STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & REHABILITATION	306 DEER PARK ROAD NEBO, NC 28761

(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 survey was conducted on 1/27/20 through 1/31/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #K32T11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 1/27/20 through 1/31/20. A total of 2 allegations were investigated and both were unsubstantiated. Event ID# K32T11.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		2/28/20

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

Electronically Signed | 02/21/2020

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and resident and staff interview the facility failed to honor a resident's choice for the time of day he received showers for 1 of 1 resident reviewed for choices (Resident #52). The findings included: Resident #52 was admitted to the facility on 02/05/19 with diagnoses that included hypertension, Alzheimer's disease, hemiplegia and depression. Review of the quarterly Minimum Data Set (MDS) dated 11/25/19 revealed Resident #52 was cognitively intact. The MDS further revealed Resident #52 required extensive two-person assistance with bed mobility, transferring, dressing and personal hygiene. Resident #52 was dependent of one-person assistance with bathing. Review of an undated admission pictorial care card based on the resident's preference revealed Resident #52 had stated he wanted a day shift shower using a shower chair. Review of the shower schedule for January 2020 revealed Resident #52 was listed under the second shift showers on Wednesday and Saturday.	F 561	(1) The facility failed to honor a resident's choice for the time of day he received showers for 1 of 1 resident reviewed for choices (Resident #52). Resident #52 was interviewed and his shower preferences were updated on Activities of Daily Living (ADL) on 01/30/20. Resident received shower on 01/30/20 and ongoing per preferences. (2) All residents have the potential to be affected. Administrator, Director of Nursing (DON), and Staff Development Nurse Educator performed interviews of all residents or guardians to establish/confirm resident or guardian wishes related to shower times and days and completed ADL updates to reflect preference or choice on 02/14/20. (3) Administrator and Staff Development Nurse Educator began 100% in-servicing of all staff on 02/06/20 and completed 02/17/20 to ensure compliance with policy and expectations were met related to assisting residents in exercising their rights, specifically the right to self-determination and the importance of relaying preference changes to Nursing Administration. Shower preferences will be reviewed during Care Plan reviews with resident/responsible party. DON/Designee will audit shower	

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F 561	Continued From page 2 An observation conducted on 01/30/20 at 9:00 AM revealed Resident #52 sitting in his wheelchair with brown debris on his shirt, jacket and pants. Resident #52 had dry, flaky skin noted to his face, dirty hair and body odor. On 1/30/20 at 9:50 AM an interview was conducted with Resident #52. The interview revealed he had not received his showers as scheduled which was two per week on Wednesday and Saturday. Resident #52 stated he had requested to have his shower time changed from second shift to first shift however it had not been changed. He stated he did not want to take a shower in the afternoons or at night and had told staff members. The interview further revealed when Resident #52 was asked to take a shower it was on second shift usually at smoking time or later after supper. Resident #52 stated he was scheduled to have a shower on 01/29/20 however hadn't received one because the staff member had asked him during smoking time at 4:00 PM and had not asked again until 10:30 PM that night. He stated he had initially requested for his shower time to be changed 3 months prior to January 2020. Resident #52 could not recall when his last shower was given. Review of a nursing progress note dated 11/20/19 revealed Nurse #7 documented Resident #52 had refused his shower three times stating he wanted his showers in the mornings not at night. On 1/30/20 at 1:56 PM an telephone interview was conducted with Nurse #7. Nurse #8 stated she did not recall writing the progress note and indicated Resident #52 had refused his shower on multiple occasions because he wanted his showers in the morning.	F 561	documentation, shower preferences, and shower history of each resident weekly x 4 weeks, then monthly x 4. All staff hired after this date will be provided with a signed education regarding policy and expectation related to assisting residents in exercising their rights, specifically the right to self-determination and the importance of relaying preference changes to Nursing Administration to ensure compliance. (4) DON/Designee will audit shower preferences and documentation for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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F 561	Continued From page 3	F 561		

An interview conducted on 01/30/20 at 4:15 PM with NA #12 revealed he was taking care of Resident #52 on 01/29/20 during second shift. He stated Resident #52 was a second shift shower and the shower team had not completed his assigned shower. The interview revealed he asked Resident #52 at 4:00 PM while the resident was waiting at the door to go outside at the 4:00 PM smoking time to take a shower and the resident declined stating he wanted to go outside and smoke. He stated when he got back to the resident he declined because it was late, and he just wanted to go to sleep. NA #12 stated it was difficult to give showers on second shift due to the supper meal, smoking times and assisting residents in bed. He stated Resident #52 had told him he would like a first shift shower. The interview revealed he had informed a first shift NA of this request in the past but he could not recall the name of who he told.

An interview conducted on 01/30/20 at 9:35 PM with the Director of Nursing (DON) revealed the facility had identified issues with their shower logs. She stated after reviewing the shower log for Resident #52 from November and December the log was unacceptable. She stated if the resident had refused a "R" would be placed into the boxes under the assigned date however the log just showed the resident had not received a shower and no refusals were documented. The DON stated Resident #52 was currently scheduled as a second shift shower and was unaware of the resident's wishes to change to a first shift shower. She stated the nurse on duty should have informed her the resident wanted to change times. The DON stated the residents were asked their preference on admission by the

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F 561	Continued From page 4 nurse and it was placed into the pictorial care card regarding showers. If the residents do not have a preference their shower is based on their room number. The nurse or NA were responsible for completing the pictorial care card on admission. The DON explained Resident #52's shower was based from his room number and not his admission pictorial care card. After reviewing Resident #52's care card she stated he should have been scheduled for a first shift shower. An interview conducted on 01/31/20 at 11:29 AM with the Administrator revealed staff members were expected to work around the resident's preference and time they wanted a shower. She stated if a resident wanted a first shift shower they should be scheduled as a first shift shower. The interview revealed the facility had been conducting shower audits however had stopped the audits in August 2019 which had probably led to the issue, stating if they had continued the audit this wouldn't have occurred. The interview revealed residents were asked on admission of their shower preference and the information was placed on their pictorial care card. She stated the information should directly reflect the resident's preference.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		2/28/20

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F 578	Continued From page 5 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to ensure advanced directive information in a resident's medical record for the type of resuscitation procedure and advanced medical treatment to be provide was accurate for 1 of 1 sampled resident reviewed for	F 578	(1) The facility failed to ensure advanced directive information in a resident's medical record for the type of resuscitation procedure and advanced medical treatment to be provided was accurate for 1 of 1 sampled resident	

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F 578	Continued From page 6 advance directives (Resident #24. Findings included: Resident #24 was readmitted to the facility on 05/23/19 with diagnoses which included hypertension, diabetes and Alzheimer's disease. Resident #24's medical record contained a "Goldenrod" form with a Do Not Resuscitate (DNR) order. The form had an effective date of 06/13/19, did not specify an expiration date and was signed by the Nurse Practitioner. The resident's medical record also contained a Medical Order for Scope of Treatment (MOST) dated 08/08/19. The MOST form specified; Cardiopulmonary Resuscitation (CPR) was to be attempted, a full scope of treatment was to be provided, antibiotics provided if indicated, intravenous fluids if indicated, and a feeding tube for a defined trial period. The form specified the information on the form was discussed with and agreed to with the patient and was signed by the Nurse Practitioner and Resident #24. The facility's social worker was listed as the health care professional who prepared the form. Resident #24's Physician progress notes, dated after 08/08/19, revealed the resident's code status was Do Not Attempt Resuscitation (DNR/no CPR). The resident's Interdisciplinary Team Meeting minutes dated 08/14/19 to present specified the resident's code status was "DNR/MOST." Resident #24's annual Minimum Data Set (MDS) dated 10/28/19 indicated she was cognitively	F 578	reviewed for advance directives (Resident #24). Resident #24 was interviewed and advanced directive documentation was updated to reflect Resident #24's preferred code status on 01/27/20 by the Social Services Director (SSD). (2) All residents have the potential to be affected. SSD conducted a review of all residents' advanced directive information on 01/29/20 to ensure accurate and complete. (3) Administrator and Staff Development Nurse Educator began 100% in-servicing of all staff on 02/06/20 and completed 02/17/20 to ensure compliance with policy and expectations were met related to assisting residents in exercising their rights, specifically the right to formulate an advance directive and the importance of relaying choice changes to Nursing Administration. Clinical Nurse Educator provided in-servicing to the interdisciplinary team on 02/07/20 to ensure compliance with policy and expectations were met related to maintaining updated resident care plans. SSD/designee will complete audit of advanced directives for each resident weekly x 4 weeks, then monthly x 4. All staff hired after this date will be provided with a signed education regarding policy and expectation related to assisting residents in exercising their rights, specifically the right to formulate an advance directive and the importance of relaying choice changes to Nursing Administration to ensure compliance. (4) SSD/Designee will audit advanced directive information for potential	

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F 578	Continued From page 7 intact for daily decision making. An interview was conducted with Resident #24 on 01/27/20 at 3:50 PM. The resident was asked about her preference for her advanced directives. The resident stated she would want to have CPR and be resuscitated. An interview on 01/27/20 at 3:59 PM with the interim Director of Nursing (DON) revealed she thought Resident #24 did not want to be resuscitated. After the DON reviewed the resident's advanced directive information she stated, "I don't know what happened with this MOST form, but I know the resident is a DNR." The DON stated she would talk with the resident and find out her wishes. An interview on 01/27/20 at 4:25 PM with the DON revealed she spoke with Resident #24 and the resident stated she wanted to be resuscitated. The DON stated she obtained an order for the resident to be "Full Scope of Treatment". The DON further stated she removed the "Goldenrod" form, which specified the resident did not want to be resuscitated, from resident's medical record. An interview on 01/29/20 at 3:45 PM with the Social Services Director (SSD) revealed she was unaware Resident #24's Advanced Directive in the medical record (DNR/no CPR) did not reflect the resident's preference to receive CPR until the DON brought it to her attention. The SSD stated it was her responsibility to ensure the resident's Advanced Directive was in the chart and signed. The SSD stated when she placed Resident #24's MOST form in the resident's medical record she did not compare it to the information on the resident's "Goldenrod" form to make sure they	F 578	interventions and documentation that may be required. Results of these reviews will be taken to the QAPI meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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F 578	Continued From page 8 contained the same information. An interview on 01/29/20 at 3:57 PM with the Administrator revealed she was not aware the Advanced Directive information in Resident #24's medical record did not correspond with the resident's wishes. The Administrator stated she understood the significance of this error. She stated the SSD was responsible for Advanced Directives and she expected the resident's Advanced Directive to be accurately documented, communicated, and accurate when placed in the resident's medical record.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Hospice for 1 of 3 residents (Resident #92) reviewed for MDS accuracy. The findings included: Resident #92 was admitted to the facility on 10/16/2019 with multiple diagnoses including hypertension and non- Alzheimer's dementia. A review of a physician order dated 12/18/19 revealed Resident #92 was admitted under the care of Hospice with a diagnosis of bilateral subdural hematomas.	F 641	(1) The facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Hospice for 1 of 3 residents (Resident #92) reviewed for MDS accuracy. The MDS for Resident #92 was modified to correct the coding of section O on 01/30/20 and submission accepted on 01/31/20. (2) All residents receiving Hospice services have the potential to be affected. An initial audit of all active resident MDS was completed on 02/07/20 by MDS Coordinators and updated if indicated for residents with Hospice services. (3) Clinical Nurse Educator provided in-servicing to MDS nursing staff on 02/07/20 to ensure compliance with policy	2/28/20

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F 641	Continued From page 9 Resident #92's significant change MDS dated 12/31/19 indicated the resident was not receiving Hospice services. On 01/29/20 at 3:52 PM an interview was conducted with MDS Nurse #1. During the interview she stated Resident #92 was admitted under the care of Hospice services on the date of 12/18/19 and the 12/31/19 significant change MDS was for Hospice care. The interview revealed the resident's MDS dated 12/31/19 should have reflected Resident #92 was receiving Hospice services. She stated the information on the MDS assessment had been miscoded. On 01/31/20 at 8:20 AM an interview was conducted with the Director of Nursing (DON). The interview revealed Resident #92 was receiving Hospice services. She stated she expected the MDS nurses to code the information correctly to directly reflect the care the residents received. The DON stated Resident #92's MDS should have been coded to reflect she was receiving Hospice services. On 01/31/20 at 11:29 AM an interview was conducted with the Administrator. She stated Resident #92's significant change MDS should reflected the resident was receiving Hospice care.	F 641	and expectations were met related to the correct coding of section O of the MDS. DON/designee will complete audit of MDS for accuracy of Hospice coding 5 x a week x 4 weeks, weekly x 4 weeks, then monthly x 3. (4) DON/designee will report audit findings for potential interventions that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		2/28/20

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F 655	Continued From page 10	F 655		

effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, Hospice nurse and staff

(1) The facility failed to include Hospice in

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F 655	Continued From page 11 interviews, the facility failed to include Hospice in the baseline care plan for 1 of 3 residents reviewed for hospice and end of life care (Resident #260). The findings included: Resident #260 was admitted to the facility on 1/23/20 with diagnoses that included cardiomyopathy (heart muscle disease) and chronic heart failure. An entry Minimum Data Set (MDS) assessment dated 1/23/20 indicated Resident #260 entered the facility from Hospice. The admission MDS dated 1/30/20 was still in progress and had not been completed. Resident #260's baseline care plan dated 1/23/20 did not include Resident #260 was receiving Hospice services. A review of a physician progress note dated 1/24/20 revealed Resident #260 had been transferred from a residential Hospice care facility and had been originally admitted to Hospice services on 9/1/19. On 1/29/20 at 3:38 PM, an interview conducted with the MDS Coordinators revealed the nurse who admitted Resident #260 was responsible for completing the baseline care plan but did not expect her to include Hospice care on the baseline care plan. The MDS Coordinators could not give a reason why Hospice care was not included in the baseline care plan. The MDS Coordinators stated that after they completed the MDS assessment, they did include Hospice in the comprehensive care plan.	F 655	the baseline care plan for 1 of 3 residents reviewed for hospice and end of life care (Resident #260). Resident # 260's baseline care plan was updated to include Hospice on 01/31/20 by MDS Coordinators. (2) All residents receiving Hospice services have the potential to be affected. A review of documentation including MDS for residents receiving Hospice services was performed on 02/07/20 by MDS Coordinators and updated if indicated for residents with Hospice services. (3) Clinical Nurse Educator provided in-servicing to the interdisciplinary team on 02/07/20 to ensure compliance with policy and expectations were met related to including Hospice services in the baseline care plan. Staff Development Nurse Educator completed in-servicing 02/18/20 for all licensed and non-licensed nursing staff to ensure compliance with policy and expectations were met related to baseline care plans. DON/Designee will bring charts for new admissions and residents that Hospice has newly admitted to the next morning clinical meeting for a review of the baseline care plan including notation of Hospice care, if applicable. DON/Designee will complete audit of residents receiving hospice services weekly x 4 and then monthly x 4. Each licensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to base line care plans. (4) DON/designee will report audit findings for potential interventions that may be required. Results of these reviews will be	

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F 655	Continued From page 12 On 1/30/20 at 10:19 AM, a phone interview conducted with the Hospice nurse assigned to Resident #260 revealed he had been admitted from their in-house facility. The Hospice nurse had come on 1/24/20 to check on Resident #260 and stated she usually came to the facility twice a week to check on her Hospice residents. On 1/31/20 at 9:20 AM, an interview conducted with the Social Worker revealed Resident #260's baseline care plan was completed by the nurse who admitted him to the facility and agreed that she should have included Hospice care in his baseline care plan. The Social Worker stated that she had not discussed Resident #260's baseline care plan with his guardian and shared that she did not know who was responsible for this. On 1/31/20 at 10:41 AM, a phone interview conducted with Nurse #1 revealed she had admitted Resident #260 to the facility on 1/23/20 and had completed his baseline care plan. Nurse #1 confirmed that Resident #260 had been admitted from Hospice and agreed that she should have included Hospice in his baseline care plan. Nurse #1 stated that she must have just missed it. Nurse #1 did not know anything about an admission care plan meeting wherein they discussed a new resident's care plan with the resident and/or guardian. On 1/31/20 at 11:56 AM, an interview with the interim Director of Nursing (DON) revealed the admitting nurses filled out an interdisciplinary care plan summary which they shared with the resident and/or guardian, but this had not been done with Resident #260. The interim DON	F 655	taken to the QAPI Committee monthly meeting for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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F 655	Continued From page 13 agreed that the admitting nurse should have included Hospice in Resident #260's baseline care plan. On 1/31/20 at 11:15 AM, an interview with the Administrator revealed the admitting nurses were responsible for completing the baseline care plans and agreed that Hospice should have been included in Resident #260's baseline care plan. The Administrator stated the Social Worker should have initiated the admission care plan meeting, but she was not sure if this had been done for Resident #260.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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	F 656		2/28/20

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F 656	Continued From page 14 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to implement care plan interventions for fall mats for 1 of 4 residents reviewed for accidents (Resident #91). The findings included: Resident #91 was admitted to the facility on 9/25/19 with diagnoses that included pulmonary embolism, spinal stenosis, quadriplegia and epilepsy. The Care Area Assessment (CAA) from the admission Minimum Data Set (MDS) assessment dated 9/30/19 indicated Resident #91 had been admitted to the facility following back surgery due to a fall at home that resulted in spinal cord injury. Resident #91 had limited use of upper and lower extremities due to quadriplegia. The CAA further	F 656	(1) The facility failed to implement care plan interventions for fall mats for 1 of 4 residents reviewed for accidents (Resident #91). Resident #91□s caregiver guide was updated to include fall mat and fall mat was placed next to resident□s bed on 01/31/20 by Staff Development Nurse Educator. (2) All residents with care plan interventions have the potential to be affected. The interdisciplinary team conducted a review of all residents□ fall interventions and care plans were updated as indicated on 02/14/20. (3) Clinical Nurse Educator provided in-servicing to the interdisciplinary team on 02/07/20 to ensure compliance with policy and expectations were met related to maintaining updated resident care	

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F 656	Continued From page 15 indicated Resident #91 was at risk for falls related to medication use, history of falls, weakness, impaired mobility and impaired use of upper and lower extremities. A review of a Resident Incident Report dated 11/16/19 indicated Resident #91 was observed lying on the floor face down. Resident #91 obtained an abrasion to the right knee and was assessed immediately by the nurse practitioner. An immediate action taken to minimize reoccurrence was the use of fall mats. The quarterly MDS assessment dated 12/31/19 indicated Resident #91 was cognitively intact, required extensive physical assistance with all activities of daily living, had impairment on both sides of both upper and lower extremities and had no falls since the previous assessment. Resident #91's care plan dated 1/7/20 revealed Resident #91 was at risk for falls due to confusion, gait/balance problems, psychoactive drug use and history of falls due to impaired mobility to lower extremities related to spinal cord injury. The goal listed was for Resident #91 to not sustain serious injury through the next review date. The following interventions were listed: anticipate and meet the resident's needs, call light within reach, encourage to use call light, prompt response to all requests for assistance, educate about safety reminders and what to do if a fall occurs, follow facility fall protocol and PT (Physical Therapy) to evaluate and treat as ordered or as needed. Fall mat at bedside was added on 11/16/19. During an interview with Resident #91 while lying in bed on 1/27/20 at 10:53 AM, an observation of	F 656	plans and caregiver guides. Staff Development Nurse Educator completed in-servicing 02/18/20 for all licensed and non-licensed nursing staff to ensure compliance with policy and expectations were met related to following care plan interventions. All foldable fall mats that are removed from the floor when transferring residents from bed will be replaced with beveled fall mats that remain on the floor. DON/Designee will complete audit of documentation and placement of fall interventions weekly x 4 and then monthly x 4. Each licensed and unlicensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to following care plan interventions to ensure compliance. (4) DON/designee will report audit findings for potential interventions that may be required. Results of these reviews will be taken to the QAPI Committee monthly meeting for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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F 656	Continued From page 16	F 656		

her room revealed no fall mats on the floor beside her bed. Resident #91 stated she slid off her bed at the facility, but she did not get hurt.

An observation of Resident #91 on 1/28/20 at 8:50 AM revealed she was asleep in bed with no fall mats on the floor beside her bed.

An observation of Resident #91 on 1/28/20 at 1:46 PM revealed she was lying in bed with no fall mats on the floor beside her bed.

An observation of Resident #91 on 1/29/20 at 8:50 AM revealed she was lying in bed with no fall mats on the floor beside her bed.

On 1/29/20 at 10:39 AM, an interview conducted with Nurse Aide (NA) #1 revealed she took care of Resident #91 and was familiar with her care. NA #1 stated they put fall mats on the floor for Resident #91 when they took off her side rails from her bed but ever since they had put her side rails back, NA #1 had not seen any fall mats being used for Resident #91.

On 1/29/20 at 2:28 PM, an interview conducted with Nurse #2 revealed Resident #91 should have fall mats at the bedside and verified they had been folded up and were placed behind Resident #91's headboard. Nurse #2 stated that Resident #91's fall mats should have been placed on the floor beside her bed when she was in the bed. Nurse #2 also said she was not sure how long the fall mats had been folded up behind her headboard. Nurse #2 remembered initiating them in November after a fall, but she forgot to update the pictorial care card that the NAs used to guide the resident's daily care.

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F 656	Continued From page 17 On 1/29/20 at 3:38 PM, an interview conducted with the MDS Coordinators revealed Resident #91 should have had fall mats on the floor beside her bed. The MDS Coordinators stated the fall mats were added to Resident #91's care plan on 11/16/19 and nursing staff was supposed to make sure that this was in place. They stated the care plans were kept in a binder at the nurses' station, but they had to update them, so they have not been available for staff use. On 1/30/20 at 3:00 PM, an interview with NA #6 revealed she was familiar with Resident #91 and stated the fall mats had not been at the bedside for a while. NA #6 stated this information was in her care plan which was in a brand-new binder that was placed at the nurses' station this week. On 1/31/20 at 11:07 AM, an interview with the interim Director of Nursing (DON) revealed Resident #91 should have had fall mats on the floor beside her bed whenever she was in bed. She had not been aware that they have not been in place for Resident #91. On 1/31/20 at 11:15 AM, an interview conducted with the Administrator revealed fall mats should have been on the floor beside Resident #91's bed. She stated she could understand if staff had to fold it up when getting her up from the bed but if Resident #91 was in bed, the fall mats should have been in place.	F 656		
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 be-	F 657		2/28/20

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F 657	Continued From page 18 (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 record reviews and resident and staff interviews, the facility failed to update a care plan to reflect the resident's correct code status for 1 of 1 resident (Resident #24) reviewed for advanced directives. Findings included: Resident #24 was readmitted to the facility on 05/23/19 with diagnoses which included diabetes and Alzheimer's disease. Resident #24's medical record contained a	F 657	(1) The facility failed to update a care plan to reflect the resident's correct code status for 1 of 1 resident (Resident #24) reviewed for advanced directives. The care plan was updated to reflect Resident #24's correct code status by Social Services Director (SSD) on 01/29/20. (2) All residents have the potential to be affected. SSD conducted a review of all residents' advanced directives and care plans were updated as indicated on 01/29/20. (3) Clinical Nurse Educator provided	

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F 657	Continued From page 19 "Goldenrod" form with a Do Not Resuscitate (DNR) order. The form had an effective date of 06/13/19, did not specify an expiration date and was signed by the Nurse Practitioner. The resident's medical record also contained a Medical Order for Scope of Treatment (MOST) dated 08/08/19. The MOST form specified; Cardiopulmonary Resuscitation (CPR) was to be attempted, a full scope of treatment was to be provided, antibiotics provided if indicated, intravenous fluids if indicated, and a feeding tube for a defined trial period. The form specified the information on the form was discussed with and agreed to with the patient and was signed by the Nurse Practitioner and Resident #24. The facility's social worker was listed as the health care professional who prepared the form. The resident's Interdisciplinary Team Meeting minutes dated 08/14/19 to present specified the resident's code status was "DNR/MOST." Resident #24's annual Minimum Data Set (MDS) dated 10/28/19 indicated she was cognitively intact for daily decision making. Resident #24's current care plan dated 11/09/19 revealed a care plan for the residents Advanced Directives related to End of Life. The goal was to obtain and establish Advance Directives. The interventions included ensure resident has copy of DNR order on file in chart. An interview was conducted with Resident #24 on 01/27/20 at 3:50 PM. The resident was asked about her preference for her advanced directives. The resident stated she would want to have CPR and be resuscitated.	F 657	in-servicing to the interdisciplinary team on 02/07/20 to ensure compliance with policy and expectations were met related to maintaining updated resident care plans. SSD/designee will complete audit of care plans for accuracy of advanced directives 5 x a week x 4 weeks, weekly x 4 weeks, then monthly x 3. (4) SSD/Designee will audit advanced directive care plans for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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F 657	Continued From page 20 An interview on 01/29/20 at 3:45 PM with the Social Services Director (SSD) revealed it was her responsibility to ensure the Advanced Directive was in the chart and signed. The SSD stated she was also responsible for establishing and updating resident care plans related to Advance Directives. She stated Resident #24's care plan had not been updated to reflect the change in her code status. An interview was conducted on 01/29/20 at 3:57 PM with the Administrator. The Administrator stated the SSD was responsible for the Advanced Directives and the care plan for the Advanced Directives. According to the Administrator, she expected the resident's care plan to reflect the correct information about the resident's advanced directive.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		2/28/20

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F 690	Continued From page 21 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to empty urinary catheter bags and provide urinary catheter care for 2 of 2 residents reviewed for indwelling urinary catheters (Resident #260 and Resident #41). The findings included: A review of the facility's policy entitled, "Catheter Care, Urinary" revised on October 2010 read in part "2. d. Empty the collection bag at least every eight (8) hours." 1. Resident #260 was admitted to the facility on 1/23/2020 with diagnoses that included cardiomyopathy (heart muscle disease), chronic heart failure, cerebrovascular accident and urinary retention.	F 690	(1) The facility failed to empty urinary catheter bags and provide urinary catheter care for 2 of 2 residents reviewed for indwelling urinary catheters (Resident #260 and Resident #41). Urinary catheter equipment and bags of resident #260 and resident #41 were checked on 01/31/20 near the end of third shift by Director of Nursing (DON) and addressed as indicated. (2) All residents with indwelling urinary catheters have the potential to be affected. DON completed a review of all residents with indwelling Foley catheters to ensure compliance for proper and timely catheter care on 02/05/20. (3) Staff Development Nurse Educator completed in-servicing 02/18/20 for all licensed and non-licensed nursing staff to	

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F 690	Continued From page 22 An entry Minimum Data Set (MDS) assessment dated 1/23/2020 indicated Resident #260 entered the facility from Hospice. The admission MDS dated 1/30/20 was still in progress and had not been completed. A review of a Nursing Evaluation dated 1/23/2020 indicated Resident #260 was oriented to person, required extensive physical assistance with all activities of daily living, had left-sided weakness and had a urinary catheter in place. Resident #260's baseline care plan dated 1/23/2020 revealed he had a urinary catheter related to urinary retention. The goal listed was for Resident #260 not to develop any complications associated with catheter usage within the next review. The following interventions were listed: provide catheter care per policy, keep catheter tubing free of kinks, keep drainage bag below level of bladder, prevent tension on urinary meatus (opening) from catheter and dignity bag in place. An observation of Resident #260 on 1/27/2020 at 9:33 AM revealed his urinary catheter bag was almost full and there was approximately ½ of an inch at the top of the bag that did not contain urine. An observation of Resident #260 on 1/28/2020 at 8:45 AM revealed his urinary catheter bag was almost full and had approximately an inch at the top of the bag that did not contain urine. On 1/29/2020 at 6:05 AM, an interview conducted with Nurse Aide (NA) #3 revealed she had taken care of Resident #260 on night shift on 1/27/2020 but did not have time to do urinary catheter care	F 690	ensure compliance with policy and expectations were met related to proper and timely catheter care. DON/Designee will complete audit of catheter care for residents with indwelling urinary catheters 5 x a week x 4 weeks, weekly x 4 weeks, then monthly x 3. Each licensed and unlicensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to catheter care to ensure compliance. (4) DON/Designee will audit catheter care for residents with indwelling urinary catheters for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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on Resident #260 or empty his urinary catheter bag. NA #3 had worked by herself with 53 residents from 11:00 PM to 4:00 AM due to 2 callouts. NA #3 only had time to answer call lights and do incontinence rounds.

On 1/29/2020 at 6:45 AM, an interview conducted with NA #4 revealed she had taken care of Resident #260 on night shift on 1/28/2020 but did not have time to do urinary catheter care or empty his urinary catheter bag. NA #4 stated they did not have enough staff on night shift, so she did not have time to do urinary catheter care. NA #4 stated the only things she had time to do when she worked by herself with 53 residents was incontinence rounds and answering call lights.

An observation of Resident #260 on 1/29/2020 at 9:54 AM with NA #1 and NA #2 revealed Resident #260's urinary catheter bag was almost full, and NA #1 drained it twice as the output was over 1000 milliliters (ml) which was the maximum amount the urine container could hold. A crusty brownish drainage was observed at the tip of the urinary catheter insertion site.

An interview with NA #1 on 1/29/2020 at 10:00 AM revealed she always observed Resident #260's urinary catheter bag full in the mornings and needed to be emptied. NA #1 stated she sometimes emptied Resident #260's urinary catheter bag twice in her shift and it should be emptied by night shift NA before they leave but it wasn't done all the time.

On 1/30/2020 at 11:30 AM, a phone interview conducted with NA #5 revealed she had taken care of Resident #260 on night shift on 1/26/2020

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and had to work by herself with 53 residents from 11:00 PM to 3:00 AM. NA #5 stated she did not have time to empty Resident #260's urinary catheter bag and was unable to do urinary catheter care due to Resident #260 being agitated that night.

On 1/31/20 at 8:34 AM, an interview conducted with the interim Director of Nursing (DON) revealed night shift NA should have time to empty urinary catheter bags and that it should be done with every care round and as needed. The interim DON stated urinary catheter care should also be done with every care round and as needed. If the NA was unable to provide urinary catheter care, this should have been reported to the nurse and documented in his chart. The interim DON shared she was not aware that the NAs have not been able to provide urinary catheter care to Resident #260.

On 1/31/20 at 11:15 AM, an interview conducted with the Administrator revealed urinary catheter care and emptying of the urinary catheter bags should be done during each care round and as needed, and that the NA should have time to do this task.

2. Resident #41 was admitted to the facility on 8/8/19 with diagnoses that included bladder neck obstruction and benign prostatic hyperplasia (BPH) - enlargement of the prostate gland.

The quarterly Minimum Data Set (MDS) assessment dated 11/15/19 indicated Resident #41 was severely cognitively impaired, required extensive physical assistance with activities of daily living, had an indwelling urinary catheter and was frequently incontinent of bowel.

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Resident #41's care plan dated 12/18/19 indicated Resident #41 required assistance with toileting and had a urinary catheter due to BPH. The following interventions were listed: change urinary catheter per orders, refer to Urology as ordered and urinary catheter care per policy.

An observation made of Resident #41 on 1/27/2020 at 10:03 AM revealed his urinary catheter bag was almost full and had about an inch at the top of the bag that did not contain urine.

An observation made of Resident #41 on 1/28/2020 at 8:46 AM revealed his urinary catheter bag almost full and had about an inch at the top of the bag that did not contain urine.

On 1/29/2020 at 6:05 AM, an interview conducted with Nurse Aide (NA) #3 revealed she had taken care of Resident #260 on night shift on 1/27/2020 but did not have time to do urinary catheter care on Resident #260 or empty his urinary catheter bag. NA #3 had worked by herself with 53 residents from 11:00 PM to 4:00 AM due to 2 callouts. NA #3 only had time to answer call lights and do incontinence rounds.

On 1/29/2020 at 6:45 AM, an interview conducted with NA #4 revealed she had taken care of Resident #41 on night shift on 1/28/2020 but did not have time to do urinary catheter care or empty his urinary catheter bag. NA #4 stated they did not have enough staff on night shift, so she did not have time to do urinary catheter care. NA #4 stated the only things she had time to do when she worked by herself with 53 residents was incontinence rounds and answering call

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lights.

An observation made of Resident #41 on 1/29/2020 at 10:29 AM with NA #1 and NA #2 revealed Resident #41's urinary catheter bag being completely full. NA #1 drained the bag three times and obtained approximately 2200 ml urine output.

On 1/29/2020 at 10:39 AM, an interview with NA #1 revealed this was the first time during her shift that she had provided care to Resident #41. NA #1 stated she always observed Resident #41's urinary catheter bag being full at the start of her shift and it looked like it had not been emptied on night shift. NA #1 stated urinary catheter care should be done with each incontinence care and the urinary catheter bag should be emptied at least once a shift.

On 1/30/2020 at 11:30 AM, a phone interview conducted with NA #5 revealed she had taken care of Resident #41 on night shift on 1/26/20 and had to work by herself with 53 residents from 11:00 PM to 3:00 AM. NA #5 couldn't remember if she had emptied Resident #41's urinary catheter bag and stated she did not provide urinary catheter care to Resident #41 because he refused it at night.

On 1/31/2020 at 8:34 AM, an interview conducted with the interim DON revealed night shift NA should have time to empty urinary catheter bags and that it should be done with every care round and as needed. The interim DON stated urinary catheter care should also be done with every care round and as needed. If Resident #41 refused to have urinary catheter care done, this should have been reported to the nurse and documented in

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F 690	Continued From page 27 his chart. The interim DON shared she was not aware that Resident #41 had been refusing urinary catheter care at night. On 1/31/20 at 11:15 AM, an interview conducted with the Administrator revealed urinary catheter care and emptying of the urinary catheter bags should be done during each care round and as needed, and that the NA should have time to do this task.	F 690		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		2/28/20

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F 725	Continued From page 28 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide sufficient nursing staff for urinary catheter care (Resident #260 and Resident #41). This affected 2 of 2 residents reviewed. The findings included: This tag was cross-referenced to F-690: F-690 - Based on record review, observations and staff interviews, the facility failed to empty urinary catheter bags and provide urinary catheter care for 2 of 2 residents (Resident #260 and Resident #41) reviewed for indwelling urinary catheters. A review of the Daily Staffing Assignment Sheets revealed: 1. 1/2/20 - Nurse Aide (NA) #5 worked from 11:00 PM to 5:00 AM by herself on South which had 53 residents. 2. 1/4/20 - NA #7 worked from 3:00 AM to 7:00 AM by herself on North which had 58 residents. 3. 1/22/20 - NA #3 worked from 11:00 PM to 5:00 AM by herself on South. 4. 1/26/20 - NA #5 worked from 11:00 PM to 3:00 AM by herself on South. 5. 1/27/20 - NA #7 worked from 11:00 PM to 3:00 AM by herself on North. On 1/29/20 at 5:41 AM, an interview with Nurse #1 revealed they were supposed to have at least 2 NA on each side but had to work with only 1 NA on South the night before because of a call-out.	F 725	(1) The facility failed to provide sufficient nursing staff for urinary catheter care for Resident #260 and Resident #41. Director of Nursing (DON) completed a review of all residents with indwelling Foley catheters to ensure compliance for proper and timely catheter care on 01/31/20. (2) All residents with indwelling urinary catheters have the potential to be affected. DON completed a review of all residents with indwelling Foley catheters to ensure compliance for proper and timely catheter care on 02/05/20. The DON reviewed staffing schedules to ensure sufficient staff scheduled to provide resident care needs as indicated. (3) The Administrator and Staff Development Nurse Educator began 100% in-servicing of all staff on 02/06/20 and completed 02/17/20 to ensure compliance with policy and expectations were met related to attendance policy and call-ins. Staff Development Nurse Educator completed in-servicing 02/18/20 for all licensed and non-licensed nursing staff to ensure compliance with policy and expectations were met related to proper and timely catheter care. Current open positions include Nurses and CNAs on second and third shifts with active recruitment methods in place. Open positions are advertised online, with the Employment Security Commission, on social media, and at job fairs. Online advertisements will be updated at least	

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F 725	Continued From page 29 Nurse #1 stated it was hard to get everything done with only 1 NA for 53 residents. On 1/29/20 at 5:48 AM, an interview with NA #8 revealed she had come in at 5:00 AM this morning to help on night shift. NA #8 stated she came in early all the time because they were short-staffed on night shift. On 1/29/20 at 5:58 AM, an interview with NA #7 revealed she had been working at the facility since November and had worked by herself 2 to 3 times on one side. NA #7 stated all she had time for were to do incontinence rounds, answer call lights and monitor residents who were trying to get out of bed. On 1/30/20 at 8:15 AM, an interview with the Staffing Coordinator revealed the facility currently had open positions for 2 NA on evening shift and 4 NA on night shift. They also needed to hire 2 nurses for day shift, 4 nurses for evening shift and 1 part-time nurse for night shift. The Staffing Coordinator stated a lot of NA on night shift had quit within the past month and she had to cover the shift by having NA work over or come in early. She had posted their open positions online and on social media. They had hired 2 staff members as hospitality aide until they completed their certification to work as a NA. A bonus had been offered for any staff member who worked an extra shift and she had also called prn (as needed) staff to work. They did not use agency staff to help with their staffing. On 1/30/20 at 9:49 AM, an interview with Nurse #3 revealed she was one of the day shift unit managers but had been pulled to work on a hall this week due to a nurse who recently quit. Nurse	F 725	once a week for maximum reach. Referral bonuses will continue. Administrator/designee, DON/designee, and Staffing Coordinator/designee will have staffing meeting to discuss open positions, recruitment efforts, and upcoming schedules 5 x a week x 4 weeks, weekly x 4 weeks, and ongoing as needed. Staffing patterns audit tool will be completed at staffing meeting. Staff hired after this date will be provided with a signed education regarding policy and expectations were met related to attendance policy and call-ins to ensure compliance. Each licensed and unlicensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to catheter care to ensure compliance. (4) DON/Designee will audit staffing patterns for potential interventions that may be required to ensure sufficient staffing. Results of these reviews and progress on recruitment efforts for open positions will be taken to the QAPI meeting monthly for monitoring and discussion to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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#3 said she was the nurse on-call on 1/26/20 but did not get notified about night shift being short due to a call-out until 11:00 PM. At that time, all the evening shift NA had left and refused to stay over. Nurse #3 stated there wasn't anybody else to call and she was unable to come in and work that night because she was scheduled to work from 7:00 AM to 7:00 PM the next day.

On 1/30/20 at 11:30 AM, a phone interview conducted with NA #5 revealed she had worked by herself on South a couple of times to take care of 53 residents on night shift. NA #5 shared she had voiced her concerns to the interim Director of Nursing (DON) and the Administrator that it was unsafe to leave the care of 53 residents to 1 NA on night shift.

On 1/30/20 at 3:37 PM, an interview with NA #1 revealed the facility did not have enough staff on evening and night shifts since November. NA #1 stated she had to stay over a lot of times to help on the evening shift and worked an average of 100 hours per two weeks.

On 1/31/20 at 8:34 AM, an interview with the interim Director of Nursing (DON) revealed the facility did not have enough NA for night shift but she was unaware that there had been nights when 1 NA had to work a time period by themselves to take care of 53-58 residents. She stated the on-call nurse should have called staff members to cover the shift.

On 1/31/20 at 11:15 AM, an interview with the Administrator revealed she would have to check with Human Resources about their open positions. She was unaware that there had been nights when 1 NA had to work a time period by

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F 725	Continued From page 31 themselves to take care of 53-58 residents. She stated callouts were addressed by the star program wherein a staff member assigned a star on the schedule was required to either come in early or stay over and callouts during the weekends should have been addressed by the on-call nurse. The Administrator stated they advertised their job openings online and on social media. The facility also had conducted job fairs and offered bonuses for referrals of new staff.	F 725		
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. §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.	F 761		2/28/20

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F 761	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of expired medications stored in 1 of 3 medication carts (Purple cart on North Hall) and 1 of 2 Medication Prep Rooms (South Hall) reviewed for medication storage. Findings included: 1. During an observation of the Medication Prep Room labeled as South Hall Medication Storage Room on 01/31/20 at 8:35 AM, the following medications were found in the cabinet and available for use: a. Nicotine transdermal system patch 21 milligrams (mg) delivered over 24 hours with 13 patches inside the box with expiration date of 12/2019. b. Nicotine transdermal system patch 7 mg delivered over 24 hours with 14 patches inside the box with expiration date of 12/2019. c. Carrasyn V hydrogel wound dressing 3 ounces with expiration date of 10/2019 - 2 tubes An interview with the Nurse #2 on the South Hall on 01/31/20 at 9:03 AM revealed the medications were expired and should have been removed from the Medication Room. An interview with the interim Director of Nursing (DON) on 01/31/20 at 09:36 AM revealed the medications should have been removed from the Medication Room and sent back to pharmacy. She went on to say the Medication Rooms were	F 761	(1) The facility failed to dispose of expired medication stored in 1 of 3 medication carts and 1 of 2 Medication Prep Rooms. The expired medications were removed from use by the Director of Nursing (DON) and returned to the supplying pharmacy for appropriate disposal on 01/31/20. Medications were available for residents as prescribed. (2) All residents have the potential to be adversely affected. Medication carts, Medication Prep Rooms, and the central supply closet were reevaluated to ensure compliance was met with labeling and storage of medications and supplies. (3) The Administrator and Staff Development Nurse Educator began 100% in-servicing of all staff on 02/06/20 and completed 02/17/20 to ensure compliance with policy and expectations were met related to labeling and storage of medications and supplies policy and procedure. The Staff Development Nurse Educator completed in-servicing of all nurses 02/18/20 to ensure compliance of the procedure of verifying the expiration dates for all medication prior to delivery. DON/Designee will complete medication storage audit 7x a week x 4 weeks, weekly x 4 weeks then monthly x 3. DON/Designee will complete supply storage audit 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3. Staff hired after this date will be provided with a signed education regarding policy and expectation related to labeling and storage of medications and supplies to	

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F 761	Continued From page 33 supposed to be checked for expired medications by the 3rd shift nurses. According to the interim DON, expired medications in the Medication Room was unacceptable and stated she would be doing additional education for the nurses. An interview with the Administrator revealed she expected expired medications to be removed from the Medication Rooms and returned to the pharmacy. 2. During an observation of the Purple Cart on the North Hall on 01/31/20 at 10:00 AM, a card of Divalproex Delayed Release (Depakote) 125 mg capsules with 29 capsules remaining on the card with an expiration date of 12/2019 was on the cart and available for use. An interview with Certified Medication Aide (CMA) #1 on the North Hall on 01/31/20 at 9:42 AM revealed the Depakote was expired and should have been removed from the cart and sent back to pharmacy. An interview with the interim Director of Nursing (DON) on 01/31/20 at 09:36 AM revealed the medication should have been removed from the Purple Cart on North Hall and sent back to pharmacy. She went on to say the Medication Carts were supposed to be checked for expired medications by the 3rd shift nurses. According to the interim DON, expired medications in the Medication Carts was unacceptable and stated she would be doing additional education for the nurses. An interview with the Administrator revealed she expected expired medications to be removed from the Medication Carts and returned to the	F 761	ensure compliance. (4) DON/Designee will review audit of medication and supply storage areas for labeling and storage of medications and supplies monthly x 3 for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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	345233	A. BUILDING _____ B. WING _____	C 01/31/2020

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F 761	Continued From page 34 pharmacy.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove nutritional supplements with expired expiration dates from 1 of 2 nourishment rooms and failed to label opened milk cartons and food items with the date they were opened in 2 of 2 nourishment rooms. The findings included: On 01/27/20 at 09:08 AM, observations in nourishment room #1, located on the 100 hallway, revealed 10, eight-ounce cartons of a nutritional supplement with an expired expiration	F 812	(1) The facility failed to remove nutritional supplements with expired expiration dates from 1 of 2 nourishment rooms and failed to label opened milk cartons and food items with the date they were opened in 2 of 2 nourishment rooms. The 10 cartons of nutritional supplement, 2 opened eight-ounce cartons of milk, resident food item, and 1 opened twenty-eight-ounce container of peanut butter were removed from use and discarded on 01/30/20 by the food Service Director (FSD). (2) All residents receiving nutritional	2/28/20

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F 812	Continued From page 35 date of 09/01/19, were stored in a cabinet. The refrigerator in nourishment room #1 contained; 1 opened eight-ounce carton of milk, about half full, without a date to indicate when it was opened, and 1 resident food item resembling a creamy dip, about half full, with an opened date of 01/20/20. On 1/27/20 at 9:14 AM observations in nourishment room #2, located on the 200 hallway, revealed 1 twenty-eight-ounce container of peanut butter, about half full, without a date to indicate when it was opened, was stored in a cabinet. The refrigerator in nourishment room #2 contained; 1 opened eight-ounce carton of milk, about ¾ full, without a date to indicate when it was opened. An interview was conducted with the Food Service Director (FSD) on 01/29/20 at 4:24 PM. The FSD reported that all food was to be labeled when opened with an opened date and a use by date. The FSD stated that kitchen staff checked the nourishment room refrigerator units daily, but did not discard resident foods, that was left to nursing staff. If a food or beverage is found with an expired expiration date or it is opened and not labeled with a date that it was opened, the staff should discard it. She further reported that checking dates on nutritional supplements was the nursing staff's responsibility, but that kitchen staff should have thrown out the container of peanut butter that was not labeled with a date when it was opened. The Administrator was interviewed on 01/30/20 at 11:27 AM. The Administrator explained food items were to be labeled with the date they are opened, a use by date and are to be discarded 3 days	F 812	supplement, milk, resident food items, or peanut butter have the potential to be adversely affected. Nutrition rooms and kitchen food storage areas were reevaluated to ensure compliance was met with labeling and storage of medications and supplies. (3) The Administrator and Staff Development Nurse Educator began 100% in-servicing of all staff on 02/06/20 and completed 02/17/20 to ensure compliance with policy and expectations were met related to labeling and storage of food items policy and procedure. FSD/Designee will audit food storage locations. Results of the audit will be taken to the QAPI meeting to evaluate compliance. FSD/Designee will complete audit 7x a week x 4 weeks, weekly x 4 weeks then monthly x 3. Staff hired after this date will be provided with a signed education regarding policy and expectation related to labeling and storage of food to ensure compliance. (4) FSD/Designee will review audited food storage areas for labeling and storage of food monthly x 3 for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. Administrator is responsible for ongoing compliance. (5) The facility will be in compliance as of 02/28/20.	

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F 812	Continued From page 36 after they are opened. The Administrator stated the observed expired foods should have been thrown out and the items without labels should have been labeled when opened. The Administrator further reported that both dietary staff and nursing aides were expected to maintain the nourishment rooms.	F 812		
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	F 842		2/28/20

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F 842	Continued From page 37 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed 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 observations, record review, resident and staff interviews, the facility failed to	F 842	(1) The facility failed to accurately document the provision of tracheostomy	

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F 842	Continued From page 38 accurately document the provision of tracheostomy care for 1 of 1 resident reviewed for respiratory care (Resident #45). Findings included: Resident #45 was admitted to the facility on 07/03/15 with diagnosis of chronic obstructive pulmonary disease (COPD). Additional diagnoses included acute on chronic respiratory failure, dependence on supplemental oxygen and encounter for attention to tracheotomy. A review of a physician's order dated 03/06/19 indicated Resident #45 was to receive tracheostomy care every day to include cleaning inner cannula with trach care kit and replace to trach. The quarterly Minimum Data Set (MDS) assessment dated 11/12/19 indicated Resident #45 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and required supplemental oxygen and tracheostomy care. Care plan reviewed and continued on 01/28/20 indicated Resident #45 had a tracheostomy and required supplemental oxygen related to COPD. It was reported in the care plan that Resident #45 requested frequent tracheostomy care. A review of the Treatment Administration Record (TAR) for the month of December 2019 revealed that for the dates of 12/03/19, 12/04/19, 12/07/19, 12/08/19, 12/09/19, 12/11/19, 12/12/19, 12/16/19, 12/17/19, 12/28/19, 12/20/19, 12/21/19, 12/22/19, 12/24/19, 12/26/19, 12/27/19, 12/28/19, 12/29/19, 12/30/19 and 12/31/19 there was no	F 842	care for 1 of 1 resident reviewed for respiratory care (Resident #45). Resident was assessed by Nursing Supervisor and Director of Nursing (DON) to ensure appropriate tracheostomy care was provided and documented on 01/30/20. (2) All residents with tracheostomies have the potential to be affected. DON conducted a review of all residents with tracheostomies to ensure compliance for documented tracheostomy care on 02/05/20. (3) Staff Development Nurse Educator completed in-servicing 02/18/20 for all licensed and non-licensed nursing staff to ensure compliance with policy and expectations were met related to proper and timely documentation. DON/Designee will audit tracheostomy care documentation for residents with tracheostomies 5 x a week x 4 weeks, weekly x 4 weeks, then monthly x 3. Each licensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to the documentation of tracheostomy care to ensure compliance. (4) DON/Designee will audit tracheostomy care for residents for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI meeting monthly for monitoring to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. DON is responsible for ongoing compliance. (5) The facility will be in compliance as of	

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F 842	Continued From page 39	F 842		

documentation to indicate that tracheostomy care had been provided as ordered by the physician.

On 01/30/20 at 9:48 AM an interview was conducted with Nurse #3 who stated she was responsible to document that tracheostomy care had been provided 12/08/19, 12/09/19, 12/11/19, 12/20/19, 12/22/19, 12/26/19, 12/29/19 and 12/31/19. Nurse #3 shared that tracheostomy care had been provided per physician's order and often times more than once/day as requested by Resident #45. Nurse #3 explained that she forgot to document on Resident #45's TAR that tracheostomy care was provided.

On 01/31/20 at 8:41 AM a telephone interview was conducted with Nurse #4 who stated she was responsible to document that tracheostomy care had been provided for Resident #45 on 12/04/19, 12/07/19, 12/12/19, 12/16/19, 12/17/19, 12/18/19, 12/21/19, 12/30/19. Nurse #4 shared that the tracheostomy care had been provided per physician's order. Nurse #4 explained that she must have forgotten to document on Resident #45's TAR that tracheostomy care was provided.

On 01/30/20 at 01:50 PM a telephone interview was conducted with Nurse #5 who recalled that she was responsible to document that tracheostomy care had been provided for Resident #45 on 12/24/19 and 12/28/19. Nurse #5 shared that the tracheostomy care had been provided per physician's order and often times more frequently because Resident #45 would request it be provided more often. Nurse #5 explained that she must have forgotten to document on Resident #45's TAR that tracheostomy care was provided.

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F 842	Continued From page 40 On 01/31/20 at 10:08 AM a telephone interview was conducted with Nurse #6 who reported that she was responsible for providing and documenting that tracheostomy care had been provided for Resident #45 on 12/27/19. Nurse #6 explained that she always provided tracheostomy care as ordered and that the resident did not let staff miss treatment. Nurse #6 further stated that she must have forgotten to document on Resident #45's TAR that tracheostomy care was provided. On 01/30/20 at 10:03 AM an interview was completed with Resident #45 who reported that he did receive tracheostomy care every day and that it was never missed. On 01/30/20 at 11:18 AM an interview was conducted with the Interim Director of Nursing (DON) who stated her expectation was nursing staff documented when a treatment was completed on the TAR. The DON reported that she was aware staff were not diligent about documenting treatments and that the facility was attempting to improve in this area. On 01/31/20 at 11:30 AM an interview was conducted with the Administrator who stated her expectation was that tracheostomy care for Resident #45 should have been documented by Nurse #3, 4, 5, and 6 when completed.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		2/28/20

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F 867	Continued From page 41 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification and complaint investigation surveys of 2/1/19 and 7/18/19. This was for two recited deficiencies that were originally cited in February 2019 and July 2019 and were subsequently recited on the current recertification and complaint investigation survey of 1/31/20. The recited deficiencies were in the areas of Sufficient Nursing Staff (F-725) and Self-Determination (F-561). The continued failure of the facility during three Federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag was cross-referenced to: F-725 Sufficient Nursing Staff: Based on observations, staff interviews and record review, the facility failed to provide sufficient nursing staff for urinary catheter care (Resident #260 and Resident #41). This affected 2 of 2 residents reviewed. During the annual recertification and complaint investigation survey of 2/1/19, the facility was cited for failure to provide showers due to insufficient staffing for 6 of 7 residents sampled	F 867	(1) The facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification and complaint investigation surveys of 2/1/19 and 7/18/19 related to Sufficient Nursing Staff and Self-Determination. This affects Resident #260 and Resident #41 related to Sufficient Nursing Staff for catheter care and Resident #52 regarding self-determination for shower preferences. Director of Nursing (DON) completed a review of all residents with indwelling Foley catheters to ensure compliance for proper and timely catheter care on 01/31/20. Resident #52 was interviewed and his shower preferences were updated on Activities of Daily Living (ADL) on 01/30/20. Resident received shower on 01/30/20 and ongoing per preferences. (2) All residents have the potential to be adversely affected in the areas of Sufficient Nursing Staff and Self-Determination. (3) The Administrator, Director of Nursing, and interdisciplinary team were educated by the Regional Director of Operations (RDO) on the policy and procedure of the facility's Quality Assurance Performance Improvement Program (QAPI) on 02/06/20. The education included	

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F 867	Continued From page 42 for activities of daily living. F-561 Self-Determination: Based on observation, record review, and resident and staff interviews, the facility failed to honor a resident's choice for the time of day he received showers for 1 of 1 resident reviewed for choices (Resident #52). During a complaint investigation survey on 7/18/19, the facility was cited for failure to honor a resident's choice for showers for 1 of 3 residents reviewed for choices. During an interview on 1/31/20 at 11:30 AM, the Administrator stated they had been conducting shower audits but had stopped in August 2019. She further stated that the QAA committee had not followed up on the staffing issues. The Administrator acknowledged that it was her responsibility to continue to follow up on concerns identified from the previous surveys.	F 867	identifying areas of continuous quality monitoring and the tools to be used, monitoring activities, a focus on the processes that affect resident outcomes, and performance improvement. Ongoing monitoring including but not limited to daily staffing meetings & recruitment efforts for the topics of sufficient nursing staff including to provide catheter care as indicated as well as ongoing audits for resident self-determination will be used to re-establish the facility's outcomes. The Administrator is accountable for the overall implementation and functioning of the QAPI program. (4) The QAPI committee will meet monthly to continue to monitor and identify areas of improvement to include survey deficiencies. The Committee will address the identified needs through improvement, action plans, and monitoring for ongoing effectiveness of such plans. In the area of sufficient nursing staff, the DON will report findings from reviews of staffing pattern audits to the QAPI committee, and the QAPI committee will discuss open positions and recruitment efforts. Results of catheter care reviews will be presented to the QAPI committee by the DON. In the area of self-determination, the DON will report findings from reviews of shower preference and documentation audits to the QAPI committee. The Administrator is responsible for ongoing compliance. The Regional Director of Operations will review the facility QAPI meeting minutes for up to six months to ensure ongoing compliance. (5) The facility will be in compliance as of	

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F 867	Continued From page 43	F 867	02/28/20.	