STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 01/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	**1206 N FULTON STREET RAEFORD, NC 28376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification/Complaint Investigation survey was conducted on 11/14/19 through 11/19/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #28MR11.	E 000		
F 000	INITIAL COMMENTS	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		2/11/19

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

Electronically Signed | 02/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician and staff interviews, the facility failed to notify the physician regarding not administering prescribed bilateral positive airway pressure (BIPAP) for 1 of 1 sampled resident (Resident # 86). Findings included: Resident #86 was admitted to the facility on 12/17/18. Diagnosis included; Muscle Weakness, Congestive Heart Failure, Diabetes, Hypertension, and Obstructive Sleep Apnea. The Minimum Data Set (MDS) dated 12/24/18 and coded as an admission assessment indicated Resident #86 had clear speech, was	F 580	On 1/25/2019 MD was notified by the Director of Nursing that resident # 86 had not received BIPAP services since order was written on 1/15/2019. All other resident receiving CPAP and/or BIPAP services were interviewed by the ADON on 1/29/2019 to validate resident refusals. Two other residents in the building had orders for CPAP and/or BIPAP services and both acknowledged and confirmed the documented refusals. MD was made aware of both resident's documented refusals and non compliance with their CPAP/BIPAP.	

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F 580	Continued From page 2 cognitively intact, and exhibited no rejection of care. She required two-person physical assist with bed mobility, and transfers. A review of the physicians' order dated 1/15/19 documented an order in place for BiPAP at bedtime- apply mask at 8:00 PM and remove at 6:00 AM. An interview was conducted with Resident #86 on 1/22/19 @ 12:30 PM. She stated that she had not used the BIPAP machine since she's been at the facility, due to "nobody knows how to use the machine". She stated she would use the machine if she knew how, or if she was asked to, and thought it would make her feel better. A follow up interview was conducted with Resident # 86 on 1/24/19 @ 5:45 AM. She stated that she did not wear BIPAP during the night, or any night. She stated the nurse did not ask her about using BIPAP, and that she would use it if the nurse asked her to. A review of the nursing progress notes dated 1/16/19 through 1/26/19, revealed no documentation that the physician was notified of resident #86 not using BIPAP. An interview was conducted with nurse #1 on 1/24/19 @ 6:20 AM. He stated the Resident did not use BIPAP during his shift from 7:00 PM through 7:00 AM. He stated she "never wears it". He stated the physician was not notified that the resident had not used BIPAP. An interview was conducted with the resident's physician on 01/25/19 @ 9:44 AM regarding BIPAP use. He stated he was unaware that the	F 580	Education will be provided to all nurses on the Change in Condition policy and MD notification by the DON or designee by 2/11/2019. All newly hired nurses will receive education on MD notification as it relates to resident refusals by the DON or designee during orientation to the facility. The 24 hour report will be audited by the DON or designee 5x a week to identify documented resident refusals. The DON will ensure that the MD is notified of any documented medication or treatment that is refused by a patient more than three times. The audits will be reviewed weekly in the facility's Risk Meeting and monthly in the QAPI meeting for a period of 3 months. The facility's decision to extend the audits will be based on the results of the audits.	

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F 580	Continued From page 3 resident was not using BIPAP, and the order was placed due to her many cardiovascular issues and nighttime hypoxia. He stated her outcome would be improved with the use of BIPAP. He stated he was not aware that staff were not applying the BIPAP, and stated his expectation was that BIPAP should be administered when ordered. An interview was conducted with the Director of Nursing on 01/26/19 @ 10:43 AM. She stated it's her expectation that physician orders were being followed as prescribed, and that staff should have notified the physician that the resident was not using BIPAP.	F 580		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		2/11/19

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F 583	Continued From page 4 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to prevent personal confidential medical information from being exposed for others to view on 4 of 7 residents reviewed for medication pass. (Resident #12, Resident #44, Resident #86 and Resident #312). Findings included: 1. Medication pass observations with Nurse #1 on 01/24/19 from 5:55 AM to 6:35 AM revealed the following: a) A medication observation pass was conducted on 01/24/19 at 5:55 AM with Nurse #1 on the 200 hall mobile medication cart. The cart was noted to have a computer system setup on top of the medication cart of which the nurse accessed to retrieve the electronic Medication Administration Records (eMAR) for Resident #12. The eMAR was noted to have the resident ' s name and room number on the record as well as all of the medications that needed to be administered at this time. Nurse #1 completed placing the	F 583	Immediately, upon receiving notification regarding Electronic Medical Record privacy screen not being used by nurse, the Director of Nursing conducted a 100% audit of all medication carts to ensure no patient information was visible. This audit was completed on 1/26/2019. Nurse #1 was removed from the staffing schedule on 1/26/2019 due to the violation of facility policy. All Nurses and Medication Aides will receive education from the DON or designee on HIPAA and the requirement of always ensuring each residents information remains private. This education will be completed by 2/11/2019. All newly hired nurses and medication aides will receive education from the DON or designee on HIPAA and the requirement of always ensuring each resident's information remains private	

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F 583	Continued From page 5 prescribed medications into a medication cup, closed the drawers to the 200 hall medication cart and proceeded into Resident #12 ' s room. Nurse #1 left the computer screen open with the resident ' s medical information displayed while the nurse was away from the cart. Staff members were observed walking pass the cart during this time. Nurse #1 returned to the cart at 6:03 AM. b) A medication observation was conducted on 01/24/19 at 6:05 AM with Nurse #1 on the 200 hall mobile medication cart. Nurse #1 retrieved Resident #44 ' s eMAR from the computer system. The eMAR was noted to have the resident ' s name and room number on the record as well as all of the medications that needed to be administered at this time. Nurse #1 completed placing the prescribed medications into a medication cup, closed the drawers to the 200 hall medication cart and proceeded into Resident #44 ' s room. Nurse #1 left the computer screen open with the resident ' s medical information displayed while the nurse was away from the cart. The nurse returned to the cart at 6:13 AM. At this time, Nurse #1 was called to the 100 hall by another staff member. Nurse #1 proceeded to the 100 hall. A continued observation of the computer screen revealed that the screen remained opened with the resident ' s medical information displayed while the nurse went to the 100 hall. Staff members were observed walking pass the cart during this time. Nurse #1 returned from the 100 hall at 6:30 AM. The medical record remained displayed. c) A medication observation was conducted on 01/24/19 at 6:30 AM with Nurse #1 on the 500 hall mobile medication cart (which was located beside the 200 hall medication cart). The cart	F 583	during orientation. An audit will be conducted by the DON or designee at least 10 times a week for 90 days, to include all shifts and weekends to ensure continued compliance with privacy related to Resident Information. The audits will be reviewed in the facility's QAA meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.	

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F 583	Continued From page 6	F 583		

was noted to have a computer system setup on top of the medication cart of which the nurse accessed to retrieve Resident #312 ' s eMAR. The eMAR was noted to have the resident ' s name and room number on the record as well as all of the medications that needed to be administered at this time. Nurse #1 completed placing the prescribed medications into a medication cup, closed the drawers to the 500 hall medication cart and proceeded into Resident 312 ' s room. Nurse #1 left the computer screen open with the resident ' s medical information displayed while the nurse was away from the cart for approximately 5 minutes. Staff members were observed walking pass the medication cart during this time.

d) A medication observation was conducted on 01/24/19 at 6:35 AM with Nurse #1 on the 500 hall mobile medication cart. Nurse #1 retrieved Resident #86 ' s eMAR from the computer system. The eMAR was noted to have the resident ' s name and room number on the record as well as all of the medications that needed to be administered at this time. Nurse #1 drew up the prescribed insulin in an insulin syringe, closed the drawers to the 500 hall medication cart and proceeded into Resident #86 ' s room. Nurse #1 left the computer screen open with the resident ' s medical information displayed while the nurse was away from the cart for approximately 10 minutes. The hallway was not visible from the room during this medication pass.

An interview was conducted with Nurse #1 on 01/24/19 at 6:55 AM. Nurse #1 reported that he usually left the screen open while he was working and stated "it ' s just easier." Nurse #1 stated he had been educated to lock the computer screen

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F 583	Continued From page 7 whenever the computer was unattended to prevent others from viewing confidential medical information. Nurse #1 locked the 200 hall computer screen as well as the 500 hall computer screens at this time. An interview was conducted with the Director of Nursing (DON) at 12:05 PM on 01/26/19. The DON stated that no resident records should be exposed where other people can see them. The DON reported her expectation of the nursing staff was to lock the computer screens prior to leaving the medication carts unattended.	F 583		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician and staff interviews, the facility neglected the resident by failure to provide prescribed respiratory care by not administering bilevel positive airway pressure (BIPAP) as ordered by	F 600	Assistant Director of Nursing ensured proper function of machine for resident #86 on 1/25/2019. ADON also ensured that the Bipap was applied correctly to the resident on 1/25/2019 before leaving the	2/11/19

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F 600	Continued From page 8 the physician for 1 of 1 sampled resident (Resident # 86). Findings included: Resident #86 was admitted to the facility on 12/17/18. Diagnosis included; Muscle Weakness, Dysphagia, Congestive Heart Failure, Diabetes, Hypertension, Chronic Kidney Disease, Obstructive Sleep Apnea. The Minimum Data Set (MDS) dated 12/24/18 and coded as an admission assessment indicated Resident #86 had adequate hearing and vision, clear speech, was cognitively intact, and exhibited no rejection of care. She required two-person physical assist with bed mobility, and toileting, and total dependence with transfers, dressing, personal hygiene, and bathing. A review of the care plan dated 1/18/19 documented that the resident required oxygen and BIPAP related to congestive heart failure, and obstructive sleep apnea. Interventions included use of continuous oxygen and monitoring for symptoms which included labored respirations. A review of the physicians' order dated 1/15/19 documented an order in place for BiPAP at bedtime- apply mask at 8:00 PM and remove at 6:00 AM. A review of the progress notes dated 1/18/2019 titled, MDS Reconciliation Note, showed documentation that staff reported that resident developed shortness of breath when lying flat. An interview was conducted with Resident #86 on 1/22/19 @ 12:30 PM. She stated she gets	F 600	facility. All other residents receiving CPAP or BIPAP services were assessed by the ADON to validate the residents documented refusals and to ensure that the machines were working properly. Two other residents in the building had orders for CPAP and/or BIPAP services and both verbalized that they only wear them when they are experiencing shortness of breath or trouble sleeping. MD and RPs were made aware of their refusals and both have been care planned to reflect Education will be provided to all nurses by the Director of Nursing or designee on Providing Respiratory Services to include the application of BIPAP/CPAP by 2/11/2019. Education will be provided to all staff by DON and/or designee on Abuse and Neglect by 2/11/2019 Education will also be provided to all new nurses by the Director of Nursing and/or designee on Providing Respiratory Services to include the application of BIPAP/CPAP on orientation. Education will be provided to all newly hired staff by DON and/or designee on Abuse and Neglect during orientation. An audit tool will be used to record observation to determine that Respiratory services related to BIPAP and/or CPAP usage are being provided to those residents requiring such treatment. The audits will also include observation to determine that Proper technique for	

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F 600	Continued From page 9 "choked up at times and had a lot of mucus" and stated she had not used the BIPAP machine since she's been at the facility, due to "nobody knows how to use the machine". She stated she would use the machine if she knew how, or if she was asked to, and thought it would make her feel better. An interview was conducted with nurse aide # 1 on 1/24/19 @ 6:00 AM. She stated she made frequent checks on the resident throughout her shift from 11:00 PM through 7:00 AM due to her needing to be repositioned and stated she had not seen her wear BIPAP during her shift. She stated she didn't recall seeing her wear it at all. An interview was conducted with nurse #1 on 1/24/19 @ 6:20 AM. He stated the Resident did not use BIPAP during his shift from 7:00 PM through 7:00 AM. He stated she "never wears it", and stated the physician was not notified that the resident had not used BIPAP. An observation of the residents BIPAP machine was conducted on 1/25/19 @ 9:30 AM. The data log on the machine showed therapy hours recorded as 0.00 hours used. The BIPAP machine was at the bedside, no water was in the chamber, and the mask was not assembled. An observation and interview were conducted on 01/25/19 11:30 AM with nurse # 5 who was the assigned day shift nurse for resident # 86. She stated the resident had never worn BIPAP. The nurse was observed demonstrating how to use the BIPAP machine. She stated she was not familiar with its use and stated that a "liquid" needed to be added to the machine. When asked what type of liquid, she stated normal saline. She	F 600	applying the BIPAP/CPAP is being used. The audits will be completed by the Director of Nursing or designee 5 times a week for 90 days, in which all shifts to include weekends will be represented. The audits will be reviewed weekly in the facility's Risk Meeting and monthly in the QAPI meeting for a period of 3 months. The facility's decision to extend the audits will be based on the results of the audits.	

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F 600	Continued From page 10 stated she needed more training regarding BIPAP use. An interview was conducted with the resident's physician on 01/25/19 @ 09:44 AM regarding BIPAP use. He stated he was unaware that the resident was not using BIPAP, and the order was placed due to her many cardiovascular issues and nighttime hypoxia. He stated her outcome would be improved with the use of BIPAP. He stated he was not aware that staff were not applying the BIPAP. He stated his expectation was that BIPAP should be administered when ordered, and staff should know how to use the machine and if not, they should have been trained. A follow up interview was conducted with resident # 86 on the morning of 1/26/19. After surveyor intervened, staff administered the BIPAP on the night of 1/25/19. The resident stated that she did wear BIPAP for awhile during the night, and stated she was feeling better and was breathing easier. An interview was conducted with the Director of Nursing on 01/26/19 @ 10:43 AM. She stated that none of her staff had approached her regarding the need to be trained on BIPAP use. She stated it's her expectation that staff are knowledgeable regarding the use of BIPAP and that physician orders are being followed as prescribed.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		2/11/19

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F 657	Continued From page 11 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to update the care plan for 1 of 1 sampled residents (Resident #24) identified as being at high risk for elopement to reflect actual elopement and the interventions that were put in place to prevent future episodes of elopement. Findings included: Record review revealed that Resident #24 was admitted to the facility on 09/19/17. The resident's documented diagnoses included dementia with Lewy bodies (a form of dementia	F 657	The care Plan for Resident #24 was updated on 1/29/2019 by the MDS nurse to indicate that he had a history of elopement. All incidents/accidents for January 2019 were audited by the Director of Nursing on 1/29/2019 to ensure each residents care plan was updated to reflect the event that had occurred. The DON or designee will provide	

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F 657	Continued From page 12 characterized by abnormal protein deposits in the brain which can affect thought processes, movement, behavior, and mood), hypogylcemia, epilepsy, heart failure, adult failure to thrive, and anxiety. Review of Resident #24's care plan revealed on 09/26/18 the following problem was added: "Resident resides on a secured unit r/t (due to) elopement risk/wandering secondary to Lewy body dementia." Interventions to this problem included, "Assess for appropriate placement on the unit periodically." During an interview with the Director of Nursing (DON) on 01/25/19 at 9:52 AM she stated on 01/08/19 Resident #24 eloped through an exit door on the secure unit which was open and disarmed. She reported the resident was found walking on a path in the woods without shoes and socks. According to the DON, a 01/09/19 ad hoc session of the QA Committee determined that the root cause of the elopement was the inadequate monitoring of exit doors in the building. Therefore, she stated the exit doors were now being monitored twice daily instead of weekly. During an interview with Minimum Data Set (MDS) Nurse #1 on 01/25/19 at 4:03 PM she stated care plans were updated daily on Monday - Friday and on Mondays following the weekends. She reported from the data presented in daily clinical meetings she gathered information regarding the emergence of new problems or significant changes which warranted updates to the care plans. She commented that the development of new pressure ulcers, the deterioration of existing pressure ulcers, the occurrence of accidents, and changes in	F 657	education to all nurses by 2/11/2019 on updating the care plan to reflect the change of each resident. The DON or designee will provided education to all newly hired nurses on updating the care plan to reflect the needs of each resident on orientation. The DON or designee will monitor for continued compliance by conducting an audit in which the Event log and 24 hour report are compared to each residents care plan to ensure that they are being updated. The audits will be reviewed weekly in the facility's Risk Meeting and monthly in the QAPI meeting for a period of 3 months. The facility's decision to extend the audits will be based on the results of the audits.	

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F 657	Continued From page 13 medications were some of the things that justified updates to the care plans. According to the MDS Nurse, she learned about Resident #24's elopement during the morning clinical meeting on 01/09/19. However, she stated she did not think the elopement made a difference in the resident's wellbeing or care so she left the care plan intact which documented the resident was at risk for wandering and elopement. During a follow-up interview with the DON on 01/25/19 at 4:33 PM she stated Resident #24's plan of care should have been updated after his 01/08/19 elopement to reflect that the resident had gone from being at risk for elopement to having experienced an actual elopement. She reported the QA Committee developed new elopement interventions which should have been captured in the resident's plan of care.	F 657		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility failed to prevent 1 of 6 sampled residents (Resident #24) reviewed for accidents from eloping out of an exit door in the facility's secure unit. The resident was unaccounted for during a 57 minute period in the	F 689	Past noncompliance: no plan of correction required.	2/6/19

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late afternoon of 01/08/19, and was found walking along a path in a wooded area approximately 55 feet from the exit door without socks and shoes. The resident sustained multiple scratches to his bilateral ankles and across the tops of his feet. Findings included:

Record review revealed that Resident #24 was admitted to the facility on 09/19/17. The resident's documented diagnoses included dementia with Lewy bodies (a form of dementia characterized by abnormal protein deposits in the brain which can affect thought processes, movement, behavior, and mood), hypogylcemia, epilepsy, heart failure, adult failure to thrive, and anxiety.

A 08/23/18 progress note documented Resident #24 experienced seizure activity and was sent to the emergency room for evaluation.

Review of Resident #24's care plan revealed on 09/26/18 the following problem was added: "Resident resides on a secured unit r/t (due to) elopement risk/wandering secondary to lewy body dementia." Interventions to this problem included, "Assess for appropriate placement on the unit periodically."

Review of Resident #24's care plan revealed on 10/22/18 the following problem was added: "Resident is lower functioning, dependent on staff for activities, cognitive stimulation, social interaction related to: dementia. Resident diagnosed with dementia, on special unit to provide appropriate environment to support safety of resident. Resident can also wander throughout day. Resident can have sun downing behaviors relating to dx (diagnosis) dementia."

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Interventions to this problem included, "Position resident in locations that enable resident to have frequent contact with others during activities and social (events)."

Resident #24's 10/29/18 quarterly minimum data set (MDS) documented his cognition was severely impaired, he exhibited no behaviors including wandering during the look back period, he required extensive assistance from a staff member with walking in the room and corridor and locomotion on the unit, he required supervision by a staff member with locomotion off the unit, his balance during all transitions and walking was not steady and he was only able to stabilize with staff assistance, he was always incontinent of bowel and bladder, he had one fall since his last assessment without injury, he was five feet tall and weighed 90 pounds, and he had experienced significant weight loss.

A 12/06/18 progress note documented Resident #24 was high risk for falls. "Currently wears helmet while OOB (out of bed); resident is on frequent safety rounds; facility attempts to keep resident in non-skid socks or shoes (resident removes often); encourage resident to take rest breaks."

A 12/14/18 psychiatry consult (the most recent in Resident #24's medical record) documented "alert and pleasantly confused." The consult also documented the resident's only psychotropic medication was an anti-depressant medications which the resident received daily.

A time line for 01/08/19 provided by the Director of Nursing (DON) documented that at 4:40 PM Resident #24 was observed ambulating in the hall

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on the secure unit, at 5:15 PM supper trays began to be passed on the unit, at 5:30 PM a nursing assistant (NA) questioned the whereabouts of the resident, at 5:35 PM it was discovered that one of the exit doors on the secure unit opened soundlessly, at 5:37 PM Resident #24 was found walking along a path in the woods, and at 5:41 PM the resident ambulated back into the building with staff. The time line also documented, "Outside (temperature) was noted be 57 degrees. Resident was fully dressed except for socks (and shoes) and was wearing his helmet. Vitals were within normal limits. Skin assessment was done..."

A 01/08/19 Head to Toe Evaluation documented Resident #24's blood pressure was 138/78, his pulse was 80, his respirations were 18 per minute, his temperature was 98.8 degrees, and his respirations were unlabored. The assessment documented the resident had not experienced a significant change within the last 24 hours.

During an interview with Nurse #4 on 01/25/19 at 11:10 AM she stated she was the staff member who found Resident #24 in the woods on 01/08/19. She reported Resident #24 wandered constantly on the unit, but did not seem to be truly exit seeking, and was easily redirected. She commented that after searching the unit twice when the resident could not be located at the supper meal, she assumed the resident must have left the unit through an exit door which was found unlocked during the search and did not alarm when opened. According to Nurse #4, she saw Resident #24 in the woods behind and to the side of the building, following a path that

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paralleled a property line fence. She stated the resident had on a sweat top and bottom, had his helmet on, but was barefoot. She commented dusk had just set in and the temperature was probably in the mid-50s. The nurse reported the resident did not seem anxious or distressed when she found him, and he followed staff back into the building without much persuasion. According to Nurse #4, she assessed the resident and found he had multiple scratches to his bilateral ankles and across the tops of his feet. This nurse stated staff did not go in and out of the exit doors in the unit because they did not have the code to use on the key pads.

At 11:30 AM on 01/25/18 Nurse #4 identified the location in the woods where she found Resident #24. The resident was about 55 feet away from the exit door. He had to cross a gently sloping concrete sidewalk, cross a gently sloping lawn, and enter the woods where there were trees, bushes, vines, briars, and pine needles. The resident was about 25 feet into the woods before staff located him.

During an interview with NA #8, a medication aide, on 01/25/19 at 11:18 AM she stated she worked until 3:00 PM on 01/08/19, and saw Resident #24 on and off during that shift. She explained she returned to the building around 5:00 PM to help with the supper meal, and alerted Nurse #4 when Resident #24 could not be found. She reported the resident usually ate his meals in the unit dining room, but she could not find him there, in his room, or in the hallway. According to NA #8, the last time she saw the resident he had on shoes and socks, but when he returned to the building with staff after being found in the woods he was barefoot. She commented Resident #24

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wandered in the hallways, into resident rooms, and liked to play with locks, door, and alarms.

At 12:25 PM on 01/25/19 Resident #24 kept getting up from the table in the dining room of the secure unit. He moved quickly with a slightly unsteady walk into the hallway where he was feeling along doorways, walls, and handrails. Staff would redirect the resident to the dining room, but he would be back out in the hallway in a matter of minutes.

During an interview with NA #3 on 01/25/19 at 2:58 PM she stated that on first shift Resident #24 wandered throughout the unit, was easy to redirect, and was cooperative and mild mannered.

During an interview with NA #6 on 01/25/19 at 3:43 PM she stated she helped care for Resident #24 on second shift. She reported the resident wore a helmet because he had impaired balance. She commented she was working on 01/08/19 and remembered seeing the resident sometime between 4:30 PM and 5:15 PM when supper trays began to be passed on the secure unit. The NA stated she was surprised that an exit door in the unit was found unlocked since staff did not have the code to go in and out.

During an interview with NA #7 on 01/25/19 at 3:50 PM she stated she also cared for Resident #24 primarily on second shift, but she felt the resident became more anxious on second shift. She explained in the past the resident pulled items off the walls and got himself tangled up in curtains in another resident's room on second shift. She commented the resident did not like to stay in one place for very long.

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Beginning at 9:22 AM on 01/25/19 the Maintenance Manager (MM) stated there were nine exit doors in the building. The front door was Wanderguard protected, and the other eight doors were key pad protected. He reported that he checked the functionality of the Wanderguard door three times weekly, and was checking the key pad systems at the other eight doors monthly until his corporate supervisor suggested increasing the frequency to weekly in the fall/winter of 2018 due to remodeling which increased the traffic flow through the building. According to the MM, when checking the key pad doors he made sure they were locked, made sure the alarm sounded when he lifted the maglock override covers, and made sure the maglock switches were in the up or "on" position.

During an interview with the DON on 01/25/19 at 9:52 AM she stated that once Resident #24 was safely back inside the building the door through which he exited was examined, and it was found that the maglock switch was flipped down (off) which prevented the door from alarming when the resident opened it and went through it. An employee was assigned to monitor this door until other doors in the building could be examined. According to the DON, pins were also found in the maglock override systems of three doors, including the exit doors at either end of the secure unit and one door in the front of the building outside of the unit. These pins prevented an alarm from sounding when the maglock override cover was lifted. The DON commented that Resident #24 had a tendency to tamper with switches and alarms during his wandering.

During a telephone interview with Resident #24's

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primary physician and Medical Director (MD) of the facility on 01/26/19 at 10:55 AM he stated he was made aware of Resident #24's elopement on 01/08/19, the same evening the event occurred. He reported there was a lot of resident activity in the secure unit so it would be important to take extra precautions to make sure the exit doors on the unit were locked and alarmed. He commented that his main concern for Resident #24 related to the elopement was the resident's exposure to the weather for an undetermined period of time. The MD acknowledged that Resident #24 had some diagnoses such as epilepsy, hypogyclemia, and heart failure which could have been of concern in an elopement situation, but he stated he thought all these conditions were currently under good control.

Corrective Action for Those Residents Having the Potential to be Affected by the Same Deficient Practice:

Immediately following Resident #24's elopement the facility used its 01/08/19 census to do a total facility head count and all residents were accounted for. The facility also did an inspection of all nine exit doors in the facility to make sure they were functioning correctly. The functionality of the Wanderguard system on the front door was verified, and the other eight doors were checked to make they were locked and alarming properly. Pins were removed from three maglock override systems. By 01/09/19 elopement risk assessment were completed for all residents in the building with moderately or severely impaired cognition. Those residents found to be at high risk for elopement, outside of the secure unit, had Wanderguard bracelets applied.

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Measures to be Put in Place or System Changes to Ensure the Deficient Practice Would Not Reoccur:

A facility-wide in-service was provided to all disciplines working in the facility on 01/09/19 during which the elopement policy and code green elopement protocol were reviewed. Any staff not able to attend was informed that they could not begin work again until they received the training and signed that they understand the information. It was determined all new staff members would receive education on the elopement policy and code green elopement protocol during orientation. An ad hoc session of the facility's Quality Assurance (QA) Committee met on 01/09/19, and determined the root cause analysis of Resident #24's elopement was inadequate monitoring of the doors in the building. Therefore, beginning on 01/09/19 all doors protected with the key pad system were monitored twice daily, in the AM and PM, rather than just weekly. On 01/09/19 education was provided to all maintenance personnel and department heads about the new schedule for door inspections and the need to make sure all doors were locked, the door alarmed when the maglock override cover was lifted, the maglock switch was in the "on" position (up), and there were no devices inserted into the maglock system which affected the integrity of the alarmed doors.

Monitoring of Performance to Ensure Solutions are Sustained:

On 01/09/19 the MM began keeping a log book in which he documented his twice daily checks of the exit doors in the building. Twice a day door monitoring was to be completed for 30 days, then

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the frequency of the monitoring was decreased to once daily for 30 days and then returned to weekly as was the frequency prior to the 01/08/19 elopement event. Effective 01/09/19 the DON monitored the MM log book weekly to ensure that the checks were being completed per the QA Committee's recommendations. After the new elopement risk assessments were completed on 01/09/19, eight residents outside the secure unit had Wanderguard bracelets applied. The medication administration and treatment administration records for these residents were updated to allow for documentation on each shift that the bracelets were in place and daily documentation that the bracelets were functional. Effective 01/09/19 the DON monitored these administration records weekly to make sure staff were documenting placement and functionality.

Title of Person(s) Responsible for Implementing the Acceptable Plan of Correction:

Effective 01/09/18 the facility Administrator and the DON were designated as being ultimately responsible for the implementation of this plan of correction to ensure the facility attained and maintained substantial compliance.

Validation of the above referenced plan of correction was completed on 01/26/19 during an extended survey. Validation included inspection of all nine exit doors in the facility on 01/25/19 which revealed all doors were functioning and alarming per manufacturer expectations. Interviews were conducted with staff from various disciplines and shifts who were able to verify in-servicing on 01/09/19 about elopement policy and protocol. The MM's log book for door inspections and DON sign-offs were reviewed for

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F 689	Continued From page 23 frequency and documentation of door/alarm functionality. The placement of Wanderguard bracelets on the eight residents outside of the secure unit was verified, and a tester was used to determine that the bracelets were functional. The medication and treatment administration records and the DON sign-offs were reviewed to ensure the placement/functionality of the bracelets was being documented per the QA Committee's recommendations. Interviews with staff members verified that no residents had eloped since 01/08/19. The date of 01/09/19 was validated as the facility's date of compliance.	F 689		
F 692 SS=D	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; §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	F 692		2/11/19

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F 692	Continued From page 24 by: Based on observation, staff interview, and record review the facility failed to provide nutritional supplements as ordered by the physician for 1 of 5 sampled residents (Resident #59) reviewed for nutrition. Findings included: Resident #59 was admitted to the facility on 09/30/16. The resident's documented diagnoses included abnormal weight loss, hypertension, hyperlipidemia, vitamin D deficiency, osteoporosis, and gastroesophageal reflux. The resident's weight summary documented she weighed 111.2 pounds on 06/03/18, 113.2 pounds on 08/09/18, 102.8 pounds on 09/07/18, 101.6 pounds on 10/05/18, and 98.6 pounds on 11/05/18. Following a swallow study, a 11/19/18 physician order changed Resident #59's diet to puree food with nectar thick liquids. A 11/29/18 Registered Dietitian (RD) Note documented, "Pt (patient) continues to spit out contents of mouth into trash can....diet is puree and now nectar thick liquids...weight is 97.1 pounds, which is a little more stable this month. Significant weight loss noted and addressed prior. Trending down overall, weekly weights in place to assess trends. PO intake (intake by mouth) is 75-100 % most meals....She does swallow sweets usually per her nurse. She receives Resource supplement qid (four times daily) for nutritional support. Takes her meds (with) this and usually swallows....Continue Resource supplements. Continue weekly weights to assess trends, honor preferences, add pudding/ Magic Cups tid (three times daily) (with) meals as she is noted to like	F 692	The Magic Cup Supplement was provided by the charge nurse on 1/25/2019 at dinner and documented on the MAR. A 100% audit was conducted by the facility's dietician on 1/26/2019 to ensure that supplement orders in the Electronic Medical Record were also reflected in the tray card system. A 100% audit was conducted on 1/26/2019 by the Dietary Manager for each tray that contained an ordered supplement. All Dietary Staff will receive education from the facility's Certified Dietary Manager regarding Tray Card Accuracy in regard to ensuring all items listed on tray card are contained on the trays prior to leaving the dietary department by 2/11/2019. All nursing staff will receive education from the DON or designee regarding tray card accuracy and the requirement of ensuring that the contents of the tray match the tray card prior to providing the tray to the resident by 2/11/2019. All newly hired Dietary Staff will receive education from the facility's Certified Dietary Manager regarding Tray Card Accuracy in regard to ensuring all items listed on tray card are contained on the trays prior to leaving the dietary department during orientation to the facility.	

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F 692	Continued From page 25 and swallow sweets...." The resident's weight summary documented she weighed 94.8 pounds on 12/04/18. A 12/27/18 RD Note documented, "...po intake is 75- 100 % most meals. Hx (history) of spitting most of her food into trash can and not swallowing unless sweet. Interventions in place to sweeten food as desired. She does swallow sweets usually per her nurse. She receives Resource supplement qid for nutritional support. Takes her meds w/ this and usually swallows....Added Magic Cups tid (with) meals as she is noted to like and swallow sweets...." 12/27/18 physician orders initiated Magic Cup (sweet nutritional supplement resembling ice cream) TID and Remeron (appetite stimulant) 15 milligrams (mg) nightly. On 01/03/19 Resident #59's care plan was updated, and the following problem was identified: "Resident has increased nutrition/ hydration risk related to: Therapeutic diet and diagnoses of Intellectual Disabilities, Sarcoidosis (inflammation of lungs and lymph nodes), Legally Blind, Hypertension. Resident spitting food out-diet downgraded to pureed." Interventions to this problem included, "Provide diet per order." The resident's weight summary documented she weighed 89.3 pounds on 01/08/19. The resident's 01/11/19 significant change minimum data set (MDS) documented the resident's cognition was severely impaired, she exhibited no behaviors including resistance of care, she was independent in eating after set-up	F 692	All newly hired nursing staff will receive education from the DON or designee regarding tray card accuracy and the requirement of ensuring that the contents of the tray match the tray card prior to providing the tray to the resident during orientation to the facility. All tray cards containing a supplement will continue to be audited by the Dietary Manager five times a week for 90 days to ensure that supplements are on the tray. Audits will be reviewed weekly in the facility's Risk Meeting, and monthly in our QAA meeting for 3 months to ensure continued compliance. The facility's decision to extend the audits will be based on the findings of the audits.	

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help from staff, she was 64 inches tall and weighed 89 pounds, she experienced significant weight loss, and the resident was on a mechanically altered diet.

A 01/15/19 physician order initiated palliative care services for Resident #59.

A 01/17/19 RD Note documented, "...Continue Resource supplements, Magic Cups per orders...."

During an interview with Nurse #3 on 01/24/19 at 12:05 PM she stated Resident #59 ate 90 - 100% of her meals, but then spit most of the food out about five minutes later. She reported the resident was receiving Resource supplement with her medications, and she usually drank 75 - 100% of that without spitting much of it out. (Review of the resident's medication administration record revealed she was receiving the Resource as ordered).

During an observation on 01/24/19 at 12:38 PM Resident #59 was eating lunch in her room, but did not have a Magic Cup on her tray even though it was documented on her tray slip that one should have been delivered with her meal. Nurse #3 brought the resident sugar packets which the resident requested, and applied the sugar to the resident's food.

During a follow-up observation on 01/24/19 at 12:58 PM as Resident #59's meal tray was being removed it was noted that her plate was cleaned, but no Magic Cup was present.

During an interview with Nursing Assistant (NA) #7 on 01/24/19 at 3:50 PM she stated all NAs

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were supposed to make sure they compared the tray slips to the meal trays to make sure resident likes and dislikes were being honored and nutritional supplements documented on the tray slips were sent out on meal trays by the kitchen. She reported the kitchen was supposed to be informed immediately if something was missing on the trays or if the wrong foods were provided.
During an observation on 01/25/19 at 6:00 PM Resident #59 was eating supper in her room, but did not have a Magic Cup on her tray even though it was documented on her tray slip that one should have been delivered with her meal. At this time the resident requested staff to bring her coffee with lots of sugar and cream.
During a follow-up observation on 01/25/19 at 6:22 PM Resident #59 was no longer actively eating, but she had eaten 90% of her food. However, a Magic Cup was still not present.
During an interview with the Speech Therapist (ST) on 01/26/19 at 9:12 AM he stated Resident #59 continued to excessively chew her food, but spit most of it out. He estimated that the resident only swallowed 50% of what she put in her mouth. He reported the resident drank nectar thick liquids well, especially coffee with meals and between meals. He commented both Magic Cups and thickened Resource were appropriate supplements for Resident #59's diet prescription. According to the ST, Resident #59 drank Resource well, and ate her Magic Cups about 50% of the time.
During an interview with the Dietary Manager (DM) on 01/26/19 at 9:33 AM she stated Resident #59's weight had spiraled downward. She reported the resident was placed on supplements and was involved with the ST. She commented that Resident #59 had told her that she liked sweet stuff, fried chicken, and coffee. According

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F 692	Continued From page 28 to the DM, the resident's responsible party declined the use of a feeding tube. She stated the dietary employee at the end of the tray line operation was supposed to check the food, beverage, and supplements on the meal trays against the tray slips. She explained that this person was supposed to correct any discrepancies before the trays went out to the hall, and nursing assistants were supposed to check meal trays to make sure all preferences, dislikes, and supplements documented on the tray slip were honored. She commented there was a trainee working on the trayline this week, but she was not supposed to be left alone. She remarked that this situation may have contributed to Resident #59 not getting her Magic Cups. During a telephone interview with the RD on 01/26/19 at 9:51 AM he stated Resident #59 expressed that she liked foods that tasted sweet, and he reported he observed the resident swallowing sweet foods better than other foods. He explained this tendency to swallow sweet foods better was one of the factors in selecting Magic Cups as a supplement to help promote some weight gain and hault future weight loss for Resident #59. According to the RD, the dietary employees should be double checking to make sure that the supplements provided by the dietary department were on resident meal trays.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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	F 695		2/11/19

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F 695	Continued From page 29 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, physician and staff interviews, the facility failed to provide respiratory care by not administering bilevel positive airway pressure (BIPAP) per physician orders for 1 of 1 sampled resident (Resident # 86). Findings included: Resident #86 was admitted to the facility on 12/17/18. Diagnosis included; Muscle Weakness, Dysphagia, Congestive Heart Failure, Atrial Fibrillation, Diabetes, Hypertension, Chronic Kidney Disease, Obstructive Sleep Apnea. The Minimum Data Set (MDS) dated 12/24/18 and coded as an admission assessment indicated Resident #86 had clear speech, was cognitively intact, and exhibited no rejection of care. She required two-person physical assist with bed mobility, and toileting, and total dependence with transfers, dressing, personal hygiene, and bathing. A review of the care plan dated 1/18/19 documented that the resident required oxygen and BIPAP related to congestive heart failure, and obstructive sleep apnea. Interventions included use of continuous oxygen and monitoring for symptoms which included labored respirations. A review of the physicians' order dated 1/15/19 documented an order in place for BiPAP at bedtime- apply mask at 8:00 PM and remove at	F 695	Resident #86s physician orders were reviewed by the Assistant Director of Nursing regarding the Respiratory Services on 1/25/2019. An audit was conducted by the ADON on 1/29/2019 for each resident having an order for a Bi-Pap or C-Pap to ensure that the facility staff was compliant with providing the physician ordered respiratory service. All other resident receiving C-pap and/or Bi-pap services were assessed by the ADON to validate resident refusals and to ensure that the machines were working properly. Two other residents in the building had orders for Cpap-BiPap services and both verbalized that they only wear them when they are experiencing shortness of breath or trouble sleeping. MD and RPs were made aware of their refusals and both have been care planned to reflect. Education will be provided to all nurses by the Director of Nursing or designee on Providing Respiratory Services to include the application of BIPAP/CPAP by 2/11/2019 Education will also be provided to all new nurses by the Director of Nursing and/or designee on Providing Respiratory Services to include the application of	

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F 695	Continued From page 30 6:00 AM. An interview was conducted with Resident #86 on 1/22/19 @ 12:30 PM. She stated that she had not used the BIPAP machine since she's been at the facility, due to "nobody knows how to use the machine". She stated she would use the machine if she knew how, or if she was asked to, and thought it would make her feel better. A follow up interview was conducted with Resident # 86 on 1/24/19 @ 5:45 AM. She stated that she did not wear BIPAP during the night, or any night. She stated the nurse did not ask her about using BIPAP, and that she would use it if the nurse asked her to. An interview was conducted with nurse aide # 1 on 1/24/19 @ 6:00 AM. She stated she made frequent checks on the resident throughout her shift from 11:00 PM through 7:00 AM, due to her needing to be repositioned and stated she had not seen her wear BIPAP during her shift, and didn't recall seeing her wear it at all. An interview was conducted with nurse #1 on 1/24/19 @ 6:20 AM. He stated the Resident did not use BIPAP during his shift from 7:00 PM through 7:00 AM. He stated she "never wears it", and stated the physician was not notified that the resident had not used BIPAP. An observation of the residents BIPAP machine was conducted on 1/25/19 @ 9:30 AM. The data log on the machine showed therapy hours recorded as 0.00 hours used. The BIPAP machine was at the bedside, no water was in the chamber, and the mask was not assembled.	F 695	BIPAP/CPAP on orientation. An audit tool will be used to record observation to determine that Respiratory services related to BIPAP and/or CPAP usage are being provided to those residents requiring such treatment. The audits will also include observation to determine that Proper technique for applying the BIPAP/CPAP is being used. The audits will be completed by the Director of Nursing or designee 5 times a week for 90 days, in which all shifts to include weekends will be represented. The audits will be reviewed weekly in the facility's Risk meeting and in the facility's QAA meeting monthly for three months. The facility's decision to extend the audits will be based on the results of the audits.	

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F 695	Continued From page 31 An interview was conducted with the resident's physician on 01/25/19 @ 9:44 AM regarding BIPAP use. He stated he was unaware that the resident was not using BIPAP, and the order was placed due to her many cardiovascular issues and nighttime hypoxia. He stated her outcome would be improved with the use of BIPAP. He stated he was not aware that staff were not applying the BIPAP, and stated his expectation was that BIPAP should be administered when ordered. An interview was conducted with the Director of Nursing on 01/26/19 @ 10:43 AM. She stated that none of her staff had approached her regarding needing to be trained on BIPAP use. She stated it's her expectation that staff are knowledgeable regarding the use of BIPAP and that physician orders are being followed as prescribed.	F 695		
F 761 SS=D	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 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.	F 761		2/11/19

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F 761	Continued From page 32 §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 observations and staff interviews the facility failed to secure 3 out of 7 mobile medications carts observed during medication pass for the 100, 200 and 500 halls. Findings included: An observation on 01/24/19 at 5:40 AM revealed mobile medication carts for the 200 and 500 hall were unlocked. The 2 carts were located side by side and were unsupervised from 5:40 AM till 5:50 AM. There were no residents or visitors observed near or around the carts. Staff members were noted walking past the carts. An interview was conducted with Nurse #1 on 01/24/19 at 5:50 AM. Nurse #1 stated he was aware the medication carts were unlocked and reported he usually kept them unlocked through the night. An observation of a medication pass was conducted on 01/24/19 at 5:55 AM on Resident #12. Nurse #1 completed placing the prescribed medications into a medication cup and closed the drawers to the 200 hall medication cart. Nurse #1 did not secure the cart prior to walking away from	F 761	Immediately, upon receiving notification regarding the unsecured medication cart, the Director of Nursing conducted a 100% audit of all medication carts to ensure no medication carts had been left unsecured and unattended. This audit was completed on 1/26/2019. Nurse #1 was removed from the schedule on 1/26/2019 due to violation of facility policy. All Nurses and Mediation Aides will receive education from the DON or designee regarding Resident safety as it relates to securement of medication carts. This education will be provided by 2/11/2019. All newly hired Nurses and Mediation Aides will receive education from the DON or designee regarding Resident safety as it relates to securement of medication carts during orientation to the facility. An audit will be conducted by the DON or designee at least 10 times a week for 90	

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F 761	Continued From page 33 the cart to administer the medications. The 200 and 500 mobile medication carts were left unsupervised and unsecured. There were no residents noted in the hallway, but staff members were noted walking past the cart. Nurse #1 returned back to the 200 and 500 hall carts at 6:05 AM and was informed by a nursing assistant that Resident #44 had a head ache and needed something for pain. Nurse #1 checked the resident ' s medication orders and placed the prescribed medication into a medication cup and closed the drawers to the 200 hall medication cart. Nurse #1 did not secure the 200 or the 500 mobile medication carts prior to walking away from the carts to administer the medication. There were no residents noted to be near or around the carts during this medication pass, but staff were noted passing the carts. Nurse #1 returned to the 200 cart at 6:13 AM and secured the 200 hall and 500 hall mobile medication carts at this time. At 6:20 AM, Nurse #1 was called to the 100 hall. An observation at 6:23 AM revealed the mobile medication cart on the 100 hall was unsecured and had been unsupervised. There were no residents noted near or around the cart at this time, but staff were noted passing by the cart. Nurse #1 returned to the 100 cart and secured the cart at 6:28 AM. An interview was conducted with Nurse #1 on 01/24/19 at 6:30 AM. Nurse #1 reported he was the nurse responsible for the 100, 200, and 500 halls during this shift and was aware he left the 100 cart unsecured and unsupervised. Nurse #1 reported he was educated to keep the medications carts secured at all times when they were unattended. Nurse #1 stated he should have secured the medication carts.	F 761	days, to include all shifts and weekends to ensure continued compliance with safety as it relates to ensuring the securement of all medication carts. Additional education and counseling will be completed by the DON or designee on a situational basis if carts are noted to be left unlocked and unattended during scheduled audits. The audits will be reviewed in the facility's QAPI meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.	

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F 761	Continued From page 34 An interview was conducted with the Director of Nursing (DON) on 01/26/19 at 11:56 AM. The DON reported her expectations of the nurses were to keep the mobile medication carts secured at all times when unsupervised.	F 761		
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	F 842		2/11/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed 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 staff interview and record review the facility failed to document information about an incident of elopement in the medical record for 1	F 842	A progress note was added to resident #24s medical record on 1/29/2019 to reflect that he exited the facility on	

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F 842	Continued From page 36 of 6 sampled residents (Resident #24) who were reviewed for accidents. The facility also inaccurately documented respiratory care that was not provided by signing off on the medication administration record (MAR) that was administered for 1 of 1 sampled residents (Resident #86). Findings included: 1. Record review revealed that Resident #24 was admitted to the facility on 09/19/17. The resident's documented diagnoses included dementia with Lewy bodies (a form of dementia characterized by abnormal protein deposits in the brain which can affect thought processes, movement, behavior, and mood), hypogylcemia, epilepsy, heart failure, adult failure to thrive, and anxiety. During an interview with the Director of Nursing (DON) on 01/25/19 at 9:52 AM she stated on 01/08/19 Resident #24 eloped through an exit door on the secure unit which was open and disarmed. During an interview with Nurse #4 on 01/25/19 at 11:10 AM she stated she was the staff member who found Resident #24 in the woods on 01/08/19. She reported Resident #24 wandered constantly on the unit, but did not seem to be truly exit seeking, and was easily redirected. She commented that after searching the unit twice when the resident could not be located at the supper meal, she assumed the resident must have left the unit through an exit door which was found unlocked during the search and did not alarm when opened. According to Nurse #4, she saw Resident #24 in the woods behind and to the side of the building, following a path that paralleled a property line fence. She stated the	F 842	1/8/2019 unsupervised. Every accident and incident in January 2019 was reviewed by the Director of Nursing on 1/29/2019 to ensure each residents medical record was updated to reflect the event that had occurred. The Medication Administration Record for resident #86 was reviewed on 1/25/2019.The Assistant Director of Nursing conducted an audit on 1/26/2019 of each residents requiring C-Pap or Bi-Pap treatments to ensure that the documentation reflected the actual treatments being provided. All nurses will receive education from the DON or designee regarding the importance of accuracy as it relates to documentation practices. Education will be completed by 2/11/2019. All newly hired nurses will receive education from the DON or designee regarding the importance of accuracy as it relates to documentation practices during orientation to the facility. An audit will be conducted by the DON or designee to ensure documentation accurately reflects the respiratory services that are being provided to each resident receiving C-Pap/Bi-Pap services. In addition, the DON or designee will conduct an audit to verify that each event that occurs has a corresponding progress note and updated plan of care. Audits will be conducted by the DON or designee 5 times a week for 90 days to ensure on going compliance.	

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resident had on a sweat top and bottom, had his helmet on, but was barefoot. She commented dusk had just set in and the temperature was probably in the mid-50s. The nurse reported the resident did not seem anxious or distressed when she found him, and he followed staff back into the building without much persuasion.

Review of Resident #24's medical record revealed there was no documentation about his 01/08/19 elopement.

During a follow-up interview with Nurse #4 on 01/25/19 at 2:52 PM she stated she provided a statement to the DON about her recollection of events before, during, and after Resident #24's 01/08/19 elopement. However, she reported she was unsure why she did not document the circumstances surrounding this elopement in a progress note. She commented nurses were told to document the details about all accidents/incidents in the electronic medical record.

During a follow-up interview with the DON on 01/25/19 at 4:33 PM she stated the nurse who witnessed incidents/accidents such as elopements should write a progress note which captured as much detail about the event as possible. She reported since she was present in the building after Resident #24's 01/08/19 elopement she did put some information about it into a section of the electronic medical record which was accessible only to the management/corporate staff.

2) Resident #86 was admitted to the facility on 12/17/18. Diagnosis included; Muscle Weakness,

Audits will be reviewed in the facility's QAA meeting monthly for three months. The facility's decision to extend the audits will be based on the results of the audits.

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Dysphagia, Congestive Heart Failure, Diabetes, Hypertension, Chronic Kidney Disease, Obstructive Sleep Apnea.

A review of the physicians' order dated 1/15/19 documented an order in place for BiPAP at bedtime- apply mask at 8:00 PM and remove at 6:00 AM.

A review of the Medication Administration Record (MAR) dated 1-1-19 through 1-31-19, documented BIPAP had been administered on 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, and 1/24.

An observation of the residents BIPAP machine was conducted on 1/25/19 @ 9:30 AM. The data log on the machine showed therapy hours recorded as 0.00 hours used. The BIPAP machine was at the bedside, no water was in the chamber, and the mask was not assembled.

An interview was conducted with Resident # 86 on 1/24/19 @ 5:45 AM. She stated that she did not wear BIPAP during the night, or any night. She stated the nurse did not ask her about using BIPAP, and that she would use it if the nurse asked her to.

An interview was conducted with nurse aide # 1 on 1/24/19 @ 6:00 AM. She stated that she made frequent checks on the resident throughout her shift from 11:00 PM through 7:00 AM, due to her needing to be repositioned or needing water. She stated she had not seen her using BIPAP during her shift and stated she didn't recall seeing her wear it at all.

An interview was conducted with nurse # 1 on

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F 842	Continued From page 39 1/24/19 @ 6:20 AM. He stated the resident did not wear BIPAP during his shift. He stated she " never wears it". A follow up interview was conducted with nurse # 1 on 1/24/19 @ 6:45 AM. He stated he did sign off on the MAR that the treatment was administered. He stated that he could go in and change the MAR to show that it was not given if needed. He stated he did not administer BIPAP during his previous shift on 1/23/19. An interview was conducted with the Director of Nursing on 01/26/19 @ 10:43 AM. She stated it's her expectation that staff are accurately documenting on the MAR.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		2/11/19

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 41 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean and disinfect personal glucometers (a device used to check chemical blood sugars) which were stored in the resident ' s rooms for 3 of 4 observations during medication passes. (Resident #12, Resident #86 and Resident #100). Findings included: A review of the facility policy entitled "Blood glucose monitoring via finger stick and cleaning of glucometers" (Originated on 10/15/15 and revised on 11/28/18) read, in part: #4 wipe glucometer surface using a germicidal disposable wipe with bleach per manufacturer ' s directions and recommendations," and #10 (after blood sample obtained) "Clean glucometer equipment according to the facility cleaning procedure listed above." A review of the germicidal manufactures ' instructions on the container, which was stored in the medication carts, revealed the device should be cleansed with friction and wrapped in the microbial wipe for 4 minutes. A review of an In-Service attendance record on 12/11/18 regarding blood glucose monitoring via finger stick and cleaning of glucometers revealed Nurse #1 and Nurse #3 signed the In-Service	F 880	On January 26, 2019 Assistant Director of Nursing cleaned the glucometers for Resident #12, Resident #86 and Resident #100 according to the facility policy. An audit was conducted by the Assistant Director of Nursing on 1/26/2019 of all residents using glucometers in which all glucometers were cleaned and stored according to facility's policy. All nurses will receive education on the facility's glucometer cleaning policy and procedure. The education will be provided by the DON or designee by 2/11/2019. All newly hired nurses will receive education on the facility's glucometer cleaning policy and procedure by the DON or designee during orientation to the facility. An audit tool will be used to record the following information: 1. Observation of cleaning and storage of glucometer according to facility's policy and 2. Verification that each resident was tested with his/her own person glucometer. The audits will be conducted by the DON or designee 10 times a week, in which audits	

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F 880	Continued From page 42 indicating they received a skills check of cleaning glucometers. a) An observation of a medication pass was conducted on 01/24/19 at 5:55 AM for Resident #12. Nurse #1 sanitized both hands, applied gloves and removed the personal glucometer from the storage bag which was labeled with Resident #12 ' s name. Nurse #1 did not clean the device prior to use. Nurse #1 proceeded to obtain the chemical blood sugar (CBG) from Resident #12 after disinfecting the tip of the finger with a packaged alcohol wipe. Nurse #1 used a lancet (a small needle with a sharp point) to obtain the blood sample to apply to the glucometer strip for Resident #12. Once the result displayed on the device, Nurse #1 then removed the contaminated glucometer strip from the glucometer and placed the device back in the storage bag. Nurse #1 did not clean the glucometer prior to placing the device back in the storage bag. Nurse #1 removed the gloves and folded the contaminated strip into the gloves and discarded it. Nurse #1 disposed of the lancet in the Sharps container (a secured container used to dispose of contaminated needles and sharp medical utensils). b) An observation of a medication pass was conducted on 01/24/19 at 6:50 AM. Nurse #1 sanitized hands, applied gloves and removed the personal glucometer from the storage bag which was labeled with Resident #86 ' s name. Nurse #1 did not clean the device prior to use. Nurse #1 proceeded to obtain the blood sample on Resident #12 after disinfecting the tip of the finger with a packaged alcohol wipe. Nurse #1 used a lancet to obtain the blood sample to apply to the glucometer strip for Resident #86. Once the	F 880	will be conducted throughout all shifts, including weekends. The audits will be reviewed weekly in Risk meeting and in the facility's QAA meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.	

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result displayed on the device, Nurse #1 removed the contaminated glucometer strip from the glucometer and placed the device back in the storage bag. Nurse #1 did not clean the glucometer prior to placing the device back in the storage bag. Nurse #1 removed the gloves and folded the contaminated strip into the gloves and discarded it. Nurse #1 disposed of the lancet in the Sharps container.

An interview was conducted with Nurse #1 on 01/24/19 at 7:00 AM. Nurse #1 reported each resident had their own glucometer devices in their rooms. Nurse #1 reported they were cleaned every couple of uses. Nurse #1 stated he believed the policy was to clean them once per day. Nurse #1 stated the glucometer devices needed to be cleansed with a microbial wipe with bleach and it should be wiped down for a minute and placed on a paper towel to dry. Nurse #1 stated he usually did not clean the glucometers and thought they were to be cleaned one time per day. Nurse #1 stated, "I know I should have cleaned them, obviously, I should clean them now."

c) An observation during a medication pass of Nurse #3 on 01/24/19 at 11:30 AM on Resident #100 revealed Nurse #3 washed her hands, applied gloves and removed the personal glucometer device from the storage bag which was labeled with Resident #100 ' s name. Nurse #3 did not clean the device prior to use. Nurse #3 proceeded to obtain the blood sample from Resident #100 after disinfecting the tip of the finger with a packaged alcohol wipe. Nurse #1 used a lancet to obtain the blood sample to apply to the glucometer strip for Resident #100. Once the result displayed on the device, Nurse #3 then

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removed the contaminated glucometer strip from the glucometer. Nurse #3 folded the contaminated strip into her gloves and disposed of the gloves. Nurse #3 used the approved germicidal wipes and rubbed the glucometer with friction to disinfect the device. Nurse #3 then wrapped the machine with a new germicidal wipe and stated it needed to be wrapped for 4 minutes and pointed to the package of the germicidal wipes which indicated to disinfect for 4 minutes. Nurse #3 disposed of the lancet in the Sharps container.

An interview was conducted with Nurse #3 on 01/24/19 at 11:37 AM. Nurse #3 stated she was in serviced about a month ago to clean the glucometers after each use. Nurse #3 stated she believed the glucometer only needed to be disinfected after each use. Nurse #3 stated it should have been cleaned prior to use because the nurse could not be sure if it was disinfected after it was last used by another nurse.

An interview was conducted with the Director of Nursing (DON) on 01/26/19 at 11:30 AM. The DON reported her expectations were that the nurses should be cleaning and disinfecting the glucometers before and after each use per the policy and to follow the manufactures ' directions. The DON reported just because the residents have personal glucometers, this would not change how they should be sanitized.