18 read in part, Resident #69 on contact isolation due to extended spectrum beta-lactamase (ESBL) (type of microorganism) urine until healed. Review of the quarterly minimum data set (MDS) dated 06/14/18 revealed that Resident #69 was moderately impaired for daily decision making and required limited extensive assistance of one staff member with toileting. The MDS further revealed that Resident #69 had 1 unstageable pressure ulcer that was present on admission to the facility and was receiving pressure ulcer care. Review of a physician's order dated 07/06/18 read, wound culture to left heel due to redness around wound.	F 686	nurses by Director of Nursing and Assistant Director of Nursing to assess for containment of urine to prevent spread of infections to wounds by 12/07/18. New hires will be educated by the DON/Nurse Management to assess for containment of urine to prevent spread of infections to wounds during the orientation process. Director of Nursing and Nurse Management will audit to ensure urine is contained on residents with wounds will be performed weekly x 12 weeks. 4. The Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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Review of a laboratory report dated 07/09/18 read, Site: left heel. Result heavy growth non-lactose fermenting gram negative rod. This isolate is an extended spectrum beta lactamase (ESBL) producing microorganism.

An observation of Resident #69 was made on 11/06/18 at 2:25 PM. Resident #69 was resting in bed with eyes open. She was alert and verbal and no dressing was noted to the left leg.

An interview was conducted with the Wound Nurse (WN) on 11/07/18 at 12:18 PM. The WN stated that Resident #69 had been hospitalized back in April 2018 for a cardiac event and when she returned to the facility she had a wound to her left heel. The WN stated that initially it was necrotic over the heel and she was being followed by the wound doctor. She added that initially they were applying skin prep to the left heel and then on 05/18/18 the necrotic tissue came off and the treatment was changed to something more appropriate for an open wound. The WN stated that at the time Resident #69 was up in her wheelchair daily and used her feet to propel herself around the facility and they had placed EZ boots on her and she refused to wear them. She added that Resident #69 would kick the EZ boots off because they would not allow her to propel herself in her wheelchair. The WN stated that Resident #69 would attempt to toilet herself, but she would not make it to the toilet and would often urinate and defecate on the floor and then walk and move through it while getting back in her wheelchair. The WN added that Resident #69 would often remove the dressing from her left foot despite the reinforced dressing they applied to the wound. She

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stated that one day the wound started to have some redness around the edges of the wound and they decided to culture the wound and it came back with ESBL in the wound. The WN stated she believed that the ESBL in the heel came from the urine that she would walk through while attempting to toilet herself. After the culture came back with ESBL the WN stated she was again placed on isolation precautions and given intravenous (IV) antibiotics and the treatment was changed. The WN stated that during this time Resident #69 began to have a functional decline and was getting up in her wheelchair less and less and would leave the EZ boots in place which helped the overall wound.

An interview was conducted with Nursing Assistant (NA) #1 on 11/07/18 at 2:45 PM. NA #1 confirmed that she routinely cared and was familiar with Resident #69. NA #1 stated that when Resident #69 had the wound to her heel she would often get up on her own and would attempt to toilet herself even though she was not safe to do so. NA #1 stated that they would catch her in the bathroom toileting herself and she would miss the commode and would urinate and defecate on the floor and then walk/move through it trying to get back to her wheelchair. She added that they would have to clean up Resident #69 and the floor. NA #1 stated that Resident #69 was a very heavy wetter and would void in large amounts at a time, soiling her clothes, brief, wheelchair cushion, and floor under her.

An interview was conducted with NA #2 on 11/07/18 at 3:15 PM. NA #2 confirmed that she routinely cared for Resident #69 and was familiar

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with her. NA #2 confirmed that Resident #69 used to toilet herself and would often urinate on the floor and then walk through it trying to get out of the bathroom. NA #2 stated that they tried to keep a close eye on Resident # 69, but they would often times catch her going into the bathroom or coming out of the bathroom. She added if Resident #69 was in an activity they would catch her leaving the activity and going to her room, "and we knew she was going to the bathroom, but we just could not catch her every time." NA #2 confirmed that Resident #69 was a very heavy wetter and voided in large amounts and would often soak her brief, clothes, wheelchair cushion, and floor under her.

An interview was conducted with the Medical Director (MD) on 11/08/18 at 12:35 PM. The MD stated that Resident #69 had poorly controlled diabetes and "the majority of diabetic ulcers grow out ESBL or E-Coli". The MD stated that the wound was contaminated from somewhere and it would not have taken long after the contamination to show signs of infection like redness or foul odor because of her poorly controlled diabetes. The MD added that the treatment of the UA that grew ESBL and the wound that grew ESBL would be the same, IV antibiotics and isolation precautions to try to limit the contamination. The MD stated that Resident #69 "notoriously voided in great amounts" and would not always call for help to the toilet. If the staff saw her heading towards the bathroom they would assist her, but she was someone who would not call for help consistently due to her dementia.

An interview was conducted with the former Infection Control Nurse (ICN) on 11/09/18 at 10:59

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F 686	Continued From page 32 AM. The ICN confirmed that she had just resigned her position on 11/02/18. She stated that Resident #69 was tracked a lot through the infection control program because of her history of infections. She added that Resident #69 was readmitted with a pressure ulcer to her left heel and was seen by wound care. The ICN stated she felt like Resident #69 ' s left heel became infected through her incontinent episodes and then walking through the urine to get back to her wheelchair after self-toileting. The ICN confirmed that with each infection that Resident #69 had that grew ESBL she was placed on isolation precautions, but she liked to roam around the facility and attend activities and would often void in large amounts soiling herself, her clothes, and her dressing to the foot. An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON stated that at the time Resident #69 still had the notion to go to the bathroom and she was trying to self-toilet, but she would not always make it to the toilet in time. The DON stated that the only way to prevent the contamination and what she expected the staff to do was increase their checks of Resident #69 and if the left heel dressing was soiled to change it more often.	F 686		
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	F 690		12/7/18

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F 690	Continued From page 33 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure catheter bags and/or catheter tubing was kept out of contact with the floor for 2 of 5 residents reviewed for catheter care (Resident #39 and Resident #70). The Findings Included:	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI 1. Resident #39 and Resident #70 observed with catheter bag or catheter tubing directly on floor. Resident # 39 and # 70 catheter bag/tubing were positioned off the floor by the Director of Nursing and Unit Manager on 11/7/2018.	

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F 690	Continued From page 34 1. Resident #39 was admitted to the facility on 06/08/18 with diagnoses that included neuromuscular dysfunction of bladder, presence of urinary tract infection, and presence of artificial hip, gross hematuria, Alzheimer's disease and acute kidney failure among others. A review of Resident #39's most recent Minimum Data Set (MDS) Assessment dated 08/13/18 and coded as a quarterly assessment revealed resident to be cognitively impaired. Further review revealed Resident #39 required extensive assistance with her activities of daily living (ADLs) while she required total assistance with bathing. Resident #39 was coded as having a neurogenic bladder and had no issues with pressure sores at the time. A review of Resident #39's monthly November 2018 physician orders revealed orders that included suprapubic catheter care and orders for cleaning and changing of the catheter equipment. A review of Resident #39's current care plan indicated Resident #39 had a suprapubic catheter due to a neuromuscular dysfunction of her bladder. Further review revealed interventions that included hand washing by staff before and after delivery of care, to monitor for signs and symptoms of infection, to provide perineal care as indicated, to provide treatment to the suprapubic catheter as ordered and provide catheter care as ordered. An observation of Resident #39 on 11/05/18 at 11:58 AM as Resident #39 was being transferred to her room for lunch in her wheelchair. The observation at this time revealed Resident #39's catheter bag to be dragging on the floor under her wheelchair with an audible dragging sound	F 690	2. Residents with catheters have the potential to be affected by this alleged deficient practice. Audit completed by Unit Manager on 11/7/2018 to ensure all current residents with catheters/tubing were not on the floor. 3. Director of Nursing and Assistant Director of Nursing will re-educate licensed nurses and resident care specialist by 12/07/18 regarding catheters/tubing not touching the floor. New hires will be educated by the DON/Nurse Management on the catheters/tubing not touching the floor during the orientation process. Director of Nursing and Assistant Director of Nursing will audit all catheters/tubing weekly x 12 weeks to ensure catheters/tubing not touching the floor. 4. The Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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observed.

An observation of Resident #39 on 11/06/18 at 9:49 AM revealed Resident #39 was in her room to the right side of her bed, watching television. An observation of Resident #39's catheter bag and tubing revealed it was sitting directly on the floor at this time.

An additional observation of Resident #39 was completed on 11/07/18 at 3:09 PM. At this time Resident #39 was sitting in her wheelchair, in her room. Resident #39's catheter tubing was observed sitting directly on the floor.

An interview with Nurse #1 on 11/07/18 at 3:22 PM revealed nurses and nurse aides were responsible for catheter care unless there was specific instructions for dressing or cleaning of the catheter, then a nurse would be responsible to provide appropriate catheter care. She further reported that catheter bags should hang below the resident's bladder and the catheter bag and tubing should not come into contact with the floor.

An interview with Unit Manager #1 that occurred on 11/07/18 at 3:29 PM revealed a resident's catheter bag and tubing should not come into contact with the floor. When asked to observe Resident #39's catheter tubing, which was still on the floor at this time, she reported "it's probably not a good idea for it (the catheter tubing) to be like that". At that time she proceeded to adjust Resident #39's leg strap to ensure the tubing was no longer in contact with the floor. She reported she needed to complete staff education to ensure facility staff knew to check and ensure residents with

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catheters did not have their catheter bags and tubing in contact with the floor.

During an interview with the Director of Nursing on 11/08/18 at 4:07 PM it was revealed it was her expectation that catheter bags and tubing be elevated off the floor. She reported if a catheter bag or tubing had been observed touching the floor it was not in the correct spot and stated again she expected catheter bags and tubing to not touch the floor.

An interview with the Administrator on 11/08/18 at 4:11 PM revealed it was her expectation that catheter bags and tubing not come into contact with the floor.

2. Resident #70 was most recently admitted to the facility on 09/09/18 with diagnoses that included benign hyperplasia with lower urinary tract symptoms, intra-abdominal and pelvic swelling, obstructive and reflux uropathy, urinary tract infections, malignant neoplasm of the prostate and anxiety disorder among others. A review of Resident #70's most recent Minimum Data Set (MDS) Assessment dated 09/23/18 and coded as a 14 day assessment revealed Resident #70 was moderately impaired cognitively. Resident #70 was assessed as requiring extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Resident #70 was coded as having an indwelling catheter.

A review of Resident #70's November 2018 physician orders revealed orders that included suprapubic catheter care and orders for cleaning and changing of the catheter equipment.

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A review of Resident #70's current care plan revealed a care plan that addressed his need for a Foley catheter due to a prostate mass resulting in bladder obstruction. Interventions within the care plan included to check tubing for kinks, ensuring the catheter tubing was anchored appropriately, hand washing before and after delivery of care and to observe and document for changes in condition, discomfort or frequency or urination among others.

An observation was completed of Resident #70 on 11/05/18 at 12:04 PM wherein Resident #70 was observed eating his lunch meal in his room while sitting in his wheelchair. Further observation of Resident #70 at this time revealed his catheter tubing was running down his left leg to the outside of his left foot before making contact with the floor and then traveling underneath his left foot which was observed to be flat to the floor, before rising back up to the catheter bag.

An additional observation was made of Resident #70 on 11/05/18 at 4:16 PM in which he was observed in bed resting. Further observation of Resident #70 at this time revealed his bed to be in low position allowing for a majority of Resident #70's catheter bag to come into contact with the floor. Resident #70's catheter bag was observed to be hanging from the bottom bar support of the bed frame close to the midsection of the bed.

During an interview with Nurse #1 on 11/07/18 at 3:22 PM it was revealed nurses and nurse aides were responsible for catheter care unless there was specific instructions for dressing or cleaning of the catheter, then a nurse would be responsible

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F 690	Continued From page 38 to provide appropriate catheter care. She further reported that catheter bags should hang below the resident's bladder and the catheter bag and tubing should not come into contact with the floor. An interview with Unit Manager #1 on 11/07/18 at 3:29 PM revealed when a resident required the use of a low bed the staff should take the catheter bag and use a provided clip to clip it to the top of the mattress at the foot of the bed while making sure the bag remains below the bladder. She reported when the catheter bag is hung in this manner it ensured the tubing and the catheter bag to not come into contact with the floor. She reported catheter bags and tubing should not come into contact with the floor. During an interview with the Director of Nursing on 11/08/18 at 4:07 PM she reported that residents in low bed who had catheters, the catheter bag should be placed using a clip at the foot of the resident's bed at the top of the mattress in order to keep the catheter bag below the bladder and off of the floor. She reported if the catheter bag was hung and touching the floor that it was not secured in the expected place. She reported it was her expectation that catheter bags and tubing should not come into contact with the floor. An interview with the Administrator on 11/08/18 at 4:11 PM revealed it was her expectation that catheter bags and tubing not come into contact with the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		12/7/18

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F 695	Continued From page 39 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to administer oxygen continuously as ordered by the physician for 1 of 2 residents sampled that required oxygen (Resident #40). The findings included: Resident #40 was admitted to the facility on 04/20/18 with diagnoses that included: chronic obstructive pulmonary disease, dementia, anxiety, and others. Review of a physician's order dated 08/01/18 read, oxygen at 3 liters per minute via nasal cannula continuously. Monitor oxygen saturation every day and night shift. Review of the quarterly minimum data set (MDS) dated 08/14/18 revealed that Resident #40 was severely cognitively impaired for daily decision making and required assistance with activities of daily living. The MDS further indicated that Resident #40 received hospice services and required oxygen during the assessment reference period. An observation of Resident #40 was made on	F 695	F695 Respiratory/Trach Care and Suctioning 1. The facility did not administer oxygen continuously as ordered for Resident #40. Resident # 40 was assessed for need for continuous oxygen and per the medical director the order was changed to PRN on 11/7/2018. 2. Residents that requires oxygen has the potential to be affected by this alleged deficient practice. Audit completed by DON on 11/12/2018 of current residents with orders for oxygen. Any issues were corrected. 3. Re-education to licensed nursing staff will be completed by 12/07/18 by the Director of Nursing and Assistant Director of Nursing regarding oxygen orders being implemented per physician order. New hires will be educated by the DON/Nurse Management on oxygen orders being implemented per physician orders during the orientation process. Director of Nursing and Nurse Management will audit 5 residents weekly x 12 weeks to ensure oxygen orders are implemented per physician order. 4. The Director of Nursing will report	

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F 695	Continued From page 40 11/05/18 at 11:08 AM. Resident #40 was sitting in her wheelchair in no acute distress. There was an oxygen concentrator sitting by her bed and was turned to 3.5 liters of oxygen. The oxygen tubing was on Resident #40's face but was not in place for inhaling the oxygen it was on her cheek. An observation of Resident #40 was made on 11/06/18 at 10:14 AM. Resident #40 was sitting up in her wheelchair next to her bed in no acute distress. There was an oxygen concentrator sitting next to her wheelchair that was turned off and oxygen tubing was rolled up in a plastic bag. An interview was conducted with the Hospice Nurse (HN) on 11/07/18 at 2:14 PM. The HN confirmed that Resident #40 was oxygen dependent at 3 liters per minute and without her oxygen her oxygen levels would quickly go down. The HN stated that if the staff observed her without the oxygen they should immediately replace the oxygen. She added that Resident #40 could not maintain appropriate oxygen levels and required oxygen continuously. The HN stated that she had tried to remove the oxygen and her oxygen levels dropped to 85% due to her poor air exchange. The HN stated that once she replaced the oxygen her oxygen level quickly came back up to 95% which was much more appropriate. An interview was conducted with Nursing Assistant (NA) #1 on 11/07/18 at 3:01 PM. NA #1 confirmed that she routinely cared for and was familiar with Resident #40. NA #1 stated that Resident #40 wore oxygen, but she would remove it at times and she would have to replace it. NA #1 added that when she observed Resident #40 without her	F 695	findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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oxygen on she would also report it to the nurse but stated most of the time she did not mess with the oxygen.

An interview was conducted with NA #2 on 11/07/18 at 3:09 PM. NA #2 confirmed that she was familiar with Resident #40. NA #2 stated that Resident #40 wore oxygen at all times and the only time she had seen her without the oxygen was during her showers. NA #2 stated if she saw Resident #40 without her oxygen she would replace the oxygen and alert the nurse.

An observation of Resident #40 was made on 11/07/18 at 3:27 PM. Resident #40 was observed in an activity in the dining room and was observed to have no oxygen in place.

An interview was conducted with Nurse #7 on 11/08/18 at 5:55 PM. Nurse #7 confirmed that she routinely cared and was familiar with Resident #40. Nurse #7 also confirmed that Resident #40 had an order for oxygen at 3 liters per minute via nasal cannula continuously. She added that at times Resident #40 would remove it more so in the afternoon when her confusion increased. Nurse #7 stated that when Resident #40 removed the oxygen the staff immediately would attempt to replace it.

An interview was conducted with the Director of Nursing (DON) on 11/09/18 at 2:22 PM. The DON stated that the staff had been performing trials of no oxygen with Resident #40 and each time her oxygen levels were fine except at night she would require the oxygen. The DON stated that she expected the staff to ensure that the ordered

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F 695	Continued From page 42 amount of oxygen was administered and if Resident #40 did not need the oxygen to communicate that with the medical doctor and obtain new orders.	F 695		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, 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,	F 842		12/7/18

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F 842	Continued From page 43 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed 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, staff and physician interviews, the facility failed to correctly document code status for 1 of 4 residents (Resident #9) sampled for activities of daily living (ADL).	F 842	F842 Resident Records □ Identifiable Information 1. Resident #9 code status was documented incorrectly on physician progress notes dated 10/17/18, 10/22/18,	

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F 842	Continued From page 44 The findings included: Resident #9 was admitted to the facility on 05/08/18 with diagnoses which included anxiety disorder, dementia with Lewy bodies, major depressive disorder, Parkinson's disease and others. A review of her quarterly Minimum Data Set (MDS) dated 10/11/18 revealed she had moderately impaired cognition for daily decision making and required extensive assistance of 1-2 staff for all activities of daily living (ADL). A review of her chart revealed a Do Not Resuscitate (DNR) order was written on 10/16/18 and signed by the medical director. The goldenrod form was in the front of her chart and easily visible. A further review of the chart revealed three progress notes written after the DNR order, and signed by the medical director and read in part as follows: 1. Date of Service (DOS): 10/17/18 - Progress Note - History - Code Status: Full Scope of Treatment 2. DOS: 10/22/18 - Progress Note - History - Code Status: Full Scope of Treatment 3. DOS: 10/24/18 - Progress Note - History - Code Status: Full Scope of Treatment An interview on 11/08/18 at 12:51 PM with the Medical Director (MD) revealed the progress notes on 10/17/18, 10/22/18 and 10/24/18 were written by him. The MD stated the Full Scope of Treatment was his error and it should have read	F 842	and 10/24/18. Resident # 9 code status on physician progress notes was corrected on 11/8/2018 to reflect Do Not Resuscitate. 2. Current residents have the potential to be affected by this alleged deficient practice. Audit of all current residents physician□s progress notes to ensure code status is documented accurately was completed on 11/16/2018 and corrections were made as necessary. 3. Medical Director was educated on ensuring code status is accurately reflected on physician progress notes by the Director of Nursing on 11/8/2018. Medical Records will audit 5 charts weekly x 12 weeks to ensure code status is reflected accurately on physician□s progress notes. 4. The Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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F 842	Continued From page 45 DNR effective 10/16/18. The MD stated it was his error in his dictation and he should have documented the change in code status correctly on his note. An interview on 11/09/18 at 3:27 with the Director of Nursing revealed it was her expectation the MD and providers would document the correct code status on all resident notes.	F 842		