



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 10, 2018

Monica Brutsman, Administrator  
The Terraces of Boise  
5301 E. Warm Springs Ave.  
Boise, ID 83716

Provider #: 135141

Dear Ms. Brutsman:

On **March 23, 2018**, a survey was conducted at The Terraces of Boise by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 20, 2018**. Failure to submit an acceptable PoC by **April 20, 2018**, may result in the imposition of civil monetary penalties by **May 13, 2018**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Denial of payment for new admissions effective June 23, 2018**
- **Civil money penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 23, 2018**, if substantial compliance is not achieved by that time.

Monica Brutsman, Administrator  
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**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

**F0606-- Not Empoy/Engage Staff w/Adverse Actions**  
**F0883-- Influenza and Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

- The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
- Residents **#1-8, #9-12, #14, #16, #19, #75 and #121** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

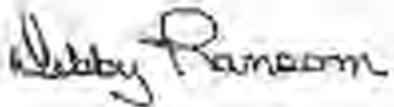
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **April 20, 2018**. If your request for informal dispute resolution is received after **April 20, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

dr/lj  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135141</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TERRACES OF BOISE, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5301 E WARM SPRINGS AVE BOISE, ID 83716</b>
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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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted March 19, 2018 to March 23, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Jenny Walker, RN Teri Hobson, RN</p> <p><b>ABBREVIATIONS:</b></p> <p>ADLs = Activities of Daily Living ADON = Assistant Director of Nursing BP = Blood Pressure CDC = Centers for Disease Control CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation CT = Computerized Axial Tomography Scan CVA = Cerebral Vascular Accident DNS = Director of Nursing Services DOO = Director of Operations EMAR = Electronic Medication Administration Record I&amp;A = Incident and Accident report LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set PCV13 =Pneumococcal conjugate vaccine (protects against 13 strains of pneumococcal bacteria) PPSV23 = Pneumococcal polysaccharide vaccine (protects against 23 strains of pneumococcal bacteria) PRN = as needed PT = Physical Therapy OT = Occupational Therapy</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>04/20/2018</b>
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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 575	<p>Continued From page 2</p> <p>representatives. The failure to provide the Medicare, Ombudsman, and the State Survey Agency contact information affected 17 of 17 (#1-#8, #9-#12, #14, #16, #19, #75, #121) sample residents residing in the facility and the other 3 residents residing in the facility. This had the potential for more than minimal harm if residents required assistance from any of these agencies, but did not know how to contact an agency representative. Findings include:</p> <p>On 3/19/18 at 7:30 PM, it was observed that the contact information for Medicare and the State Survey Agency was not posted in the facility.</p> <p>On 3/19/18 at 7:30 PM, the Ombudsman contact information was observed in the den of Redwood building (1 of 2 residential buildings) on the inside wall covered by the door. The Ombudsman contact information was not accessible to residents and resident representatives at the Redwood building.</p> <p>On 3/20/18 at 2:15 PM, 4 of 4 residents attending the group meeting, were not aware of how to contact Medicare, the Ombudsman, or the State Survey Agency.</p> <p>On 3/21/18 at 2:15 PM, the Administrator was not aware of the need to post contact information for Medicare and the State Survey Agency. The Administrator was informed the Ombudsman contact information was not accessible for residents and resident representatives at the Redwood building.</p>	F 575	<p>updated and relocated. A statement that resident or family members may file a complaint with the State Ombudsman and/or State Survey Agency concerning resident abuse, neglect, exploitation or misappropriation of resident property was updated on the framed posting, that is located in Redwood and Maple skilled houses, on the wall in a common hallway. on 4/19/18 LSW educated residents residing in the SNF facilities, to the location of the postings and the general information listed on the postings.</p> <p><b>OTHER RESIDENTS POTENTIALLY AFFECTED:</b> Residents residing in a skilled houses have the potential to be affected.</p> <p><b>MEASURES PUT IN PLACE AND SYSTEMIC CHANGES:</b> Postings are compared to 483.1 and comply with regulation. Posting for the next to be opened skilled house has been updated and framed. Administrator will review State informational letters when they are received and update postings to reflect any new changes.</p> <p><b>ONGOING MONITORING:</b> Updates or changes to F575 will be reflected in facility postings. Administrator and LSW responsible for ongoing monitoring.</p>		
F 577 SS=F	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		4/27/18	

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F 577	<p>Continued From page 3</p> <p>§483.10(g)(10) The resident has the right to-</p> <p>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and</p> <p>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.</p> <p>§483.10(g)(11) The facility must--</p> <p>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.</p> <p>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and resident, staff, and resident representative interviews, it was determined the facility failed to ensure the results of the facility's most recent certification survey and complaint survey were readily accessible for review. This failed practice directly impacted 5 of 5 residents (#2 and 4 of 4 residents in the resident group interview) interviewed and 1 of 1 resident representative interviewed regarding</p>	F 577	<p><b>CORRECTIVE ACTION:</b> A sign was mounted by the main entrance of each skilled house that identified where the survey results were located for review.</p> <p><b>OTHER RESIDENTS POTENTIALLY AFFECTED:</b> Residents and family members of those</p>		

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F 577	<p>Continued From page 4</p> <p>where the survey results were located and had the potential to impact the other 15 residents residing in the facility, their representatives, and visitors who may want to review the facility's survey history. Findings include:</p> <p>The facility's initial certification survey was completed 12/21/16 and a complaint investigation survey was completed 4/27/17.</p> <p>On 3/19/18 at 6:30 PM, a binder with the results of the two previously mentioned surveys was observed on a desk by the computer in the den of the Maple building.</p> <p>The facility provided the den in the Maple building as the work area for the survey team and the French doors to the den were closed during the survey from 3/19/18 to 3/23/18.</p> <p>At 7:00 PM, a binder with the results of the two previously mentioned surveys was observed on a desk by the computer in the den of the Redwood building.</p> <p>On 3/20/18 at 1:50 PM, Resident #2 stated he did not know where the survey results binder was located.</p> <p>On 3/20/18 at 2:00 PM, 4 of 4 residents in a group interview with surveyors in the Redwood building den said they did not know where the survey results were located.</p> <p>On 3/22/18 at 6:00 PM, one resident representative stated s/he did not know where the survey results were located. The resident representative asked to remain anonymous.</p>	F 577	<p>residents residing in each skilled house have the potential to be effected.</p> <p><b>MEASURES PUT IN PLACE/SYSTEMIC CHANGES:</b> Staff were educated on 4/12/18 and 4/16/18 to the location of the survey book in the living room common area, and its availability, should a resident or visitor request to see it.</p> <p>Residents were re-educated, that the survey book would be kept in the living room common area for anyone to review.</p> <p><b>MONITORING TO ENSURE ON GOING COMPLIANCE:</b> Social Services will remind residents during resident council meeting about the survey book and document if they feel it continues to be accessible. LSW is responsible for ongoing monitoring.</p>		

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F 577	Continued From page 5  During the survey, there were no signs in the hallways or common areas regarding where the survey results were located. The survey results were not readily accessible to residents, family members, and legal representatives of residents.  On 3/22/18 at 2:30 PM, the Administrator was informed residents residing in the facility did not know where the survey results binder was located.	F 577			
F 579 SS=F	Posting/Notice of Medicare/Medicaid on Admit CFR(s): 483.10(g)(13)  §483.10(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to prominently display information regarding how to apply for and use Medicare benefits. This deficient practice had the potential to negatively impact 17 of 17 sample residents residing in the facility (#1-#8, #9-#12, #14, #16, #19, #75, #121) and the other 3 residents residing in the facility. This placed residents at risk of not being fully informed of their rights regarding Medicare benefits. Findings include:  During initial tour on 3/19/18 at 6:30 PM, it was discovered there was no information posted within the facility regarding Medicare benefits.	F 579	<b>CORRECTIVE ACTION:</b> Postings in the facility were updated to include contact number that explained how to apply for Medicaid and how to use Medicare Benefits.  <b>OTHERS POTENTIALLY AFFECTED:</b> Residents currently residing in the facility have the potential to be affected. Postings in the facility were updated to include contact number that explained how to apply for Medicaid and Medicare Benefits, and explanation of Medicare benefits. On 3/16/18 Admission Agreement was updated to include 3 ways to apply for	4/27/18	

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F 579	Continued From page 6  On 3/21/18 at 10:30 AM, the DNS acknowledged that the facility did not have information prominently displayed regarding Medicare benefits.  On 3/21/18 at 2:15 PM, the Administrator was not aware of the regulatory requirement regarding posting information about Medicare benefits in a prominent location.	F 579	Medicare and Medicaid, and that the facility LSW can assist them if needed.  <b>SYSTEMIC CHANGES:</b> As of 4/13/18 all current residents have applied for or had Medicare benefits. LSW on 4/16/18 met with residents to determine if they had any questions about how to apply for Medicaid or Medicare, and if they had questions on how to use Medicare Benefits. No concerns noted. On 3/16/18 Admission Agreement was updated to include 3 ways to apply for Medicare and Medicaid, and that the facility LSW can assist them if needed.  <b>ONGOING COMPLIANCE:</b> If CMS changes the process for applying for Medicare or phone numbers to call the Facility postings will be updated. Administrator and LSW responsible for ongoing compliance.		
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-	F 600		4/27/18	

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F 600	<p>Continued From page 7</p> <p>§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 observation, staff interview, and review of clinical records and Incident and Accident Reports, it was determined the facility failed to ensure injuries of unknown source were recognized as potential indicators of abuse or neglect. This was true for 2 of 3 sampled residents (#11 and #14) reviewed for abuse/neglect. Specifically:</p> <p>* Resident #11 sustained a fractured 3rd rib and suspected 4th rib fracture on 9/25/17. There was no evidence the facility investigated these injuries as potential abuse to determine the cause of the injuries.</p> <p>* Resident #11 sustained a bruise of unknown source to his right upper extremity. There was no evidence the facility investigated this injury as potential abuse to determine the cause of the injury.</p> <p>* Resident #14 sustained a skin tear to the left shin on 3/16/18. There was no evidence the facility investigated this injury as potential abuse to determine the cause of the injury.</p> <p>This deficient practice created the potential for harm if the facility failed to recognize, prevent, and protect residents from potential incidents of abuse and/or neglect. Findings include:</p> <p>1. Resident #11 was admitted to the facility on</p>	F 600	<p><b>CORRECTIVE ACTIONS:</b> Resident # 11 was reassessed by SDC for any unknown injuries on 4/12/18, and there were no injuries of unknown origin. Resident and wife were interviewed by the LSW on 4/12/18 for any concerns regarding potential abuse, neglect, or injuries of unknown origin. Resident # 14 no longer resides in the facility.</p> <p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents residing in the SNF have the potential to be affected. Full body skin checks were completed by 4/13/18 to ensure any new skin conditions are documented and investigated appropriately. LSW spoke with resident council on 4/12/18 to identify any injuries of unknown origin or concerns about abuse, none were noted. Residents that did not attend resident counsel were interviewed by the LSW on 4/12/18 to identify any concerns for injuries of unknown origins, no concerns noted. Accident Incidents in the last 30 days were reviewed by the DNS on 4/12/18, for any injuries of unknown origin, and there were none.</p>		

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F 600	<p>Continued From page 8</p> <p>6/4/17 with diagnoses which included speech and language deficit, multiple rib fractures, dementia, and aphasia.</p> <p>An annual MDS assessment, dated 2/12/18, documented Resident #11 had a moderate cognitive impairment and documented he experienced one fall with no injury.</p> <p>An undated care plan, documented Resident #11 had dementia and impaired cognitive function.</p> <p>a. An I&amp;A Report, dated 9/16/17 at 11:19 AM, documented Resident #11 experienced an unwitnessed fall in another resident's bathroom.</p> <p>An I&amp;A Report, dated 9/21/17 at 2:12 AM, documented Resident #11 was observed walking in his room unattended and before a CNA could assist him, he fell and landed on his right elbow. The I&amp;A documented Resident #11 had disconnected his bed alarm to keep it from sounding. The I&amp;A documented Resident #11 experienced an injury to his right elbow from the fall.</p> <p>An I&amp;A Report, dated 9/25/17 at 5:20 AM, documented Resident #11 experienced an unwitnessed fall from bed. The I&amp;A documented his alarm was sounding and his back was against his night stand and Resident #11 had multiple skin tears to his left elbow and left hand.</p> <p>A Health Status Progress Note, dated 9/25/17 at 5:32 AM, documented by LPN #2 stated, "Residen[t's] alarm noted to be alarming at 5:10 this morning. Upon entrance into the room the CNA noted resident sitting on buttocks leaning</p>	F 600	<p><b>SYSTEMIC CHANGES:</b></p> <p>Staff educated on 4/12/18 to report all injuries or change in skin condition be reported to Administration when they are identified, to rule out any possible injuries of unknown origin an ensure prompt investigation and reporting.</p> <p>4/20/18, Transport company Owner was contacted by the Administrator to ensure drivers were educated to report abuse, injuries during transport, and or injuries of unknown origin to the Healthcare Administrator immediately.</p> <p>Facility Incident report was revised to include clear documentation of an injury of unknown origin, and requiring staff to notify Administration.</p> <p>Resident skin checks will be reviewed and audited by DNS or designee daily for 2 weeks, then weekly x 4 weeks, then Monthly thereafter for 4 months for any concerns or trends.</p> <p><b>ONGOING COMPLIANCE:</b></p> <p>Results of skin audits, and incidents of unknown origin, will be reviewed in monthly QAPI meeting for concerns or trends.</p> <p>DNS and Administrator responsible for ongoing monitoring and compliance.</p>		

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F 600	<p>Continued From page 9</p> <p>towards the left side, using his left arm to support his weight to a sitting position, This nurse noted blood to the floor near [hand] as well as on the residen[t's] arm. Resident assessed with no noted or stated pain in extremities. Residen[t's] neuro assessment completed due to not being a witnessed fall with no evidence of neurological change. Resident unable to state what happened due to being confused and not being able to get words out in proper order. Resident attends were clean and dry. Resident noted to have skin tear to left elbow as well as left ring finger next to ring. Skin tear to finger was approximated [,] cleansed with wound cleanser, and steri strips were applied. Skin tear to left elbow was approximated to most areas to include the lower portion of skin tear and the lower corner were steri stripped. Other areas were unable to be approximated and was cleansed with wound cleanser, non-adherent pad was placed and covered with kerlex in order to protect surrounding skin from tape. Resident showed no s/sx of pain with dressing change and was noted to sleep during bandage process. Resident currently in bed with no noted other injury beside skin tear."</p> <p>A Health Status Progress Note, dated 9/25/17 at 2:00 PM, documented Resident #11 had a recent fall and a large purple bruise with a large red abrasion was discovered on his left side. A stat x-ray was ordered and fractured ribs were diagnosed.</p> <p>A Health Status Progress Note, dated 9/26/17 at 12:41 AM, by LPN #2 documented the exact wording as the progress note, dated 9/25/17 at 5:32 AM by LPN #2 with the exception of the last sentence, which stated, "Res also noted to have</p>	F 600			

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F 600	<p>Continued From page 10 abrasion/bruise to mid upper back. Resident currently in bed with no noted other injury beside skin tear."</p> <p>The progress note was not dated late entry and there was no explanation why the bruise and abrasion was added to the progress note dated 9/26/17 at 12:41 AM by LPN #2.</p> <p>A 9/25/17 at 9:09 AM, physician's order documented Resident #11 was to have a "stat" x-ray to his left lower ribs to rule out injury related to a fall.</p> <p>A 9/25/17 at 11:02 AM, Radiology Interpretation Significant Findings documented Resident #11 sustained a "nondisplaced fracture of the 3rd rib." The report documented there was a question about a possible fracture of the 4th rib in addition.</p> <p>A 9/25/17 at 2:00 PM, Nurse's Note documented Resident #11 sustained a fracture to his 3rd rib and a questionable fracture to his 4th rib.</p> <p>Resident #11's clinical record did not contain progress notes on 9/25/17 between the 5:32 AM Health Status Note and 9:09 AM order for a stat X-ray, that showed the causes of the bruise and fractured rib were being investigated.</p> <p>b. An I&amp;A Report, dated 12/4/17 at 9:04 AM, documented Resident #11 sustained a bruise / injury of unknown source to his right upper extremity. The I&amp;A did not document the size of the bruise. The I&amp;A documented Resident #11 had impaired memory, utilized side rails, was an active exit seeker, had gait imbalance issues, was often confused, and utilized a walker. The</p>	F 600			

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F 600	<p>Continued From page 11 I&amp;A documented there were no witnesses found.</p> <p>Resident #11's clinical record did not contain progress notes, physician notes, or IDT follow-up documenting the size of the bruise, causality of the bruise, or/and investigation into the source of the bruise.</p> <p>On 3/23/18 at 9:32 AM, the Administrator stated she was not aware Resident #11 fractured his rib. The Administrator stated she was aware he fell multiple times. The Administrator stated the I&amp;A Reports were incomplete. The DNS, also present, and the Administrator stated a complete investigation included obtaining witness statements from all staff who worked in the last 24 hours. The Administrator stated all injuries of unknown sources were investigated for the causality.</p> <p>Resident #11's clinical record did not contain progress notes identifying the discovery of the bruise and fracture, their progression, or clear investigations of their causes. The investigations did not include a conclusion as to the source of the bruising/fracture, witness statements, staff interviews, or resident interviews to determine the origin of the bruise/fracture, or a complete investigation to rule out potential abuse or neglect.</p> <p>2. Resident #14 was admitted to the facility on 2/16/18 with multiple diagnoses, including cellulitis (infection of tissue) and osteomyelitis (infection of bone) to left foot and ankle.</p> <p>The admission MDS assessment, dated 2/23/18, documented Resident #14 was cognitively intact.</p>	F 600			

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F 600	<p>Continued From page 12</p> <p>A nurse's progress note, dated 3/16/18 at 9:44 AM, documented Resident #14 had a wound clinic appointment. The nurse's note did not document the resident had a skin tear to the left shin.</p> <p>A wound clinic progress note, dated 3/16/18, documented a new shin wound with orders to change the dressing daily.</p> <p>Resident #14's Physician Order Summary Report, dated 3/23/18, did not document the new wound care orders.</p> <p>On 3/23/18 at 1:25 PM, LPN #2 stated Resident #14 had a wound clinic appointment on 3/16/18 and an outside transport agency picked up Resident #14 around 10:00 AM. LPN #2 stated the driver came back into the facility a few minutes later and asked for some bandages. LPN #2 stated she provided bandages for the transport driver, but did not inquire about the need for the bandages. LPN #2 stated Resident #14 returned from the wound clinic and the wound clinic faxed new orders. LPN #2 said she did not recall seeing the new wound care orders for Resident #14's shin wound.</p> <p>On 3/23/18 at 2:15 PM, the outside transport agency driver stated while applying the anchors to the wheelchair in the van, the driver noticed blood and a skin tear to Resident #14's left shin. The driver stated he went back into the facility, spoke to a staff member, did not remember her name or her title, requested bandages for a skin tear to Resident #14, and the staff member brought bandages with her to the van and</p>	F 600			

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F 600	Continued From page 13 watched the driver apply a bandage to the left shin of Resident #14.  On 3/23/18 at 9:32 AM, the Administrator and the DNS stated the facility investigated injuries of unknown source as potential abuse. The Administrator stated the size of the injury of unknown source should be identified in the residents record. The Administrator stated the facility would review with their staff what to report to the Administrator to investigate.  On 3/23/18 at 11:30 AM, the DNS and ADON stated there were no nurse's notes or an incident report documented regarding a skin tear to Resident #14's left shin. The DNS stated she was unaware of an incident regarding the skin tear Resident #14 sustained on 3/16/18.	F 600			
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)  §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:  §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).  §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 604		4/27/18	

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F 604	<p>Continued From page 14 treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure residents were free from physical restraints, including bed and chair alarms, beds pushed against walls, Wanderguard alarms, bed side rails, and bed halo bars (round rails), unless needed to treat the resident's medical symptoms. This was true for 5 of 6 (#6, #11, #16, #19, and #75) residents sampled for restraints. This systemic deficient practice created the potential for harm to residents, including entrapment in side rails, increased the risk of falls, fear movement may set off an alarm, and diminished sense of dignity. Findings include:</p> <p>The facility's undated Resident Alarms Policy documented the facility used alarms in limited circumstances to meet the resident needs, goals and preferences. The policy documented the following guidelines for resident alarms:</p> <p>* "The use of alarms do not eliminate the need</p>	F 604	<p><b>CORRECTIVE ACTION FOR THOSE AFFECTED:</b> Resident #6- On 4/19/18 he was interviewed and he requested to have his bed against the wall to increase the functional space in his room. Resident requested bilat 1/4 siderails for increased bed mobility. Residents request was assessed, MD order obtained, consent received, and care planned. Resident #11- Was reassessed on 4/19/18 restraint reduction was accomplished by discontinuing the tab alarm. Upon reassessment resident #11 continues to use a Right side 1/4 rail and Left side halo assist bar for increased bed mobility and increased independence, in addition to Wandergaurd alarm. These were assessed, ordered, and care planned. Resident #16- No longer resides in the facility. Resident #19- was reassessed on</p>		

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F 604	<p>Continued From page 15 for adequate supervision." * "The facility shall establish and utilize a systematic approach for the safe and appropriate use of resident alarms." * "Evaluate and analyze risk; implement interventions to reduce risk; and monitor for effectiveness of the interventions." * "Identification of risk." * "Evaluation and analysis of risk." * "Implantation [sic] of interventions." * "Monitoring and modification." * " The IDT shall determine whether the alarm meets the definition of a restraint."</p> <p>The facility's undated Physical or Chemical Restraints Policy documented, "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The policy documented the following guidelines for physical restraints:</p> <p>* "Placing a...bed so close to the wall that the wall prevents the resident from...getting out of bed." * "The use of side rails is prohibited unless they are necessary to treat a resident's medical condition." * "Before the resident is restrained, Licensed Nursing Home will determine the presence of a medical symptom that would require the use of restraints, and how the use of the restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his/her highest level of physical and psychosocial well-being."</p>	F 604	<p>4/19/18 for the continued need for the bed alarm, bed against wall, and Halo rail. Will continue with Left Halo assist rail, Pressure pad alarm bed and w/c were discontinued on 4/26/18. They have been assessed, ordered, and care planned. Resident # 75- no longer resides in the facility.</p> <p>OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED: Residents that reside in the facility and have a "device" such as an alarm, bed rails, or bed against wall have the potential to be affected.</p> <p>SYSTEMIC CHANGES: Staff educated 4/12/18, on least restrictive interventions are tried before requesting to obtain a doctors order for any of the following: alarms to bed or chair, side rails, and bed against the wall. Standards and Guidelines #12035 was updated to reflect Halo bars and assist bars. Staff were re educated on, 4/12/18, the need for MD order, assessments for devices, consents for devices, and care planning of devices. on 4/12/18 Standards and guidelines #12035 was revised regarding devices and restrains. DNS or designee will audit rooms twice weekly for 4 weeks, then weekly for 4 weeks, and monthly for 3 months - for any devices that have been added and ensure appropriate order has been received, assessment complete, consents obtained, and care plans are in place for those</p>		

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F 604	<p>Continued From page 16</p> <p>* "Medical symptoms that warrant the use of restraints will be documented in the clinical record."</p> <p>1. Resident #19 was admitted to facility on 1/29/18 with multiple diagnoses including cognitive communication deficit.</p> <p>An admission MDS assessment, dated 2/5/18, documented Resident #19 was moderately cognitively impaired and required extensive assistance of 1 to 2 staff members for cares. The MDS assessment did not document Resident #19 utilized bed rails or alarms.</p> <p>On 3/19/18 at 6:30 PM, Resident #19 was observed resting in bed with a halo bar on the left-side and the bed was positioned with the right side of the bed against the wall. Resident #19 had an alarm on the bed.</p> <p>On 3/20/18 at 9:56 AM, Resident #19 was observed in his room sitting in his wheelchair, with an alarm on the back of his chair.</p> <p>On 3/20/18 at 9:58 AM, the DNS stated she was unaware the bed was against the wall. The DNS stated there were no assessments for alarms, halo bar or bed against the wall for Resident #19. The DNS stated there should have been consents for the restraints. The DNS agreed that the bed against the wall was considered a restraint.</p> <p>Resident #19's clinical record did not include assessments, care plans, consents, or physicians orders for the alarms, bed against the wall, and halo bar.</p>	F 604	<p>devices. Results of those audits will be reported to the monthly QAPI meeting for review and recommendations.</p> <p><b>ONGOING COMPLIANCE:</b> "Device" audits will be reviewed with IDT in monthly QAPI meeting for compliance. "Devices" will require permission to be placed from the DNS or Administrator to ensure proper steps have been taken prior to the device added. DNS responsible for on going monitoring.</p>		

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F 604	<p>Continued From page 17</p> <p>2. Resident #6 was admitted to the facility on 1/24/18 with multiple diagnoses, including mild cognitive impairment and chronic pain.</p> <p>The admission MDS assessment, dated 2/2/18, documented Resident #6 was cognitively intact, required extensive assistance for transfers with two people, and at risk for falls.</p> <p>On 3/19/18 at 7:45 PM, Resident #6 stated his bed had been against the wall for awhile and he did not consent to having the bed against the wall. He said he was not assessed to determine the need for his bed to be against the wall. Resident #6's bed was observed against the wall at that time</p> <p>The March 2018 Physician Order Summary Report did not include orders for Resident #6's bed against the wall.</p> <p>Resident #6's care plan, target dated 4/24/18, did not document the bed against the wall.</p> <p>Resident #6's clinical record did not have an assessment or consent for the bed against the wall.</p> <p>On 3/22/18 at 1:15 PM, the DNS was unable to provide an assessment, consent, care plan, and a physician order for Resident #6's bed to be against the wall.</p> <p>3. Resident #11 was admitted to the facility on 6/4/17 with diagnoses which included speech and language deficit, multiple rib fractures, dementia, and aphasia.</p>	F 604			

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F 604	Continued From page 18  An annual MDS assessment, dated 2/12/18, documented Resident #11 had moderate cognitive impairment and documented he utilized bed and chair alarms daily. The MDS did not document he utilized a Wanderguard or bed rails.  An undated care plan documented Resident #11 had dementia and impaired cognitive function.  An undated care plan documented Resident #11 was at risk for falls with or without injury related to a "recent CVA, with right side hemiparesis (paralysis), cognitive impairment, gait/balance problems, incontinence, poor communication/comprehension, and psychotropic med use and impulsivity, history of falls w/ [with] Fx [fracture]." The care plan interventions included the following:  * Resident #11's "pressure alarm to bed and wheelchair to alert staff of unsafe self-transfers and safety needs. Staff to ensure placement, turned on and functionality of the devices." * Resident #11 utilized a "bed rail on the right side of his bed for a sense of security and a halo bar to the left side of his bed to aid in independence with bed mobility and transfers."  A 12/19/17 physician's order documented Resident #11 required 1/4 bed rail on the right-side and a halo bar to the left-side.  A 1/10/18 physician's order documented Resident #11 required a pressure alarm to his bed and chair.  A Physical Restraint Informed Consent, alarm to	F 604			

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F 604	<p>Continued From page 19</p> <p>bed and wheelchair, dated 10/31/17, documented pressure type bed and wheelchair alarms were attempted prior to the change in alarms.</p> <p>Resident #11's clinical record did not contain assessments of the medical need for the bed and chair alarms, the 1/4 bed rail, and halo bar.</p> <p>On 3/20/18 at 8:39 AM, Resident #11 was observed in his wheelchair at the breakfast table and the back of his wheelchair had an alarm box attached. Resident #11's wheelchair had a Wanderguard attached under his wheelchair.</p> <p>On 3/20/18 at 8:59 AM, Resident #11's bed was observed with 1/4 bed rail on the right-side and a halo bar to the left-side.</p> <p>On 3/20/18 at 9:33 AM, Resident #11 was observed nearing the front door by himself and a proximity alarm sounded. Resident #11 stated he wanted to find his wife. Resident #11 made several attempts to leave the building to find his wife. CNA #1 approached Resident #11 and redirected him.</p> <p>On 3/20/18 at 11:01 AM, Resident #11 was observed sitting in his wheelchair staring out the window waiting for his wife to come. Resident #11 had an alarm on the back of his wheelchair and a Wanderguard under his chair.</p> <p>On 3/21/18 at 9:10 AM, Resident #11 was observed at the breakfast table with an alarm attached to the back of his wheelchair and a Wanderguard under his chair.</p>	F 604			

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F 604	<p>Continued From page 20</p> <p>On 3/22/18 at 5:36 PM, Resident #11 was observed in the hallway near the front door turning off lights with no staff members around. Resident #11's chair alarm was not attached to the back of his wheelchair during the observation.</p> <p>On 3/21/18 at 10:25 AM, the DNS stated Resident #11 had consents for the alarms and the alarms were care planned. The DNS stated she was aware of the other requirements under the new regulations for alarms and bed rails and was in the process of trying to phase out all alarms and bed rails in the facility. The DNS stated she would correct the issues with the alarms and bed rails. The DNS stated the bed rails had orders, but she could not locate the consent. The DNS could not locate the assessments for the bed rails or alarms. The DNS stated Resident #11 utilized bed rails, alarms, and a Wanderguard.</p> <p>Resident#11's clinical record did not contain evidence that Resident #11 had medical symptoms that warranted the use of the alarms and bed rails. Resident #11's clinical record did not include assessments by the interdisciplinary team, and documentation of the medical symptoms and use of the alarms and bed rails for the least amount of time possible and provide ongoing re-evaluation.</p> <p>4. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur (upper leg).</p> <p>A significant change MDS assessment, dated 2/19/18, documented Resident #16 had</p>	F 604			

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F 604	<p>Continued From page 21</p> <p>moderate cognitive impairment and did not use bed rails. The MDS documented Resident #16 did not use a bed alarm. The MDS documented Resident #16 required extensive assistance of one to two staff members for all cares.</p> <p>On 3/19/18 at 7:53 PM and on 3/20/18 at 9:47 AM, 11:05 AM, and 4:30 PM, Resident #16 was observed in bed with her bed flush against the wall under the window sill, and bilateral 1/2 bed rails.</p> <p>On 3/20/18 at 8:20 AM and 3/21/18 at 9:10 AM, Resident #16 was observed at the breakfast table with an alarm attached to the back of her wheelchair.</p> <p>An undated care plan, documented Resident #16 was at risk for falls with or without injury related to "confusion, gait/balance problems, incontinence, poor communication/comprehension, and psychoactive drug use, unaware of safety needs, [and] vision problems." Interventions were documented as: "Pressure alarm to bed and wheelchair to alert staff of unsafe self-transfers and safety needs. Staff to ensure placement, turned on and functionality of the devices."</p> <p>On 3/21/18 at 10:25 AM, the DNS and the ADON stated Resident #16 had multiple falls and was admitted with a fall history. The DNS stated Resident #16 spent time in the dining room so staff could keep her in their line of sight. The DNS stated Resident #16's room was close to the nurses' station for more frequent observation opportunities. The DNS could not locate a care plan for Resident #16's bed rails. The DNS stated</p>	F 604			

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F 604	<p>Continued From page 22</p> <p>she could not locate orders, consents, and assessments for the alarms, bed rails, or bed against the wall.</p> <p>Resident #16's clinical record did not include a physician's order with identified medical symptom being treated, and an order for the use of the specific type of restraint. The facility failed to include assessments, a care plan for the bed against the wall and bed rails, and documentation of the medical symptoms and use of the bed against the wall, bed rails, and bed and wheelchair alarms for the least amount of time possible and provide ongoing re-evaluation.</p> <p>5. Resident #75 was admitted to the facility on 3/5/18 with diagnoses which included hemiparesis (one-sided paralysis).</p> <p>An admission MDS assessment, dated 3/12/18, documented Resident #75 had a severe cognitive impairment and she did not use bed rails. The MDS documented Resident #75 required extensive assistance of one to two staff members for all cares.</p> <p>On 3/20/18 at 9:38 AM, Resident #75's bed was observed with bilateral 1/2 bed rails.</p> <p>On 3/21/18 at 7:31 AM, Resident #75 was observed in bed with bilateral 1/2 bed rails.</p> <p>On 3/21/18 at 1:30 PM, Resident #75's bed was observed with bilateral 1/2 bed rails.</p> <p>On 3/21/18 at 3:45 PM, the DNS stated she was not aware Resident #75 had bed rails and the consents, orders, care plan, assessments,</p>	F 604			

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F 604	Continued From page 23 evaluations, and other requirements would not be in the record if it was not already located. The DNS was unable to locate the missing items.	F 604			
F 606 SS=F	<p>The facility failed to include assessments, a care plan for the bed rails, and documentation of the medical symptoms and use of the bed rails for the least amount of time possible and provide ongoing re-evaluation.</p> <p>Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4)</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(3) Not employ or otherwise engage individuals who-</p> <p>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;</p> <p>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</p> <p>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, policy review, and staff interview, it was determined the</p>	F 606	CORRECTIVE ACTION FOR THOSE AFFECTED:	4/27/18	

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F 606	<p>Continued From page 24</p> <p>facility failed to ensure it followed its policy which required two reference checks be completed prior to a potential employee starting work in the facility. This was true for 2 of 5 new employees (Staff #A and Staff #B) whose personnel files were reviewed. The failure placed 17 of 17 (#1-#8, #9-#12, #14, #16, #19, #75, #121) sample residents residing in the facility and the other 3 residents residing in the facility, under Staff #A's and Staff #B's care, at increased risk of adverse events. Findings include:</p> <p>The facility's undated Abuse Prevention, Reporting, and Investigation Policy documented the following:</p> <p>"Employee and Resident Screening - Reference Checking- Verification of a minimum of 2 prior employment and eligibility for re-hiring; if there is no work history, 3 personal references will be required to be checked."</p> <p>On 3/23/18 at 11:31 AM, five new employee personnel files were reviewed for reference checks as follows:</p> <p>a. Staff #A was hired on 3/16/18. Staff #A's file did not contain reference checks at the time of the review.</p> <p>b. Staff #B was hired on 11/17/17. Staff #B's file contained 1 reference check at the time of the review.</p> <p>On 3/23/18 at 12:04 PM, the Human Resources Director stated it was difficult to obtain employer reference checks. The Human Resources Director stated she attempted to call the</p>	F 606	<p>Employee B no longer works at the facility Employee A has documented 2 reference checks in her employment file</p> <p><b>OTHERS POTENTIALLY AFFECTED:</b> Currently hired staff and future hired staff have the potential to be affected.</p> <p><b>MEASURES PUT IN PLACE/SYSTEMIC CHANGES:</b> H.R. Director was re-educated on 4/11/18 regarding requirement for a minimum of 2 prior employment references for staff, and eligibility for re-hire before staff can start work in the facility. If applicant has no prior work experience, prior employers will not release references due to policy, or prior employers do not answer requests for references, then 2 character references may be used. H.R. Director, on 4/11/18 completed an audit of current employee files to ensure 2 reference checks have been completed and documented. H.R Director will present to the Administrator all potential new hires 2 reference checks, before they can work at the facility.</p> <p><b>MONITOR PERFORMANCE/ONGOING COMPLIANCE:</b> Monthly H.R. director will audit all new hires in the last 30 days, for documentation of at least 2 employment references checks. Audit will be presented in the monthly QAPI meeting x 4 months.</p>		

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F 606	Continued From page 25 references when the employees first started working for the facility.  On 3/23/18 at 1:26 PM, the Administrator stated the facility was not following its policy by not obtaining reference checks. The Administrator referred the surveyor's questions to the Human Resources Director.	F 606			
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and review of clinical records, policies, and accident/incident reports, it was determined the facility failed to develop and operationalize policies and procedures for investigating instances of potential abuse or neglect. This created the potential for 3 of 3 sample residents (#11, #14, and #16) reviewed for abuse/neglect to experience ongoing abuse/neglect and had the potential to place the other 17 residents residing in the facility at risk of abuse, due to lack of prevention, detection, reporting, and investigation of potential abuse and neglect. Findings include:	F 607	<b>CORRECTIVE ACTIONS:</b> Resident #14- No longer resides in the facility Resident #16- No longer resides in the facility Resident #11- Full body check was completed by SDC on 4/12/18 to identify any new injuries that needed to be reported within 2 hours. None were noted. Resident and wife were interviewed on 4/12/18 by the LSW to identify any concerns regarding potential abuse, no concerns noted.	4/27/18	

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F 607	<p>Continued From page 26</p> <p>The facility's undated Abuse Prevention, Reporting, and Investigation Policy documented the following:</p> <ul style="list-style-type: none"> <li>* The policy did not define an injury of unknown source or injury of unknown origin or define corporal punishment.</li> <li>* The policy documented "Any suspicious event, such as bruising of residents ... should be reported to the Administrator...who will immediately begin the investigation."</li> <li>* Identification - The facility would determine "at risk residents" and initiate appropriate interventions with monitoring and report incidence to include "injuries of unknown origin."</li> <li>* "Investigation - Any suspicious event, such as bruising of residents...should be reported to the Administrator...who will immediately begin the investigation...In the case of injury of unknown source; dated interview will be obtained with staff having contact with the resident in the 24 hours previous to when the incident was reported."</li> </ul> <p>The Investigation section did not address how to investigate injuries of unknown sources.</p> <ul style="list-style-type: none"> <li>* "Reporting - Administrator will report all alleged violations and substantiated incidents to the state agency and other agencies as required...depending on the results of the investigation...the report of abuse or serious bodily injury should be reported no later than 2 hours after the allegation is made and no longer than 24 hours to the...completed investigations</li> </ul>	F 607	<p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents residing in the SNF have the potential to be affected. Full body skin checks were completed by 4/13/18 to ensure any new skin conditions are documented and investigated appropriately. LSW spoke with resident council on 4/12/18 to identify any injuries of unknown origin or concerns about abuse, no concerns noted. Residents that did not attend resident counsel were interviewed by the LSW on 4/12/18 to identify any concerns for potential abuse or injuries, no concerns noted.</p> <p><b>SYSTEMIC CHANGES:</b> Administrator updated Abuse policy 4/12/18, to include definition of corporal punishment and injuries of unknown origin. In addition the Administrator updated the Abuse policy to reflect how to investigate injuries of unknown origin, and that injuries of unknown origin will be investigated and reported as potential abuse. Updated policy was presented to QAPI meeting with Medical Director for Review on 4/17/18. Staff were re educated, 4/12/18, on the types of abuse including corporal punishment, how to investigate injuries of unknown origin, injuries of unknown origin will be investigated as potential abuse,</p>		

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F 607	<p>Continued From page 27 will be faxed within 5 days..."</p> <p>The Reporting section of the policy did not address injuries of unknown sources.</p> <p>* "Employee and Resident Screening - Reference Checking- Verification of a minimum of 2 prior employment and eligibility for re-hiring; if there is no work history, 3 personal references will be required to be checked."</p> <p>On 3/23/18 at 1:26 PM, the Administrator could not define what constituted injuries of unknown origin and what to report to the State Survey Agency based on the facility's policy and acquired supplemental information. The Administrator stated the facility had not investigated injuries of unknown sources as potential abuse/neglect or reported the incidents to the State Survey Agency.</p> <p>- Refer to F600 as it relates to the failure of the facility to follow its policy to ensure injuries of unknown source were investigated as potential allegation of abuse or neglect.</p> <p>- Refer to F606 as it relates to the failure of the facility to follow its policy to ensure reference checks were completed upon hiring.</p> <p>- Refer to F609 as it relates to the facility's failure to ensure allegations of abuse and neglect were reported to the State Survey Agency within 2 hours, or within 24 hours.</p> <p>- Refer to F610 as it relates to the facility's failure to follow its policy to ensure allegations of potential abuse were thoroughly investigated.</p>	F 607	<p>and the updated changes to the Abuse policy. Staff and Administration were re educated 4/11/18 and reviewed requirements for timely reporting. IDT will review incident reports in morning stand up meeting. Any incidents that are of unknown origin will be investigated and reported as potential abuse.</p> <p><b>ONGOING COMPLIANCE:</b> Reportable incidents in the last 30 days will be reviewed at the monthly QAPI meeting, with IDT and Medical Director, for thoroughness and compliance with timely reporting. DNS and Administrator are responsible for ongoing monitoring and compliance.</p>		

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F 609 SS=D	<p>Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, interview of transport company staff, and review of clinical records, policies, and accident/incident reports, it was determined the facility failed to report allegations of potential abuse or neglect to the Administrator and State Survey Agency within 2 to 24 hours.</p>	F 609	<p>CORRECTIVE ACTIONS: Resident #14- No longer resides in the facility. Resident #16- No longer resides in the facility. Resident #11- Full body check was</p>	4/27/18	

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F 609	<p>Continued From page 29</p> <p>The lack of reporting placed 3 of 3 residents (#11, #14, and #16) reviewed for abuse/neglect and the other 17 residents residing in the facility, at risk of undetected abuse or neglect. Findings include:</p> <p>The facility's undated Abuse Prevention, Reporting, and Investigation Policy documented the following:</p> <p>* The policy documented "Any suspicious event, such as bruising of residents ... should be reported to the Administrator...who will immediately begin the investigation."</p> <p>* "Reporting - Administrator will report all alleged violations and substantiated incidents to the state agency and other agencies as required...depending in the results of the investigation...the report of abuse or serious bodily injury should be reported no later than 2 hours after the allegation is made and no longer than 24 hours to the...completed investigations will be faxed within 5 days..."</p> <p>The Reporting section of the policy did not address injuries of unknown source.</p> <p>The policy did not define an injury of unknown source or injury of unknown origin.</p> <p>1. Resident #11 was admitted to the facility on 6/4/17 with diagnoses which included speech and language deficit, multiple rib fractures, dementia, and aphasia.</p> <p>Resident #11 had two incidences that were not reported to the State Survey Agency and the</p>	F 609	<p>completed by SDC on 4/12/18 to identify any new injuries that needed to be reported within 2 hours. None were noted</p> <p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents residing in the SNF have the potential to be affected. Full body skin checks were completed by 4/13/18 to ensure any new skin conditions are documented and investigated appropriately. LSW spoke with resident council on 4/12/18 to identify any injuries of unknown origin or concerns about abuse. Residents that did not attend resident counsel were interviewed by the LSW on 4/12/18 to identify any concerns for injuries of unknown origins. Accident Incidents in the last 30 days were reviewed by the DNS on 4/12/18, for any injuries of unknown origin, and there were none.</p> <p><b>SYSTEMIC CHANGES:</b> Facility Incident report was revised to include clear documentation of an injury of unknown origin, and requiring staff to notify Administration. Staff educated on 4/12/18 to report all injuries, or change in skin condition, to Administration when they are identified, to rule out any possible injuries of unknown origin an ensure prompt investigation and reporting. Staff were educated on 4/12/18 regarding the revision to the Incident form that includes the documentation of "unknown origin" and requirement to report to Administration immediately.</p>		

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F 609	<p>Continued From page 30 Administrator as follows:</p> <p>* A Health Status Progress Note, dated 9/25/17 at 2:00 PM, documented Resident #11 experienced an unwitnessed fall from his bed and a large purple bruise with a large red abrasion was discovered on his left side. A stat x-ray was ordered and fractured ribs were diagnosed.</p> <p>* An I&amp;A Report, dated 12/4/17 at 9:04 AM, documented Resident #11 sustained a bruise/injury of unknown source to his right upper extremity.</p> <p>On 3/23/18 at 9:32 AM, the Administrator stated she was not aware Resident #11 fractured his ribs. She stated she was told there was a possible fracture, and if she had known if there was an "actual" fracture she would have investigated the fracture and reported it. The Administrator stated no reportable incidences had been created for the facility. The Administrator stated injuries of unknown sources such as bruising should have been reported to the State Survey Agency.</p> <p>2. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur (upper leg).</p> <p>Resident #16 had one incident that was not reported to the State Survey Agency as follows:</p> <p>* An I &amp; A Report, dated 2/20/18 at 5:40 PM, documented Resident #16 experienced an unwitnessed fall from bed, where she sustained a hematoma (bruise) to the side of her head and a</p>	F 609	<p>4/12/18 Staff and Administration were re educated and reviewed requirements for timely reporting. IDT will review incident reports in morning stand up meeting. Any incidents that are of unknown origin will be reported within 2-24 hours to facility standards.</p> <p>ONGOING COMPLIANCE: Incidents of unknown origin, will be reviewed and discussed in monthly QAPI meeting with the Medical Director, times 4 months if there are no concerns noted, for compliance with timely reporting. DNS and Administrator are responsible for ongoing monitoring and compliance.</p>		

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F 609	<p>Continued From page 31</p> <p>skin tear to her left ear. The I&amp;A documented a picture of Resident #16 between the bed and the window. The I&amp;A documented Resident #16 was educated on her bed alarm placement.</p> <p>An Emergency Doctor Provider Notes, dated 2/20/18 at 7:11 PM, documented Resident #16 suffered an unwitnessed fall and it was "assumed" Resident #16 hit her head on either the "window sill or her bed." The note documented the facility was unsure if Resident #16 lost consciousness or not. The note documented Resident #16 had a laceration to her left ear and a hematoma to the left-side of her head.</p> <p>A Nurse's progress note, dated 2/20/18, documented Resident #16 returned from the emergency room and the "laceration appeared to extend from the edge of her ear flap to the inner aspect of the canal cartilage. Approximately 6 sutures seen."</p> <p>On 3/23/18 at 9:32 AM, the Administrator stated the facility's Incident &amp; Accident Reports were incomplete. The Administrator stated injuries of unknown sources were considered potential abuse, and the facility should have reported the incident to the State Survey Agency.</p> <p>On 3/23/18 at 10:23 AM, the Administrator stated she knew about the laceration to Resident #16's head. The Administrator stated Resident #16's room was located close to the nurses' station and staff could see into her room from the station. The Administrator stated the facility did not investigate or report the injury because of this.</p>	F 609			

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F 609	<p>Continued From page 32</p> <p>3. Resident #14 was admitted to the facility on 2/16/18 with multiple diagnoses, including cellulitis (infection of tissue) and osteomyelitis (infection of bone) to left foot and ankle.</p> <p>The admission MDS assessment, dated 2/23/18, documented Resident #14 was cognitively intact.</p> <p>A Nurse's progress note, dated 3/16/18 at 9:44 AM, documented Resident #14 had a wound clinic appointment.</p> <p>An Order Appointment Listing Report, dated 3/23/18, documented Resident #14's wound clinic appointment was 3/16/18 at 10:30 AM and an outside transport agency picked up Resident #14 at 9:45 AM and returned her at 11:45 AM.</p> <p>On 3/23/18 at 12:50 PM, the DOO from the transport agency stated the driver did notify the transport agency and the facility regarding the skin tear to Resident #14's left shin on 3/16/18 at approximately 10:15 AM.</p> <p>On 3/23/18 at 1:25 PM, LPN #2 stated Resident #14 had a wound clinic appointment on 3/16/18 and an outside transport agency picked up Resident #14 around 10:00 AM. LPN #2 stated the driver came back into the facility a few minutes later and asked for some bandages. LPN #2 stated she provided bandages for the transport driver, but did not inquire about the need for the bandages. LPN #2 stated Resident #14 returned from the wound clinic and the wound clinic faxed new orders. LPN #2 said she did not recall seeing the new wound care orders to the shin. LPN #2 stated she was unaware of the skin tear to Resident #14.</p>	F 609			

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F 609	<p>Continued From page 33</p> <p>On 3/23/18 at 2:15 PM, the outside transport agency driver stated while applying the anchors to Resident #14's wheelchair in the van, the driver noticed fresh blood and a skin tear to Resident #14's left shin. The driver stated he went back into the facility spoke to a staff member, did not remember her name or her title, requested bandages for a skin tear to Resident #14, and the staff member brought bandages with her to the van and watched the driver apply a bandage to the left shin of Resident #14. The driver stated he did not know when the skin tear occurred to Resident #14. The driver thought by telling the staff member and having the facility staff member observe him applying the bandage to Resident #14's left shin, was considered sufficient reporting of the incident to the facility.</p> <p>A Wound Clinic progress note, dated 3/16/18, documented Resident #14 had a new shin wound with orders to change the dressing daily.</p> <p>Resident #14's Physician Order Summary Report, dated 3/23/18, did not document the new wound care orders for the shin.</p> <p>The Nurse's progress note did not document when Resident #14 returned from the wound clinic appointment, the new shin wound orders, or when Resident #14 received the skin tear to the shin.</p> <p>On 3/23/18 at 9:32 AM, the Administrator stated reportable incidences were physical abuse, verbal abuse, accidental death, injuries of unknown source, such as laceration, bruises, sprains, and/or fractures.</p>	F 609			

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F 609	Continued From page 34	F 609			
F 610 SS=F	<p>On 3/23/18 at 11:30 AM, the DNS and ADON were unaware of the new wound clinic orders on 3/16/18 for Resident #14's shin daily dressing changes. The DNS and ADON were unaware Resident #14 received an unknown skin tear on 3/16/18.</p> <p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, interview with transport agency staff, and review of clinical records, and accident/incident reports, it was determined the facility failed to investigate injuries of unknown source as allegations of potential abuse or neglect. This was true for 3 of 3 sampled residents (#11, #14, and #16) reviewed for abuse/neglect and had the potential to adversely</p>	F 610	<p>CORRECTIVE ACTIONS: Resident #14- no longer resides in the facility. Resident #16- No longer resides in the facility. Resident #11- Has had no new incidents to review for the last 30 days.</p>	4/27/18	

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F 610	<p>Continued From page 35</p> <p>affect the other 17 residents residing in the facility. The deficient practice created the potential for residents' #11, #14, and #16, to experience ongoing abuse/neglect and the other 17 residents in the facility to be subjected to abuse/neglect without detection. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 6/4/17 with diagnoses which included speech and language deficit, multiple rib fractures, dementia, and aphasia.</p> <p>An annual MDS assessment, dated 2/12/18, documented Resident #11 had moderate cognitive impairment.</p> <p>An undated care plan, documented Resident #11 had dementia and an impaired cognitive function.</p> <p>Resident #11 had two incidences which were not investigated as follows:</p> <p>* A Health Status Progress Note, dated 9/25/17 at 2:00 PM, documented Resident #11 had a recent fall and a large purple bruise with a large red abrasion was discovered on his left side. A stat x-ray was ordered and fractured ribs were diagnosed. The clinical record failed to document a thorough investigation, to include: the assessment of the torso, staff and resident interviews and failed to show implementation of preventative measure to protect the resident from further injury.</p> <p>* An I&amp;A Report, dated 12/4/17 at 9:04 AM, documented Resident #11 sustained a bruise / injury of unknown source to his right upper</p>	F 610	<p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents residing in the SNF have the potential to be affected. Full body skin checks were completed by 4/13/18 to ensure any new skin conditions are documented and investigated appropriately. Incident reports were completed by SDC on 4/13/18, for any injuries that did not already have a completed incident report.</p> <p><b>SYSTEMIC CHANGES:</b> On 4/11/18, staff were re educated on thoroughly completing incident reports on all skin changes or injuries. IDT will review incident reports in morning stand up meeting to ensure they are thorough and completed timely. IDT note will be completed in the medical record of the investigation and follow up to new incident and accidents with in 5 days of the incident, by a member of the IDT.</p> <p><b>ONGOING COMPLIANCE:</b> Administrator or designee will review all completed incident reports within 5 days, and ensure medical record reflects the thorough investigation of the incident. Incident tracking sheets will be reviewed in monthly QAPI with IDT and Medical Director, for completeness. DNS and Administrator are responsible for ongoing monitoring and compliance.</p>		

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F 610	<p>Continued From page 36</p> <p>extremity. The I&amp;A report and the clinical record failed to document a thorough investigation, to include: the assessment of the arm, staff and resident interviews and failed to implement preventative measure to protect the resident from further injury.</p> <p>Resident #11's clinical record did not contain progress notes, physician notes, or IDT follow-up documenting the size of the bruise, causality of the bruise, or/and investigation into the source of the bruise.</p> <p>On 3/23/18 at 9:32 AM, the Administrator stated she was not aware Resident #11 had a fractured rib. She was aware he fell multiple times. The Administrator stated the I&amp;A Reports were incomplete. The DNS, also present, stated a complete investigation included obtaining witness statements from all staff who worked in the last 24 hours. The Administrator stated all injuries of unknown sources were investigated for the causality. The Administrator stated the facility would investigate injuries of unknown source as potential abuse. The Administrator stated the size of the injury of unknown source should be identified in the resident's record.</p> <p>Resident #11's clinical record did not contain progress notes identifying the discovery of the bruise and/or fracture, their progression, or a clear investigation of their cause. The investigations did not include a conclusion as to the source of the bruising/fracture, witness statements, staff interviews, or resident interviews to determine the origin of the bruise/fracture, or a complete investigation to rule out potential abuse or neglect.</p>	F 610			

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F 610	<p>Continued From page 37</p> <p>2. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur.</p> <p>Resident #16 had one incident not investigated as follows:</p> <p>* An I&amp;A Report, dated 2/20/18 at 5:40 PM, documented Resident #16 experienced an unwitnessed fall from bed, where she sustained a hematoma to the side of her head and a skin tear to her left ear. The I&amp;A documented a picture of Resident #16 between the bed and the window. The I&amp;A documented Resident #16 was educated on her bed alarm placement. A follow up note for the 2/20/18 fall was not completed on the I&amp;A.</p> <p>An Emergency Doctor Provider Notes, dated 2/20/18 at 7:11 PM, documented Resident #16 suffered an unwitnessed fall and it was "assumed" Resident #16 hit her head on either the "window sill or her bed." The note documented the facility was unsure if Resident #16 lost consciousness or not. The note documented Resident #16 had a laceration to her left ear and a hematoma to the left side of her head.</p> <p>A 2/20/18 Nurse's Note documented Resident #16 returned from the emergency room "prior to surgical repair of her ear." The "laceration appeared to extend from the edge of her ear flap to the inner aspect of the canal cartilage. Approximately 6 sutures seen."</p> <p>On 3/23/18 at 10:23 AM, the Administrator stated</p>	F 610			

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F 610	<p>Continued From page 38</p> <p>she knew about the laceration to Resident #16's head. The Administrator stated Resident #16's room was located close to the nurses' station and staff could see into her room from the station. The Administrator stated the facility did not investigate or report the injury because of this.</p> <p>3. Resident #14 was admitted to the facility on 2/16/18 with multiple diagnoses, including cellulitis and osteomyelitis to left foot and ankle.</p> <p>The admission MDS assessment, dated 2/23/18, documented Resident #14 was cognitively intact.</p> <p>A Nurse's progress note, dated 3/16/18 at 9:44 AM, documented Resident #14 had a wound clinic appointment.</p> <p>An Order Appointment Listing Report, dated 3/23/18, documented Resident #14's wound clinic appointment was on 3/16/18. An outside transport agency picked up Resident #14 at 9:45 AM and returned her at 11:45 AM.</p> <p>On 3/23/18 at 12:50 PM, the DOO from the transport agency stated the driver did notify the transport agency and the facility regarding the skin tear to Resident #14's left shin on 3/16/18 at approximately 10:15 AM. The DOO stated the facility did not follow up to investigate the 3/16/18 incident further.</p> <p>On 3/23/18 at 1:25 PM, LPN #2 stated Resident #14 had a wound clinic appointment on 3/16/18 and an outside transport agency picked up Resident #14 around 10:00 AM. LPN #2 stated the driver came back into the facility a few minutes later and asked for some bandages.</p>	F 610			

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F 610	<p>Continued From page 39</p> <p>LPN #2 stated she provided bandages for the transport driver, but did not inquire about the need for the bandages. LPN #2 stated Resident #14 returned from the wound clinic and the wound clinic faxed new orders. LPN #2 stated she did not recall seeing the new wound care orders related to the shin wound.</p> <p>On 3/23/18 at 2:15 PM, the outside transport agency driver stated while applying the anchors to Resident #14's wheelchair in the van, the driver noticed fresh blood and a skin tear to Resident #14's left shin. The driver stated he went back into the facility spoke to a staff member, did not remember her name or her title, requested bandages for a skin tear to Resident #14, and the staff member brought bandages with her to the van and watched the driver apply a bandage to the left shin of Resident #14. The driver stated he did not know when the skin tear occurred to Resident #14. The driver said thought telling the staff member and the facility staff member observing him apply the bandage to Resident #14's left shin, was considered reporting the incident to the facility.</p> <p>A Wound Clinic progress note, dated 3/16/18, documented Resident #14 had a new wound to her shin and to change the dressing daily.</p> <p>Resident #14's Physician Order Summary Report, dated 3/23/18, did not include the new wound care orders for the shin wound.</p> <p>The Nurse's progress note did not document when Resident #14 returned from the wound clinic appointment, the new shin wound orders, or when Resident #14 received the skin tear to</p>	F 610			

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F 610	Continued From page 40 the shin.  On 3/23/18 at 9:32 AM, the Administrator stated education needed to be completed with the staff in the facility on what to report and when to begin an investigation. The Administrator stated the DNS was the point person in charge of completing investigations. The Administrator stated she reviewed investigations after they were completed. The Administrator did not know the reason the injuries were not reported to her or investigated. The Administrator stated reportable incidences which required investigations were from physical abuse, verbal abuse, accidental death, and injuries of unknown source, such as lacerations, bruises, sprains, and/or fractures.  On 3/23/18 at 11:30 AM, the DNS and ADON stated they were unaware of the 3/16/18 wound clinic orders for Resident #14's shin wound and the need for daily dressing changes. The DNS and ADON were unaware Resident #14 received an unknown skin tear to her shin on 3/16/18.	F 610			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		4/27/18	

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F 656	<p>Continued From page 41</p> <p>(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</p> <p>(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).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 4 of 20 sample residents (#6, #16, #19 and #75) whose care plans were reviewed. The residents' care plans did not</p>	F 656	<p>CORRECTIVE ACTION FOR THOSE AFFECTED:</p> <p>Resident #75- No longer resides in the facility</p> <p>Resident #6- 4/13/18 SDC reviewed and updated residents care plan to reflect Residents current needs.</p>		

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F 656	<p>Continued From page 42</p> <p>address the use of bed rails, alarms, beds against the walls, and hydration needs. This failure created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>1. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur (upper leg).</p> <p>A significant change MDS assessment, dated 2/19/18, documented Resident #16 had a moderate cognitive impairment and did not use bed rails.</p> <p>On 3/19/18 at 7:53 PM, Resident #16 was observed in bed with her bed flush against the wall under the window sill and bilateral 1/2 bed rails.</p> <p>On 3/20/18 at 9:47 AM, Resident #16 was observed in bed with her bed flush against the wall under the window sill and bilateral 1/2 bed rails.</p> <p>Resident #16's clinical record did not contain a care plan for her bed against the wall and the bilateral 1/2 bed rails.</p> <p>On 3/21/18 at 10:25 AM, the DNS could not locate a care plan for Resident #16's bed against the wall or her bilateral 1/2 bed rails.</p> <p>2. Resident #75 was admitted to the facility on 3/5/18 with diagnoses which included hemiparesis (one-sided paralysis).</p> <p>An admission MDS assessment, dated 3/12/18,</p>	F 656	<p>Resident #16-No longer resides in the facility.</p> <p>Resident #19-4/13/18 SDC reviewed resident and updated the care plan to reflect Residents current needs.</p> <p><b>OTHERS POTENTIALLY AFFECTED-</b> Residents residing in the facility and have side rails or their beds against the wall have the potential to be affected. Residents with side rails, alarms, or bed against the wall had care plan updated to reflect current status.</p> <p><b>SYSTEMIC CHANGES:</b> Staff were in serviced on 4/12/18 that side rails, beds against the wall, and alarms require a MD order. DNS or designee will complete audits of each resident room twice a week, for 4 weeks, then weekly x 4 weeks then monthly thereafter to ensure beds against the wall, side rails, and alarms are accurately care planned. MDS or designee will review and audit MD orders written in the last 24hours and ensure that alarms, beds against the wall, and side rails have been care planned correctly. Audit will be completed 2x a week a 4 weeks, then weekly a 4 weeks, then monthly times 3 months.</p> <p><b>ONGOING COMPLIANCE:</b> Results of the audits completed by the DNS will be reviewed during the Monthly QA IDT meeting. MDS audit will report audit results to the Monthly QA meeting for review times 3</p>		

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F 656	<p>Continued From page 43</p> <p>documented Resident #75 had a severe cognitive impairment and she did not use bed rails.</p> <p>a. On 3/20/18 at 9:38 AM, Resident #75's bed was observed with bilateral 1/2 bed rails.</p> <p>On 3/21/18 at 7:31 AM, Resident #75 was observed in bed with bilateral 1/2 bed rails.</p> <p>On 3/21/18 at 3:45 PM, the DNS stated she was not aware Resident #75 had bed rails. The DNS was unable to locate a care plan for Resident #75's bilateral 1/2 bed rails.</p> <p>b. Resident #75's Care Area Assessment, dated 3/18/18, documented she was at risk of dehydration due to her need for feeding tube.</p> <p>A 3/6/18 Physician's order documented Resident #75 received 25 mg of Microzide (diuretic) daily for hypertension.</p> <p>Resident #75's clinical record did not contain a dehydration risk care plan for Resident #75.</p> <p>On 3/21/18 at 4:08 PM, the DNS stated she would expect a risk for dehydration care plan for a resident on a diuretic medication and tube feeding. The DNS stated nursing would implement the care plan and utilize recommendations from dietary for any special hydration needs.</p> <p>3. Resident #19 was admitted to facility on 1/29/18 with multiple diagnoses including cognitive communication deficit.</p>	F 656	<p>months if no concerns are noted. MDS and DNS are responsible for ongoing compliance.</p>		

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F 656	<p>Continued From page 44</p> <p>An admission MDS assessment, dated 2/5/18, documented Resident #19 was moderately cognitively impaired and required extensive assistance of 1 to 2 staff members for cares. The MDS assessment did not document Resident #19 utilized bed rails or alarms.</p> <p>On 3/19/18 at 6:30 PM, Resident #19 was observed resting in bed with a bed rail up on the left-side and the bed was positioned on the right-side of the wall. Resident #19 had an alarm on the bed.</p> <p>On 3/20/18 at 9:56 AM, Resident #19 was observed in his room sitting in his wheelchair, with an alarm on the back of his chair.</p> <p>On 3/20/18 at 9:58 AM, the DNS stated she was unaware Resident #19's bed was against the wall. The DNS stated there were no care plans for alarms, bed rails or bed against the wall for Resident #19.</p> <p>4. Resident #6 was admitted to the facility on 1/24/18 with multiple diagnoses, including mild cognitive impairment and chronic pain.</p> <p>The admission MDS assessment, dated 2/2/18, documented Resident #6 was cognitively intact, required extensive assistance for transfers with two people, and was at risk for falls.</p> <p>On 3/19/18 at 7:45 PM, Resident #6 stated his bed had been against the wall for awhile and he did not consent to having the bed against the wall nor was he assessed for the need to have his bed against the wall.</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 45 The March 2018 Physician Order Summary Report did not include orders for Resident #6's bed against the wall.  Resident #6's care plan, target date 4/24/18, did not document the bed against the wall.  On 3/19/18 at 7:45 PM, Resident #6 stated his bed had been against the wall for awhile and he did not consent to having the bed against the wall nor was he assessed for the need to have his bed against the wall.  On 3/22/18 at 1:15 PM, the DNS was unable to provide a care plan for Resident #6's bed to be against the wall.	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- (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	F 657		4/27/18	

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F 657	<p>Continued From page 46</p> <p>resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 1 of 20 residents (#57) reviewed for care plan revisions and created the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include:</p> <p>Resident #75 was admitted to the facility on 3/5/18 with diagnoses which included hemiparesis (one-sided paralysis).</p> <p>An admission MDS assessment, dated 3/12/18, documented Resident #75 had severe cognitive impairment and she had a catheter.</p> <p>A 3/5/18 Physician's order documented Resident #75 had a catheter and it was discontinued on 3/16/18.</p> <p>An undated care plan, documented Resident #75 had an indwelling catheter.</p> <p>On 3/20/18 at 11:17 AM, Resident #75 was observed without a catheter.</p>	F 657	<p><b>CORRECTIVE ACTION:</b> Resident #75 no longer resides in the facility</p> <p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents residing in the facility and have a catheter have the potential to be affected. On 4/16/18 the DNS reviewed the care plans of residents currently with a foley catheter or had one in the last 30 days, to ensure that the care plan was current.</p> <p><b>SYSTEMIC CHANGES:</b> Nursing staff were re educated on 4/11/18 and 4/12/18 on updating the care plan promptly when they get a new MD order. Starting 4/20/18, MDS will randomly audit MD orders written in last 24 hours, daily for 2weeks, weekly a 4 weeks and monthly X 3 months, to ensure that they have been care planned correctly. Care plans will be reviewed, and revised by the MDS nurse per Medicare MDSS schedule Quarterly, change of condition, and annually.</p>		

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F 657	Continued From page 47 On 3/20/18 at 1:13 PM, Resident #75 was observed without a catheter.  On 3/21/18 at 7:31 AM, Resident #75 was observed in bed without a catheter.  On 3/21/18 at 10:00 AM, LPN #4 stated Resident #75 did not have a catheter and it was recently discontinued. LPN #4 stated she would notify the DNS to update the care plan.  On 3/21/18 at 10:01 AM, CNA #2 stated Resident #75 did not have a catheter.  On 3/21/18 at 3:34 PM, the DNS stated care plans were changed when there were changes with the residents and when the facility completed residents' comprehensive assessments. The DNS stated she reviewed the care plans for accuracy or the ADON and/or the MDS nurse would review them. She did not know the reason Resident #75's care plan was not updated.	F 657	ON GOING COMPLIANCE: Results of the MDS audits of MD orders will be reviewed in Monthly QA meeting. Results of the MDS audits of care plans done quarterly, change of condition, or annually will be reviewed in Monthly QAPI meeting. MDS nurse and DNS responsible for ongoing compliance.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	F 684	CORRECTIVE ACTION FOR THOSE	4/27/18	

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F 684	<p>Continued From page 48</p> <p>review, it was determined the facility failed to ensure professional standards of practice were followed for 9 of 20 sampled residents (#1, #6, #11, #14, #16, #19, #21, #75 and #121) reviewed for standards of practice. Resident #1, #11, #16, and #19's neurological assessments were not completed or were incomplete after unwitnessed falls. Resident #16's bowel protocol was not followed. Resident #1's blood pressure was not monitored weekly, as ordered. Resident #14 and #21's progress notes were incomplete. Resident #6's Pneumococcal vaccine was not administered after a consent was signed for it to be given. Resident #75's clinical record documented catheter care was being provided after her catheter was discontinued. Resident #121's tuberculosis PPD was not administered upon admission, 3/1/18. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>The facility's Neurological Assessments-Post Accidents, dated 2/2/18, documented residents' neurological status should be assessed following an unwitnessed fall or accident with injury to the head. The policy documented neurological assessments were to be completed every 15 minutes for 1 hour, every 1 hour for 3 hours, every 4 hours for 20 hours and every 8 hours for 2 days.</p> <p>1. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur (upper leg).</p> <p>A significant change MDS assessment, dated</p>	F 684	<p>AFFECTED:</p> <p>Resident #1-Neuro checks are no longer needed for falls on 9/26/18 and 11/2/17. Starting 3/12/18 resident will have BP checks documented.</p> <p>Resident #6-Received his Pneumococcal vaccine (pcv-13)on 4/15/18.</p> <p>Resident #11-Residents fall from 9/25/17, 10/3/17, 12/30/17, and 1/27/18 neuro checks remain incomplete and are no longer necessary. Resident has no further falls requiring neuro checks. Neuro checks will be completed and documented when warranted.</p> <p>Resident #14-Resident no longer resides in the facility.</p> <p>Resident #16- No longer resides in the facility.</p> <p>Resident #19-As of 4/13/18, Resident has had no further incidents that require neuro checks to be done. Neuro checks will be completed and documented when warranted.</p> <p>Resident #21-Resident no longer resides in the facility.</p> <p>Resident #75-Resident no longer resides in the facility.</p> <p>Resident #121-Resident on 4/13/18 and 4/16/18 received his PPD shot, which was documented and results read and documented.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>Residents residing in the Facility that are newly admitted, require weekly BP, or</p>		

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F 684	<p>Continued From page 49</p> <p>2/19/18, documented Resident #16 had a moderate cognitive impairment and documented she did not experience constipation. The MDS documented Resident #16 required extensive assistance of one to two staff members for all cares.</p> <p>a. Resident #16's clinical record documented the resident experienced 2 unwitnessed falls between 1/30/18 and 2/22/18.</p> <p>Resident #16's I&amp;A Reports documented the following:</p> <p>* 1/30/18 - 4:30 PM: Resident #16 experienced an unwitnessed fall from bed. Resident #16's neurological assessment was incomplete for the 1/30/18 fall. The assessment was missing 13 of 18 entries and 4 of 18 entries were incomplete without respiration and pupil assessments. There was no reason given for the missing or incomplete entries.</p> <p>* 2/20/18 - 5:40 PM: Resident #16 experienced an unwitnessed fall from bed. A neurological assessment for Resident #16's 2/20/18 fall was not completed.</p> <p>An Imaging Result Report, dated 2/20/18 at 8:14 PM, documented Resident #16 received a CT of the head following the fall and she had soft tissue swelling and small amount of subcutaneous hematoma on the back of her head near her left ear.</p> <p>On 3/21/18 at 10:25 AM, the DNS and the ADON stated Resident #16's neurological assessment was not completed due to the CT scan results.</p>	F 684	<p>require neuro checks to be done have the potential to be affected.</p> <p>On 4/16/18 the records of Residents admitted in the last 7 days was audited for the administration and documentation of the administration for the PPD and Pneumococcal Vaccine upon admission, all had been received and documented</p> <p>On 4/16/18- the records of Residents requiring neuro checks in the last 72 hours were audited to ensure neuro checks were completed and documented, no concerns noted.</p> <p>On 4/16/18 residents that have an order for Weekly BP were audited by the DNS or Designee, to ensure the order was entered into PCC correctly and that the BP's were obtained and documented.</p> <p><b>SYSTEMIC CHANGES:</b> Staff were re educated, 4/12/18, on completing documentation, bowel protocol, and on how to properly enter MD orders such as BP weekly, into the computer correctly so that staff are aware to do the BP.</p> <p>On 4/12/18 staff re educated on the documentation of Vaccines and the need to identify which pneumococcal vaccine is being given.</p> <p>On 4/12/18 staff were re in serviced on the need to visualize residents and their devices before documenting in the medical record. Employment for the nurse responsible for documenting in error, was terminated.</p> <p>On 4/12/18 staff were re inserviced on completing neuro checks and</p>		

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F 684	<p>Continued From page 50</p> <p>The DNS stated the facility would place the resident on alert charting and not complete neurological assessments if the resident's CT results showed no abnormalities. The DNS stated the other assessments should have been completed fully.</p> <p>b. The facility failed to implement consistent bowel care for Resident #16 as evidenced by the following documentation and interventions:</p> <p>An undated care plan, documented Resident #16 had an altered elimination and bladder function related to activity intolerance, confusion, dementia, and impaired mobility. The care plan documented staff were to administer bowel medications as ordered.</p> <p>The facility's Bowel Management Procedure, dated 2012, from Briggs Healthcare, documented if a resident did not have a bowel movement in the last three days, staff were to initiate the bowel protocol. The bowel protocol was the following:</p> <ul style="list-style-type: none"> <li>* if no bowel movement in three days, provide Milk of Magnesia 30 cc</li> <li>* If no results on day four, provide a 10 mg Bisacodyl suppository</li> <li>* If no results on day five, provide a Fleet enema</li> <li>* If no bowel movement within six days, contact the provider for further instructions.</li> </ul> <p>Resident #16's Bowel Movement Record, dated 2/20/18 through 3/21/18, documented Resident #16's bowel movements. Resident #16's bowel record documented she did not have a bowel movement between 2/25/18 and 3/1/18 (5 days), 3/4/18 and 3/9/18 (6 days), and 3/13/18 and</p>	F 684	<p>documenting them, even if resident is asleep.</p> <p>Starting 4/16/18, New admission records will be audited by the DNS or Designee for the documentation of, and the administration of the PPD and the Pneumococcal Vaccine.</p> <p>DNS or designee starting 4/16/18 will audit resident records of those residents that required neuro checks to be initiated, in the last 24 hours x 2 weeks, then weekly x 4 weeks and then monthly thereafter times 3 months.</p> <p>DNS or designee will audit those same records for the complete 72 hours to ensure neuro's are being completed and documented 3xweek x 2 weeks, then weekly x 4 weeks, then monthly thereafter for 3 months.</p> <p>On 4/19/18 DNS or designee will audit the bowel documentation record daily x 2 weeks, then weekly x 4 weeks, then monthly thereafter for 3 months, for complete documentation of bowel movements and following the bowel protocol.</p> <p>Starting 4/19/18 DNS or designee will review discharge charts and audit for complete documentation and discharge status daily x 2 weeks, then weekly x 4 weeks, then monthly thereafter for 3 months.</p> <p><b>ON GOING COMPLIANCE:</b> New admission audit results will be reported to monthly QAPI for review and suggestions, times 3 months as long as there are no concerns.</p>		

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F 684	<p>Continued From page 51 3/20/18 (8 days).</p> <p>The facility tracked all residents without a bowel movement in three days on a document called the Maple Village Bowel List which documented:                      * 2/20/18 Resident #16 went seven days without a bowel movement and an enema was administered.                      * 2/28/18 Resident #16 had a bowel movement after day three and no documentation of the bowel movement in the computer.                      * 3/7/18 Resident #16 went four days without a bowel movement and Milk of Magnesia and a suppository were administered.                      * 3/17/18 Resident #16 went six days without a bowel movement and no interventions documented.                      * 3/18/18 Resident #16 went seven days without a bowel movement and Milk of Magnesia was administered.                      * 3/19/18 Resident #16 went eight days without a bowel movement and Milk of Magnesia was administered.                      * 3/21/18 Resident #16 went nine days without a bowel movement and suppository was administered.</p> <p>Resident #16's clinical record did not contain a note documenting the provider was notified when she went six, seven, or eight days without a bowel movement or that hospice was notified between 3/17/18 through 3/19/18.</p> <p>A 3/21/18 Health Status Progress Note documented, Resident #16 had not had a bowel movement for ten days, a suppository was administered and hospice was notified.</p>	F 684	<p>Neuro check audit results will be reported to monthly QAPI meeting for review and suggestion, monthly x 3 months if no on going concerns.                      Discharge chart documentation audits will be reported to the monthly QAPI meeting for review monthly times 3 months as long as there are no concerns.                      Audits of bowel care documentation and following bowel protocol will be reported to the QAPI meeting monthly x 3 months as long as there are no concerns.                      DNS responsible for ongoing compliance.</p>		

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F 684	<p>Continued From page 52</p> <p>Resident #16's MAR from 2/20/18 through 3/21/18 documented bowel medications were administered. Resident #16 was missing the following bowel medication administrations as follows:</p> <ul style="list-style-type: none"> <li>* On 3/7/18 the MAR did not document Resident #16 was administered Milk of Magnesia or a suppository.</li> <li>* On 3/18/18 the MAR did not document Resident #16 was administered Milk of Magnesia.</li> <li>* On 3/19/18 the MAR did not document Resident #16 was administered Milk of Magnesia.</li> </ul> <p>Resident #16's Bowel Movement Record, Maple Village Bowel List, Progress Notes, and MAR contained inconsistent data and conflicting interventions.</p> <p>On 3/21/18 at 12:45 PM, the DNS and the ADON stated the bowel protocol should be implemented after a resident had no bowel movement in three days. The DNS stated the staff should follow the bowel protocol of Milk of Magnesia, then a suppository, and lastly an enema. The DNS stated Resident #16 did not eat much and that was not an excuse for why her staff did not initiate the bowel protocol after day three.</p> <p>2. Resident #1 was admitted to the facility on 3/14/16 with diagnoses which included age related osteoporosis, Parkinson's, and hypertension (high blood pressure).</p> <p>A quarterly MDS assessment, dated 12/14/17, documented Resident #1 was cognitively intact</p>	F 684			

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F 684	<p>Continued From page 53 and experienced 2 or more non-injury falls.</p> <p>a. An undated care plan, documented Resident #1 was at risk for falls with or without injury related to a "gait/balance problems, reduced mobility, Parkinson's, hx [history] of falls (fall 11-2-17)."</p> <p>Resident #1's clinical record documented the resident experienced 1 unwitnessed fall on 9/26/17 and fell and hit her head on 11/2/17.</p> <p>Resident #1's I&amp;A Reports documented the following:</p> <p>* 9/26/17 - 7:15 AM: Resident #1 experienced an unwitnessed fall in the bathroom. Resident #1's neurological assessments for the 9/26/17 fall was not completed.</p> <p>* 11/2/17 - 5:39 PM: Resident #1 experienced a fall from her bed to her chair. Resident #1's neurological assessment for the 11/2/17 fall was incomplete with 3 of 22 entries missing. There was no reason given for the missing entries.</p> <p>On 3/21/18 at 10:25 AM, the DNS stated the neurological assessments were to be completed every 15 minutes for 1 hour, every 1 hour for 3 hours, every 4 hours for 20 hours and every 8 hours for 2 days. The DNS stated the staff should be completing the assessments when residents experienced unwitnessed falls or it was suspected that they hit their heads. The DNS stated the neurological assessments from September 2017 was before her time in the facility and she could not speak to the location of the assessments. The DNS stated the other</p>	F 684			

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F 684	<p>Continued From page 54 assessments should have been completed fully.</p> <p>b. The facility failed to monitor blood pressures as ordered.</p> <p>According to the 2018 Nursing Drug Handbook, those receiving Lisinopril, an antihypertensive, should have their blood pressure (BP) monitored "frequently."</p> <p>An undated care plan, documented Resident #1 had an altered cardiovascular status related to hypertension. The care plan documented vital signs were completed weekly and PRN.</p> <p>A 4/6/16 physician's order documented Resident #1 received 2.5 mg of Lisinopril one time a day for hypertension, and staff members were to assess her BP weekly.</p> <p>Resident #1's MARs from 2/1/18 through 3/21/18 documented she routinely received her Lisinopril.</p> <p>The Weights and Vitals Summary Report documented Resident #1's BP as the following:</p> <p>* 1/04/18 - 130/72 * 2/27/18 - 126/60</p> <p>Resident #1's clinical records did not contain documentation of blood pressure results after 2/27/18.</p> <p>On 3/22/18 at 2:38 PM, the DNS stated staff should have obtained weekly BP assessments.</p> <p>3. Resident #11 was admitted to the facility on 6/4/17 with diagnoses which included speech</p>	F 684			

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F 684	<p>Continued From page 55 and language deficit, multiple rib fractures, dementia, and aphasia.</p> <p>An annual MDS assessment, dated 2/12/18, documented Resident #11 had moderate cognitive impairment and documented he experienced one fall with no injury.</p> <p>Resident #11's Incident and Accident (I&amp;A) Reports documented the following:</p> <p>* 9/16/17 - 11:19 AM: Resident #11 experienced an unwitnessed fall in another residents' bathroom. The clinical records did not contain neurological assessments following this fall.</p> <p>* 9/25/17 - 5:20 AM: Resident #11 experienced an unwitnessed fall from bed. The clinical records did not contain neurological assessments following this fall.</p> <p>* 10/3/17 - 6:50 AM: Resident #11 experienced an unwitnessed fall from bed. Resident #11's neurological assessment for the 10/3/17 fall was incomplete with 2 of 22 entries missing. There was no reason given for the missing entries.</p> <p>* 12/30/17 - 5:45 PM: Resident #11 experienced an unwitnessed fall from bed. Resident #11's neurological assessment for the 12/3/17 fall was incomplete with 12 of 21 incomplete entries. There was a documented reason of "sleeping" for why the assessment was not completed.</p> <p>* 1/27/18 - 8:07 PM: Resident #11 experienced an unwitnessed fall from bed. Resident #11's neurological assessment for the 1/27/18 fall was incomplete with 5 of 18 entries missing. There</p>	F 684			

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F 684	<p>Continued From page 56 was no reason given for the missing entries.</p> <p>Resident #11's clinical record documented the resident experienced 6 unwitnessed falls between 9/16/17 and 1/27/18. Five of the six neurological assessments were not initiated or were not fully complete.</p> <p>On 3/21/18 at 10:25 AM, the DNS stated the neurological assessments were to be completed every 15 minutes for 1 hour, every 1 hour for 3 hours, every 4 hours for 20 hours and every 8 hours for 2 days. The DNS stated the staff should be completing the assessments when residents experienced unwitnessed falls or it was suspected that they hit their heads. The DNS stated the neurological assessments from September 2017 was before her time in the facility and she could not speak to the location of the assessments. The DNS stated the other assessments should have been completed fully and Resident #11 should have been woke up to assess for neurological status changes.</p> <p>4. Resident #75 was admitted to the facility on 3/5/18 with diagnoses which included hemiparesis (one-sided paralysis).</p> <p>An admission MDS assessment, dated 3/12/18, documented Resident #75 had a severe cognitive impairment and she had a catheter.</p> <p>A 3/5/18 Physician's order documented Resident #75 had a catheter and it was discontinued on 3/16/18.</p> <p>An undated care plan, documented Resident #75 had an indwelling catheter.</p>	F 684			

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F 684	Continued From page 57  A Daily Med A Assessment, dated 3/18/18 at 9:34 PM, documented Resident #75's foley catheter care was provided, patent, draining, and in proper position.  A Daily Med A Assessment, dated 3/19/18 at 9:37 PM, documented Resident #75's foley catheter care was provided, patent, draining, and in proper position.  A Daily Med A Assessment, dated 3/20/18 at 9:26 PM, documented Resident #75's foley catheter care was provided, patent, draining, and in proper position.  On 3/20/18 at 11:17 AM, Resident #75 was observed without a catheter.  On 3/20/18 at 1:13 PM, Resident #75 was observed without a catheter.  On 3/21/18 at 7:31 AM, Resident #75 was observed in bed without a catheter.  On 3/21/18 at 10:00 AM, LPN #4 stated Resident #75 did not have an catheter and it was recently discontinued.  On 3/21/18 at 10:01 AM, CNA #2 stated Resident #75's did not have a catheter.  Facility staff documented care they could not have provided as the indwelling catheter had been removed.  5. Resident #14 was admitted to the facility on 2/16/18 with multiple diagnoses, including	F 684			

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F 684	<p>Continued From page 58</p> <p>cellulitis and osteomyelitis to left foot and ankle.</p> <p>The admission MDS assessment, dated 2/23/18, documented Resident #14 was cognitively intact.</p> <p>The facility's Admit/Discharge Report from 10/1/17 to 3/22/18, documented Resident #14 was discharged to a hospital on 3/17/18.</p> <p>Resident #14's EMAR, dated 3/17/18, documented Resident #14 was at the hospital.</p> <p>There was no nurse's progress notes documented for Resident #14's transfer to the hospital for a change of condition on 3/17/18.</p> <p>On 3/23/18 at 1:45 PM, LPN #2 stated on 3/17/18, Resident #14 was in the dining room for lunch and was acting "funny." LPN #2 stated she checked Resident #14's vital signs and remembered the vital signs were low, then called Resident #14's resident representative, and the physician for orders. The physician ordered LPN #2 to send Resident #14 to the ER (emergency room) for further evaluation. LPN #2 stated she called 911 and made a copy of Resident #14's face sheet, list of allergies, history and physical, list of vital signs, and physician orders. The copies were given to the paramedics to give to the hospital. LPN #2 stated she filled out a transfer sheet for the hospital, but did not call the hospital to give a verbal report. LPN #2 stated she forgot to document a nurse's note regarding the incident.</p> <p>On 3/23/18 at 2:15 PM, RN #1 stated on 3/17/18 approximately between 1:00 PM and 2:00 PM, it was her first day of orientation, Resident #14 was</p>	F 684			

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F 684	<p>Continued From page 59</p> <p>alert, but not able to track questions and was shaking. RN #1 stated LPN #2 notified Resident #14's resident representative and physician of Resident #14's change of condition. RN #1 stated she assisted LPN #2 with making copies for the transfer to the hospital. RN #1 stated she was unaware if LPN #2 documented in the nurses' notes.</p> <p>On 3/23/18 at 2:45 PM, the DNS stated the facility's policy for discharge to the hospital was the same as the Admission, Transfer, and Discharge policy.</p> <p>The facility's undated Admission, Transfer, Discharge Policy documented, "the facility must ensure that the transfer or discharge is documented in the resident's medical record."</p> <p>On 3/23/18 at 2:45 PM, the DNS was unaware Resident #14's nurses' notes did not document Resident #14 was transferred to the hospital for a change of condition on 3/17/18.</p> <p>6. Resident # 21 was admitted to the facility on 4/25/17 with multiple diagnoses, including Parkinson's disease, dementia, and failure to thrive.</p> <p>Resident #21 was admitted to hospice services on 12/14/17 and passed away 12/21/17.</p> <p>Resident #21's hospice care plan, dated 12/19/17, documented, the staff were to observe Resident #21 closely for signs of pain and notify the physician for breakthrough pain. The staff was to work cooperatively with the hospice team to ensure Resident #21's spiritual, emotional,</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 60 intellectual, physical, and social needs are met.</p> <p>A Nurse's progress note, dated 12/20/17 at 12:09 PM, documented Resident #21 was not receiving any intake of food or fluids. Resident #21's spouse was at bedside, hospice continued to follow, and will continue to monitor closely.</p> <p>A Hospice Discharge Summary, dated 12/21/17 at 3:10 PM, documented the facility staff notified the hospice agency, Resident #21 had passed away at 3:00 PM. The hospice nurse documented, "took patient under my care and notified the husband that wife had passed away and he stated he would be over in 10 minutes."</p> <p>On 3/23/18 at 12:30 PM, the DNS stated she was unaware the facility nurses did not document Resident #21's change of condition assessments, family involvement, or coordination of care with hospice in the nurses' progress notes the last 27 hours of Resident #21's life. The DNS stated the facility nurses should have documented Resident #21's condition throughout the rest of 12/20/17 up to 12/21/17 when Resident #21 passed away. The DNS stated the nurses' notes should have included time of death, family involvement, coordination of care with hospice and notifying the physician.</p> <p>7. Resident #121 was admitted to the facility on 3/1/18 with multiple diagnoses including dementia.</p> <p>Policy Tuberculosis Control Plan dated 2012 - (infection prevention manual for long term care) *"Assignment of responsibility - The director of nursing is responsible for the implementation of</p>	F 684			

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F 684	<p>Continued From page 61</p> <p>the Tuberculosis Control Plan. The responsibility for the TB Infection Control program is shared by Physicians, administrators, and nursing staff including the Infection Preventionist."</p> <p>* "All residents will be screened on admission..."</p> <p>* "Skin test will employ a two step procedure."</p> <p>Resident #121's March 2018 MAR, documented a licensed nurse was to administer the Apilosol solution (tuberculin PPD) on 3/1/18 and read the PPD results on 3/4/18. There was no documentation on the MAR for 3/1/18 and 3/4/18, to verify the tuberculin PPD was administered and the test results read.</p> <p>On 3/22/18 at 6:15 PM, the DNS and the ADON stated Resident #121's MAR for 3/1/18 and 3/4/18 was left blank, meaning he did not receive the PPD. The DNS and the ADON stated they were in the process of making a check list system to ensure all residents received the PPD.</p> <p>8. Resident #6 was admitted to the facility on 1/24/18 with multiple diagnoses, including polyneuropathy and venous insufficiency.</p> <p>The admission MDS assessment, dated 2/2/18, documented Resident #6 was not "up to date" and was "not offered" the Pneumococcal Vaccination.</p> <p>On 3/22/18 at 5:30 PM, the Infection Control Nurse provided Resident #6's Pneumococcal Vaccine Consent Form, dated 1/25/18, which documented Resident #6 gave the facility permission for the vaccine to be administered.</p> <p>Resident #6's January 2018 MAR and TAR did</p>	F 684			

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F 684	<p>Continued From page 62</p> <p>not have documentation that Resident #6 received the Pneumococcal Vaccine.</p> <p>On 3/22/18 at 5:40 PM, the Infection Control Nurse was unable to provide documentation Resident #6 received the Pneumococcal Vaccine.</p> <p>The facility's Admission Check List for Resident #6 documented, "List must be completed within 24 hours of admission. Please initial once item is completed. When list is finished, place in DNS box." The list included, "Complete and have resident sign the Flu and Pneumovac consent sheets whether they consent or decline. If they would like the immunization, write the order and put in the doctor's box to be signed."</p> <p>9. Resident #19 was admitted to facility on 1/29/18 with multiple diagnoses including cognitive communication deficit.</p> <p>An admission MDS assessment, dated 2/5/18, documented Resident #19 was moderately cognitively impaired and required extensive assistance of 1 to 2 staff members for cares.</p> <p>On 3/21/18 at 7:30 AM, the DNS provided a copy of a fully completed Neurological Assessment related to Resident #19's unwitnessed fall which was documented on an Incident Report dated 3/15/18.</p> <p>On 3/23/18 at 9:30 AM, Resident #19's clinical record contained a scanned incomplete Neurological Assessment, dated 3/19/18, related to an unwitnessed fall noted on an Incident Report dated 3/15/18. The 3/15/18 neurological</p>	F 684			

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F 684	Continued From page 63 assessment was missing 6 of 24 entries and 2 of 24 entries were incomplete, lacking documentation of Resident #19's motor response, speech, level of consciousness, eye response, and pupil response. There was no reason given for the missing or incomplete entries.  On 3/23/18 at 9:45 AM, the DNS stated she was unsure why the Neurological Assessments were inconsistent with each other. She could not explain why the copy provided to the surveyors was complete and the scanned 3/19/18 copy in Resident #19's clinical record with incomplete.  On 3/23/18 at 10:00 AM, the Medical Records Director stated she scanned Resident #19's Neurological Assessment on 3/19/18 with a pile of other documents for other residents. The Medical Records Director stated she would later go back and stamp the documented scanned in with a date, and the date stamped on Resident #19's Neurological Assessment was 3/21/18. The Medical Records Director stated she was unable to recall if the document was completed or not when it was originally scanned in on 3/19/18.  On 3/23/18 at 10:20 AM, the DNS was unable to explain how the neurological assessment was completed for Resident #19. The DNS was unable to identify the nurse's signature on the assessment.	F 684			
F 689 SS=G	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	F 689		4/27/18	

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F 689	<p>Continued From page 64 as free of accident hazards as is possible; and</p> <p>§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, record review, and staff interview, it was determined the facility failed to provide adequate supervision to meet resident needs. This was true for 2 of 4 residents (#11 and #16) reviewed for supervision and accidents. Resident #11 was harmed when staff failed to provide adequate supervision while the resident was in his room and he fell and sustained a rib fracture. Resident #16 was harmed when she sustained a head laceration in her room falling from her bed. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 6/4/17 with diagnoses which included speech and language deficit, multiple rib fractures, dementia, and aphasia.</p> <p>An annual MDS assessment, dated 2/12/18, documented Resident #11 had moderate cognitive impairment and documented he experienced one fall with no injury. The previous quarterly MDS assessment, dated 11/27/17, documented Resident #11 experienced 2 or more non-injury falls.</p> <p>An undated care plan, documented Resident #11 had dementia and impaired cognitive function.</p> <p>An undated care plan, documented Resident #11 was at risk for falls with or without injury related to a "recent CVA, with right side hemiparesis,</p>	F 689	<p><b>CORRECTION FOR THOSE RESIDENTS AFFECTED:</b> Resident #11-Residents interventions for safety has increased supervision added to the plan of care. Increased supervision means staff would check to ensure resident is safe and that current fall interventions are in place. Starting 4/26/18 licensed staff and C.N.A's will document in EMAR that resident has been observed and that fall interventions are in place every hour times two weeks, then every two hours x 2 weeks and re evaluate for continued need for increased supervision. Resident #16-No longer resides in the facility.</p> <p><b>OTHERS WITH POTENTIAL TO BE AFFECTED:</b> Residents that reside in the SNF and have had a fall in the last 30 days will be reassessed by the DNS or designee by 4/13/18, for the potential need for increased supervision as a safety intervention.</p> <p><b>SYSTEMIC CHANGES:</b> Staff were re in serviced on 4/13/18, regarding increased supervision as a possible safety intervention for a</p>		

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F 689	<p>Continued From page 65</p> <p>cognitive impairment, gait/balance problems, incontinence, poor communication/comprehension, and psychotropic med use and impulsivity, history of falls w/ [with] Fx [fracture]." The care plan interventions were documented as follows:</p> <ul style="list-style-type: none"> <li>* Ensure Resident #11's call light was within reach and encourage him to use it as needed. Resident #11 had stopped utilizing his call light and would "yell out" for assistance. Staff were encouraged to "reorient" Resident #11 as needed.</li> <li>* Educate Resident #11 and his family on safety reminders and what to do if falls occur.</li> <li>* Ensure Resident #11's bed was in low position and at an appropriate height for transfers.</li> <li>* Ensure Resident #11 was wearing appropriate footwear when mobilizing in his wheelchair.</li> <li>* Ensure Resident #11's bedroom door is closed at night, to prevent him from closing the door himself.</li> <li>* Resident #11 utilized a "side rail on the right side of his bed for a sense of security and a halo bar to the left side of his bed to aid in independence with bed mobility and transfers."</li> <li>* "Pressure alarm to bed and wheelchair to alert staff of unsafe self-transfers and safety needs. Staff to ensure placement, turned on and functionality of the devices."</li> <li>* PT/OT were to evaluate Resident #11 and treat as ordered and PRN.</li> </ul> <p>Resident #11's clinical record documented the resident experienced 6 unwitnessed falls between 9/16/17 and 1/27/18 and 1 witnessed fall on 9/21/17.</p>	F 689	<p>resident that falls. 4/12/18 Standards and Guidelines for Policy 12053, 12035 and 13114 were revised to include increased supervision.</p> <p>Staff in serviced 4/12/18 om PCC task that has been added to identify residents that require increased supervision as a safety intervention.</p> <p>Residents that have increased supervision as an intervention, will be reviewed Monthly or with each fall by the DNS or designee to determine if increased supervision needs to be revised.</p> <p>Staff were in serviced 4/13/18, on the new supervision tracking form and how to complete the documentation.</p> <p>DNS or designee will complete weekly audits of the EMAR documentation for increased observation of resident and fall interventions daily times 2 weeks then weekly x4 weeks, then monthly times 3 months.</p> <p>DNS office has been relocated Maple, to improve visual observation of staff completing the increased observation checks.</p> <p>DNS or designee will audit daily times 2 weeks then weekly x 4 weeks, then monthly times 3 months, to ensure staff are visualizing the resident during the increased observation checks.</p> <p><b>ON GOING COMPLIANCE:</b> Results of the supervision tracking form audit will be reported to the QA committee monthly for review and suggestions. Results of the DNS's 30 day fall tracking</p>		

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F 689	<p>Continued From page 66</p> <p>Resident #11's I&amp;A Reports documented the following:</p> <p>* 9/16/17 - 11:19 AM: Resident #11 experienced an unwitnessed fall in another resident's bathroom.</p> <p>* 9/21/17 - 2:12 AM: Resident #11 was observed walking in his room unattended and before an CNA could assist him, he fell and landed on his right elbow. The I&amp;A documented Resident #11 had disconnected his bed alarm to keep it from sounding.</p> <p>* 9/25/17 - 5:20 AM: Resident #11 experienced an unwitnessed fall from bed. The I&amp;A documented his alarm was sounding with his back against his night stand. Resident #11 had multiple skin tears to his left elbow and left hand.</p> <p>A 9/25/17 at 9:09 AM, physician's order documented Resident #11 was to have a "stat" x-ray to his left lower ribs to rule out injury related to a fall.</p> <p>A Radiology Interpretation Significant Findings, dated 9/25/17 at 11:02 AM, documented Resident #11 sustained a "nondisplaced fracture of the 3rd rib." The report documented there was a question about a possible fracture of the 4th rib in addition.</p> <p>A Nurse's progress note, dated 9/25/17 at 2:00 PM, documented Resident #11 sustained a fracture to his 3rd rib and a questionable fracture to his 4th rib.</p> <p>* 10/3/17 - 6:50 AM: Resident #11 experienced</p>	F 689	<p>will be reported and reviewed in the monthly QA meeting.</p> <p>DNS and Administrator are responsible for ongoing compliance.</p>		

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F 689	<p>Continued From page 67</p> <p>an unwitnessed fall from bed. The resident was assisted into a wheelchair.</p> <p>* 11/30/17 - 4:50 PM: Resident #11 experienced an unwitnessed fall from bed. The resident was found in his room with his back resting against the wall near his bathroom. Resident #11's bed alarm was not sounding at the time of the fall and did not appear plugged in.</p> <p>* 12/30/17 - 5:45 PM: Resident #11 experienced an unwitnessed fall from bed. The resident was found in his room with his upper body lying face down on the bed. The I&amp;A documented he was trying to self-transfer.</p> <p>* 1/27/18 - 8:07 PM: Resident #11 experienced an unwitnessed fall from bed. The I&amp;A documented Resident #11 was incontinent of urine and was trying to use the restroom.</p> <p>On 3/19/18 at 8:15 PM, Resident #11 was in his room with his door closed.</p> <p>On 3/20/18 at 8:39 AM, Resident #11 was observed in his wheelchair at the breakfast table with an alarm attached to the back of his wheelchair. Resident #11's wheelchair had a Wanderguard attached under his wheelchair.</p> <p>On 3/20/18 at 9:33 AM, Resident #11 was observed nearing the front door by himself and a proximity alarm sounded. Resident #11 stated he wanted to find his wife. Resident #11 made several attempts to leave the building to find his wife. CNA #1 approached Resident #11 and redirected him.</p>	F 689			

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F 689	<p>Continued From page 68</p> <p>On 3/20/18 at 11:01 AM, Resident #11 was observed sitting in his wheelchair staring out the window waiting for his wife to come. Resident #11 had an alarm on the back of his wheelchair and a Wanderguard under his chair.</p> <p>On 3/21/18 at 9:10 AM, Resident #11 was observed at the breakfast table with an alarm attached to the back of his wheelchair and Wanderguard under his chair.</p> <p>On 3/22/18 at 5:36 PM, Resident #11 was observed in the hallway near the front door and was turning off lights with no staff members around. Resident #11's chair alarm was not attached to the back of his wheelchair during the observation.</p> <p>On 3/21/18 at 10:25 AM, the DNS stated Resident #11's wife spent time with Resident #11 throughout the day. When asked what activities were provided when Resident's #11's wife was not available the DNS stated the staff encouraged activities such as reading, making bird houses, offered snacks, calling his wife, looking out the window, and sitting in the day room. The DNS stated Resident #11's falls had no pattern that the facility had identified. When asked what intervention were in place when he was in his room the DNS stated Resident #11 had alarms in place, his bed was in low position and he wore appropriate foot wear. The DNS stated Resident #11 could not consistently remember to utilize a call light and staff should check on him. When it was brought to the DNS's attention that Resident #11 had fallen consistently in his room she was asked for evidence of what changes had been made to</p>	F 689			

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F 689	<p>Continued From page 69</p> <p>Resident #11's care plan after each fall. The DNS stated if the falls were occurring in Resident #11's room then she would expect staff to open Resident #11's door for increased supervision. The DNS was unable to provide evidence of increase supervision.</p> <p>The facility failed to modify interventions including increasing supervision after each fall to try and prevent ongoing falls in Resident #11's room.</p> <p>2. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur.</p> <p>Resident #16's Fall Risk Assessment, dated 1/31/18 documented she was a high risk for falls.</p> <p>A significant change MDS assessment, dated 2/19/18, documented Resident #16 had a moderate cognitive impairment and documented she had experienced no falls. The MDS documented Resident #16 did not use a bed alarm. The MDS documented Resident #16 required extensive assistance of one to two staff members for all cares.</p> <p>An undated care plan, documented Resident #16 was at risk for falls with or without injury related to "confusion, gait/balance problems, incontinence, poor communication/comprehension, and psychoactive drug use, unaware of safety needs, [and] vision problems." The care plan interventions were documented as followed:</p> <p>* Staff were to anticipate and meet Resident #16's needs.</p>	F 689			

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F 689	<p>Continued From page 70</p> <ul style="list-style-type: none"> <li>* Ensure Resident #16's call light was within reach and encourage her to use it as needed. Resident #16 was confused and did not utilize her call light. Staff were to anticipate Resident #16's needs.</li> <li>* Staff were to ensure Resident #16's environment was safe.</li> <li>* Resident #16 required extensive assistance of two staff members for transferring and bed mobility.</li> <li>* Educate Resident #16 and her family on safety reminders and what to do if falls occur.</li> <li>* Pressure alarm to bed and wheelchair to alert staff of unsafe self-transfers and safety needs. Staff to ensure placement, turned on and functionality of the devices.</li> <li>* Ensure Resident #16's bed was at the appropriate height for transfers.</li> <li>* Ensure Resident #16 was wearing appropriate footwear when mobilizing in her wheelchair.</li> <li>* PT were to evaluate Resident #16 and treat as ordered and PRN.</li> <li>* Ensure Resident #16's call light, water, and remote control were within her reach.</li> <li>* Review her falls for possible root causes.</li> </ul> <p>Resident #16's clinical record documented the resident experienced 2 unwitnessed falls between 1/30/18 and 2/22/18.</p> <p>Resident #16's I&amp;A Reports documented the following:</p> <ul style="list-style-type: none"> <li>* An I&amp;A Report, dated 1/30/18 at 4:30 PM, documented Resident #16 experienced an unwitnessed fall from bed. The resident was assisted back into bed. The I&amp;A documented Resident #16's bed alarm was on but did not</li> </ul>	F 689			

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F 689	<p>Continued From page 71</p> <p>sound when she moved off of her bed and towards her dresser.</p> <p>A follow up note to the 1/30/18 - 4:30 PM fall, dated 1/31/18 at 10:00 AM, documented Resident #16 was provided an interior design book and personalized activity blanket between scheduled activities.</p> <p>Resident #16's at risk for falls care plan, was revised at an unknown date, to include offering Resident #16 her an interior design book and personalized activity blanket between scheduled activities.</p> <p>* An I&amp;A Report, dated 2/20/18 at 5:40 PM, documented Resident #16 experienced an unwitnessed fall from bed, where she sustained a hematoma to the side of her head and a skin tear to her left ear. The I&amp;A documented a picture of Resident #16 between the bed and the window. The I&amp;A documented Resident #16 was educated on her bed alarm placement. A follow up note for the 2/20/18 fall was not completed on the I&amp;A.</p> <p>An Emergency Doctor Provider Notes, dated 2/20/18 at 7:11 PM, documented Resident #16 suffered an unwitnessed fall and it was "assumed" Resident #16 hit her head on either the "window sill or her bed." The note documented the facility was unsure if Resident #16 lost consciousness or not. The note documented Resident #16 had a laceration to her left ear and a hematoma to the left side of her head.</p> <p>A Nurse's Note, dated 2/20/18, documented</p>	F 689			

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F 689	<p>Continued From page 72</p> <p>Resident #16 returned from the emergency room. The "laceration appeared to extend from the edge of her ear flap to the inner aspect of the canal cartilage. Approximately 6 sutures seen."</p> <p>An undated care plan, documented Resident #16 had a fall with a laceration to the left ear and staff were to monitor Resident #16 per facility protocol for neurological assessments and assess her range of motion for 7 days and continue her "at risk interventions." No new interventions were implemented.</p> <p>On 3/19/18 at 7:53 PM, Resident #16 was observed in bed with her bed flush against the wall under the window sill and bilateral 1/2 bed rails. Resident #16's bed was in low position, Resident #16's bedside table was next to her on the other side of her bed opposite the wall.</p> <p>On 3/20/18 at 4:30 PM, Resident #16 was observed in bed with her bed flush against the wall under the window sill and bilateral 1/2 bed rails. Resident #16's bed was in low position, Resident #16's bedside table was next to her on the other side of her bed opposite the wall.</p> <p>On 3/21/18 at 10:25 AM, the DNS and the ADON stated Resident #16 she had multiple falls and was admitted with a fall history. The DNS stated Resident #16 spent time in the dining room so staff could keep her in their line of sight. The DNS stated her room was close to the nurses station for more frequent observation opportunities. The DNS did not see patterns in Resident #16's falls. The DNS stated when she fell in her room they added a busy blanket and an interior design book. The DNS stated Resident</p>	F 689			

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F 689	Continued From page 73 #16's falls seemed to have decreased since she was placed on hospice. The DNS was unable to identify additional fall interventions initiated to keep Resident #16 safe.	F 689			
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4)  §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.  §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.  §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted, individual residents were thoroughly assessed for the risk of entrapment, and a consent was in place. This was true for 4 of 5 residents (#11,	F 700		4/27/18	
			CORRECTIVE ACTION FOR THOSE AFFECTED: Resident #11-On 4/12/18 resident was re-assessed for safety and a restraint reduction was made by discontinuing his tab alarm. Resident was reassess on 4/12/18 and continues to use a 1/4 side		

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F 700	<p>Continued From page 74</p> <p>#16, #19, and #75) sampled for bed rail use and created the potential for harm from entrapment or injury related to the use of bed rails. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 6/4/17 with diagnoses which included speech and language deficit, multiple rib fractures, dementia, and aphasia.</p> <p>An annual MDS assessment, dated 2/12/18, documented Resident #11 had a moderate cognitive impairment and did not document he utilized bed rails.</p> <p>An undated care plan, documented Resident #11 had dementia and an impaired cognitive function.</p> <p>* Resident #11 utilized a "bed rail on the right side of his bed for a sense of security and a halo bar to the left side of his bed to aid in independence with bed mobility and transfers."</p> <p>A 12/19/17 physician's order documented Resident #11 required 1/4 bed rail on the right side and a halo bar to the left side.</p> <p>Resident #11's clinical record did not contain assessments of the 1/4 bed rail and a halo bar by the interdisciplinary team.</p> <p>On 3/20/18 at 8:59 AM, Resident #11's bed was observed with 1/4 bed rail on the right side and a halo bar to the left side.</p> <p>On 3/21/18 at 10:25 AM, the DNS stated she was aware of the requirements for bed rails and was in the process of trying to phase out bed</p>	F 700	<p>rail on the Right side of bed and on the left side of the Halo assist rail, for increased bed mobility and independence. Assessment documented, order received and care plan updated.</p> <p>Resident #16-No longer resides in the facility.</p> <p>Resident #19-On 4/12/18 resident was reassessed for the safety and continued need for the bed against the wall and side rail. Bed against the wall was discontinued, and the side rail to bed was changed to a Halo assist bar to increase resident independence and bed mobility.</p> <p>Resident #75-no longer resides in the facility.</p> <p><b>OTHER RESIDENTS POTENTIALLY AFFECTED:</b> Residents residing in the facility and have side rails or their beds against the wall have the potential to be affected. Residents with side rails or bed against the wall were assessed for the safety and continued need for side rails or bed against the wall.</p> <p><b>SYSTEMIC CHANGES:</b> Maintenance completed audit of all "devices" that are in place on 4/13/18, to ensure proper installation and that devices are in proper working order. Maintenance will complete audit of all rooms monthly and report findings to the</p>		

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F 700	<p>Continued From page 75</p> <p>rails in the facility. The DNS stated but she could not locate the assessments or informed consents for the bed rails.</p> <p>2. Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur.</p> <p>A significant change MDS assessment, dated 2/19/18, documented Resident #16 had moderate cognitive impairment and did not use bed rails.</p> <p>Resident #16 was observed in bed with her bed flush against the wall under the window sill and bilateral 1/2 bed rails on the following occasions: *On 3/19/18 at 7:53 PM *On 3/20/18 at 9:47 AM *On 3/20/18 at 11:05 AM *On 3/20/18 at 4:30 PM</p> <p>On 3/21/18 at 10:25 AM, the DNS stated she could not locate an order, consent, assessments to include the risk for entrapment, or a care plan for the bed rails.</p> <p>3. Resident #75 was admitted to the facility on 3/5/18 with diagnoses which included hemiparesis.</p> <p>An admission MDS assessment, dated 3/12/18, documented Resident #75 had severe cognitive impairment and she did not use bed rails.</p> <p>Resident #75's bed was observed with bilateral 1/2 bed rails on the following occasions: * 3/20/18 at 9:38 AM * 3/21/18 at 7:31 AM</p>	F 700	<p>monthly QA meeting.</p> <p>On 4/12/18 staff were re inserviced on least restrictive measures before restraints are considered.</p> <p>on 4/12/18, Standards and Guidelines #12035 was revised to clarify devices/restraints.</p> <p>Upon admission, and discharge the Admission Director will submit work orders to maintenance to notify them to check the room and remove any devices, to prevent new admissions admitting to a room with a "device" left in place in the room.</p> <p>Maintenance was re educated on 4/11/18 to not install any devices that they receive a work order for- with out first checking with the nurse that there is an MD order to place the device.</p> <p>DNS or designee will complete audit of 5 random resident rooms 2 times per week x 4weeks, 5 random resident rooms weekly for 4 weeks, then 5 random resident rooms monthly x 3 months for "devices" to ensure proper assessments are in place.</p> <p><b>ONGOING COMPLIANCE:</b> The results of maintenance's audits will be brought to monthly QA meeting to review results. QA IDT will make suggestions if needed. DNS will bring results from audits to be reviewed with IDT in the monthly QA meeting for review and suggestions. Maintenance and DNS will be responsible for on going compliance.</p>		

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F 700	<p>Continued From page 76 * 3/21/18 at 1:30 PM</p> <p>On 3/21/18 at 3:45 PM, the DNS stated she was not aware Resident #75 had bed rails. The safety assessments and informed consent would not be in the record if it was not already located. The DNS was unable to locate the missing items.</p> <p>4. Resident #19 was admitted to facility on 1/29/18 with multiple diagnoses including cognitive communication deficit.</p> <p>An admission MDS assessment, dated 2/5/18, documented Resident #19 was moderately cognitively impaired and required extensive assistance of 1 to 2 staff members for cares. The MDS assessment did not document Resident #19 had a halo bar on her bed.</p> <p>On 3/19/18 at 6:30 PM, Resident #19 was observed resting in bed with a halo bar on the left-side.</p> <p>On 3/20/18 at 9:58 AM, the DNS stated there were no risk assessments or informed, consent, for Resident #19's halo bar.</p> <p>On 3/22/18 at 11:40 AM, Maintenance Director #1 and Maintenance Director #2 stated they currently were not doing routine maintenance inspections on the beds for the bed rails or halo bars besides when they placed them on the beds. Maintenance Director #1 stated he knew when to place bed rails on the beds after a resident was assessed for the risk of entrapment, a consent was signed, bed rails were ordered, care planned, and alternatives were tried. Maintenance Director #1 stated the beds they</p>	F 700			

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F 700	Continued From page 77 used came with the bed rails and the halo bars and the nursing staff would assess the mattresses to ensure they were appropriate for the resident.  The facility was unable to provide evidence of alternatives were attempted prior to the initiation of the installation of side rails/halo side rails. The facility was unable to provide risk of entrapment assessments prior to the installation of the bed rails and evidences of risk verses benefits review with the resident or resident representative.	F 700			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the 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	F 761		4/27/18	

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F 761	<p>Continued From page 78</p> <p>systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. This was true for 1 of 2 medication storage rooms. This failure created the potential for residents to receive vaccines which were less effective than necessary to treat the conditions for which they were administered. Findings include:</p> <p>On 3/22/18 at 3:00 PM, the medication room was inspected with the DNS in attendance and the following was observed:</p> <p>a. The A multi-dose Tuberculin vaccine vial was opened 12/29/17 and expired as of 1/29/18.</p> <p>b. A multi-dose vial of a influenza vaccine was opened and not dated.</p> <p>At the time of the inspection, the DNS verified expiration dates and disposed of the expired medications.</p>	F 761	<p><b>CORRECTIVE ACTION;</b> Open and undated medications along with expired vials of medication were destroyed and taken out of circulations. Medication fridges were audited for any expired medications on 4/12/18 and none were identified.</p> <p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents receiving a PPD shot or Influenza shot have the potential to be affected.</p> <p><b>MEASURES TAKE/SYSTEMIC CHANGES:</b> Licensed staff re- educated 4/11/18, on policy for dating multi dose vial vaccines with the date they are opened and put into use, and that expired medications need to be disposed of timely. Starting 4/12/18-Night shift Nurse will complete a nightly audit that includes medication room fridges for expired medications or open and undated medications, nightly x 2 weeks, once a week x 4 weeks, then monthly thereafter. On 4/17/18 Pharmacy consultant completed a medication room audit and no expired medication was found. DNS placed a reference guide in each medication room that explains the length of time a medication can be open- before being expired.</p>		

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F 761	Continued From page 79	F 761	ONGOING COMPLIANCE: Nightly audit forms will be turned into and reviewed by the DNS for completion and/or trends, results will be shared in the monthly QAA meeting. Pharmacy consultant will complete a monthly audit of medication rooms for opened and undated medications, and expired medications. Results of the audit will be shared with the DNS that same day and reviewed in the QAA meeting. DNS responsible for ongoing monitoring and compliance.		
F 835 SS=F	Administration CFR(s): 483.70  §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, review of facility policies and procedures, staffing records, resident records, accident and incident reports, and the facility's maintenance records, it was determined the facility was not administered in a manner to effectively use its resources to attain or maintain the highest practicable well-being of each resident. The administration failed to ensure the facility was in compliance with the following regulatory requirements, which affected or potentially affected all residents in the facility. These failed practices directly impacted 20 of 20 sample residents (#1-#12, #14, #16, #19,	F 835	CORRECTIVE ACTION FOR THOSE AFFECTED: Resident #1-#12, #14, #16, #19, #21-#23,#75, and #121- Please refer to the corrective action listed for F575, F577, F579, F600, F604, F606, F607, F609, F610, F684, F689  OTHERS POTENTIALLY AFFECTED: Residents currently residing in the facility have the potential to be affected.	4/27/18	

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F 835	<p>Continued From page 80</p> <p>#21-#23, #75, and #121) and had the potential to impact the other 3 residents residing in the facility. The lack of supervision resulted in harm to Resident #11 (fractured rib) and Resident #16 (head laceration). The lack of effective oversight and planning on the part of facility administration had the potential to adversely affect the health and safety of all residents residing in the facility. Findings include:</p> <p>1. Deficiencies related to ineffective administration:</p> <p>Please refer to F575 as it pertains to the facility's lack of accessibility of required postings in the facility.</p> <p>Please refer to F577 as it pertains to the facility's lack of accessibility of the survey results in the facility.</p> <p>Please refer to F579 as it pertains to the facility's lack of postings for Medicare benefits in the facility.</p> <p>Please refer to F600 as it pertains to the facility's failure to ensure residents were free from abuse and neglect.</p> <p>Please refer to F604 as it pertains to the facility's failure to ensure residents were free from physical restraints.</p> <p>Please refer to F606 as it pertains to the facility's failure to ensure employee reference checks were completed prior to employment dates.</p> <p>Please refer to F607 as it pertains to the facility's</p>	F 835	<p><b>SYSTEMIC CHANGES:</b></p> <p>DNS and HR director were in serviced on 4/13/18 that all CPR cards, certificates, and Licenses will be kept in SDC binder. Copies of such items will require a front and back copy if there are dates, or signature on the back.</p> <p>On 4/12/18 staff were in serviced on correct way to add a late entry, or additional documentation into the computer.</p> <p>On 4/12/18 staff in serviced, medical records in serviced and DNS in serviced that starting 4/13/18 neuro checks will be attached to the incident reports and will not be scanned into resident records. DNS office on 4/17/18 was relocated to one of the SNF Villages for increased observation and oversight.</p> <p>Staff in serviced by 4/12/18, on corrective actions for F575, F577, F579, F600, F604, F606, F607, F609, F610, F684, F689.</p> <p>Audits completed for F575, F577, F579, F600, F604, F606, F607, F609, F610, F684, F689.</p> <p><b>ON GOING COMPLIANCE:</b></p> <p>Reviews of audits for F575, F577, F579, F600, F604, F606, F607, F609, F610, F684, F689 will be done in the monthly IDT QAPI meeting to monitor ongoing compliance. Consultant representative, or Executive Director, will attend monthly QAPI meeting for April, May and June to ensure POC is being followed and audits are</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	<p>Continued From page 81</p> <p>failure to ensure the current abuse and neglect policy was updated with the current regulations and was followed.</p> <p>Please refer to F609 as it pertains to the facility's failure to ensure injuries of unknown sources were reported to the State Survey Agency.</p> <p>Please refer to F610 as it pertains to the facility's failure to ensure injuries of unknown sources were investigated as potential abuse and /or neglect.</p> <p>Please refer to F684 as it pertains to the facility's failure to ensure services provided met professional standards.</p> <p>Please refer to F689 as it pertains to the facility's failure to ensure residents were free of accidents and were provided adequate supervision. Lack of supervision resulted in harm to Resident #11 when staff failed to provide adequate supervision while the resident was in his room and he fell and sustained a rib fracture. Resident #16 was harmed when she sustained a head laceration in her room falling from her bed.</p> <p>Please refer to F700 as it pertains to the facility's failure to ensure residents were thoroughly assessed for the risk of entrapment prior to the placement of bed rails.</p> <p>Please refer to F867 as it pertains to the facility's failure to maintain a quality assurance program.</p> <p>Please refer to F880 as it pertains to the facility's failure to ensure staff were trained on residents' laundry practices.</p>	F 835	<p>effective. Executive Director and Administrator are responsible for on going compliance.</p>		

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F 835	<p>Continued From page 82</p> <p>Please refer to F883 as it pertains to the facility's failure to ensure implementation of an immunization tracking system for pneumococcal vaccines.</p> <p>Please refer to F909 as it pertains to the facility's failure to ensure maintenance conducted regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment.</p> <p>2. Administrative Staff</p> <p>a. On 3/23/18 at 1:26 PM, the Administrator stated all direct care staff were CPR certified. The Administrator stated the HR department might not have updated files and the CPR cards might be in employee files. The Administrator stated the facility provided CPR training in house for staff or staff provided evidence of CPR training to the facility.</p> <p>On 3/23/18 at 3:00 PM, the Administrator provided a copy of a CPR training card for LPN #3. The CPR card was issued 5/19/17 and renewal date of 5/2019. The CPR card had LPN #3's name typed on the frontside and did not contain a backside with a signature.</p> <p>On 3/26/18 at 10:00 AM, LPN #3 stated the facility contacted her on 3/23/18 to bring a copy of her CPR card to the facility because there was not a CPR card in her file. LPN #3 stated, she did not provide a copy of her CPR card to the facility. LPN #3 provided a copy of her current CPR card to the survey team with a certificate number, LPN #3's typed name, an issue date of 3/14/17 and a</p>	F 835			

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F 835	<p>Continued From page 83 renewal date of 3/14/19. The back of the card had LPN #3's signature.</p> <p>b. A Health Status Progress Note, dated 9/25/17 at 5:32 AM, documented by LPN #2 "Residen[t's] alarm noted to be alarming at 5:10 this morning. Upon entrance into the room the CNA noted resident sitting on buttocks leaning towards the left side, using his left arm to support his weight to a sitting position, This nurse noted blood to the floor near [hand] as well as on the residen[t's] arm. Resident assessed with no noted or stated pain in extremities. Residen[t's] neuro assessment completed due to no being a witnessed fall with no evidence of neurological change. Resident unable to state what happened due to being confused and not being able to get words out in proper order. Resident attends were clean and dry. Resident noted to have skin tear to left elbow as well as left ring finger next to ring. Skin tear to finger was approximated [,] cleansed with wound cleanser, and steri strips were applied. Skin tear to left elbow was approximated to most areas to include the lower portion of skin tear and the lower corner were steri stripped. Other areas were unable to be approximated and was cleansed with wound cleanser, non-adherent pad was placed and covered with kerlex in order to protect surrounding skin from tape. Resident showed no s/sx of pain with dressing change and was noted to sleep during bandage process. Resident currently in bed with no noted other injury beside skin tear."</p> <p>A Health Status Progress Note, dated 9/26/17 at 12:41 AM, by LPN #2 documented the exact wording as the progress note, dated 9/25/17 at 5:32 AM by LPN #2 with the exception of the last</p>	F 835			

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F 835	<p>Continued From page 84 sentence, "Res also noted to have abrasion/bruise to mid upper back. Resident currently in bed with no noted other injury beside skin tear."</p> <p>The progress note was not dated late entry and there was no explanation why the bruise and abrasion was added to the progress note dated 9/26/17 at 12:41 AM by LPN #2.</p> <p>c. On 3/21/18 at 7:30 AM, the DNS provided a copy of a fully completed Neurological Assessment related to Resident #19's unwitnessed fall which was documented on an Incident Report dated 3/15/18.</p> <p>On 3/23/18 at 9:30 AM, Resident #19's clinical record contained a scanned incomplete Neurological Assessment, dated 3/19/18, related to an unwitnessed fall noted on an Incident Report dated 3/15/18. The 3/15/18 neurological assessment was missing 6 of 24 entries and 2 of 24 entries were incomplete, lacking documentation of Resident #19's motor response, speech, level of consciousness, eye response, and pupil response. There was no reason given for the missing or incomplete entries.</p> <p>On 3/23/18 at 9:45 AM, the DNS stated she was unsure why the Neurological Assessments were inconsistent with each other. She could not explain why the copy provided to the surveyors was fully completed and the scanned 3/19/18 copy in Resident #19's clinical record was incomplete.</p> <p>On 3/23/18 at 10:00 AM, the Medical Records</p>	F 835			

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F 835	Continued From page 85 Director stated she scanned Resident #19's Neurological Assessment on 3/19/18 with a pile of other documents for other residents. The Medical Records Director stated she would later go back and stamp the documented scanned in with a date, and the date stamped on Resident #19's Neurological Assessment was 3/21/18. The Medical Records Director stated she was unable to recall if the document was completed or not when it was originally scanned in on 3/19/18.  On 3/23/18 at 10:20 AM, the DNS was unable to explain how the 3/15/18 neurological assessment was completed for Resident #19. The DNS was unable to identify the nurse's signature on the assessment.	F 835			
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	F 842		4/27/18	

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F 842	Continued From page 86  §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert 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	F 842			

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F 842	<p>Continued From page 87 provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to keep accurate and complete clinical records for each resident. This was true for 4 of 20 sample residents (#s 6, 19, 75, and 121 whose records were reviewed. The deficient practice created the potential for harm when clinical information was not accurate, complete and systematically organized. Findings include:</p> <p>1. Resident #75 was admitted to the facility on 3/5/18 with diagnoses which included hemiparesis.</p> <p>An admission MDS assessment, dated 3/12/18, documented Resident #75 had a severe cognitive impairment and she had a catheter.</p> <p>A 3/5/18 Physician's order documented Resident #75 had a catheter and it was discontinued on 3/16/18.</p> <p>An undated care plan, documented Resident #75 had an indwelling catheter.</p> <p>A Daily Med A Assessment, dated 3/18/18 at 9:34 PM, documented Resident #75's foley catheter care was provided and the catheter was patent,</p>	F 842	<p>CORRECTIVE ACTION FOR THOSE AFFECTED:</p> <p>Resident # 75- No longer resides in the facility Resident #121- On 4/13/18 resident received a PPD test that was documented and read on 4/16/18. Resident#6-On 4/15/18 received the Pneumococcal Vaccine(pcv-13). Resident#19-Neuro checks are currently not necessary.</p> <p>OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED: Residents residing in the Facility that are newly admitted, or require neuro checks to be done have the potential to be affected. On 4/16/18 the records of Residents admitted in the last 7 days was audited for the administration and documentation of the administration for the PPD and Pneumococcal Vaccine upon admission. On 4/16/18- the records of Residents requiring neuro checks in the last 72 hours were audited to ensure neuro checks were completed and documented.</p>		

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F 842	<p>Continued From page 88 draining, and in proper position.</p> <p>A Daily Med A Assessment, dated 3/19/18 at 9:37 PM, documented Resident #75's foley catheter care was provided and the catheter was patent, draining, and in proper position.</p> <p>A Daily Med A Assessment, dated 3/20/18 at 9:26 PM, documented Resident #75's foley catheter care was provided and the catheter was patent, draining, and in proper position.</p> <p>The ADL Catheter Care Record, dated 3/19/18 at 2:53 AM, and 3/20/18 at 3:55 AM, documented Resident #75 was provided catheter care.</p> <p>On 3/20/18 at 11:17 AM, Resident #75 was observed without a catheter.</p> <p>On 3/20/18 at 1:13 PM, Resident #75 was observed without a catheter.</p> <p>On 3/21/18 at 7:31 AM, Resident #75 was observed in bed without a catheter.</p> <p>On 3/21/18 at 10:00 AM, LPN #4 stated Resident #75 did not have an catheter and it was recently discontinued.</p> <p>On 3/21/18 at 10:01 AM, CNA #2 stated did not have a catheter.</p> <p>On 3/21/18 at 3:34 PM, the DNS stated care plans were changed anytime there were changes with the residents and when the facility completed residents' comprehensive assessments. The DNS stated she reviewed the care plans for accuracy or the ADON and/or the</p>	F 842	<p><b>SYSTEMIC CHANGES:</b> Starting 4/16/18, New admission records will be audited by the DNS or Designee for the documentation of, and the administration of the PPD and the Pneumococcal Vaccine. DNS or designee starting 4/16/18 will audit all neuro checks initiated in previous 24hours-daily x 2 weeks, 2 random neuro checks weekly x 4 weeks, 2 random neuro checks monthly x 3 months. DNS or designee will audit those same records to ensure neuro's are being completed and documented neuro check audit will be done 3x a week x 2 weeks, 2 random neuro check documentations weekly x 4 weeks, 2 random neuro checks monthly x 3 months. On 4/12/18 staff were re educated on neuro check protocols, PPD and Pneumococcal vaccinations. On 4/12/18 Staff were re educated on documentation standards and to visualize a resident for assessment and verify devices are still in use before documenting in the EMAR. Nurse responsible for documentation errors, their employment was terminated.</p> <p><b>ON GOING MONITORING AND COMPLIANCE:</b> Results of the DNS admission audits for PPD and Vaccines will be reported to the Monthly QAPI meeting for review and suggestions. Results of the DNS or designee audits to ensure neuro checks were initiated will be</p>		

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F 842	<p>Continued From page 89 MDS nurse would review them.</p> <p>2. Resident #121 was admitted to the facility on 3/1/18 with multiple diagnoses including dementia.</p> <p>Policy Tuberculosis Control Plan dated 2012 - (infection prevention manual for long term care) *"Assignment of responsibility - The director of nursing is responsible for the implementation of the Tuberculosis Control Plan. The responsibility for the TB Infection Control program is shared by Physicians, administrators, and nursing staff including the Infection Preventionist." * "All residents will be screened on admission..." * "Skin test will employ a twostep procedure."</p> <p>Resident #121's March 2018 MAR, documented licensed nurse was to administer the Apilosol solution (tuberculin PPD) on 3/1/18 and read the PPD results on 3/4/18. There was no documentation on the MAR for 3/1/18 and 3/4/18, to verify the tuberculin PPD was administered and the test results read.</p> <p>On 3/22/18 at 6:15 PM, the DNS and the ADON stated Resident #121's MAR for 3/1/18 and 3/4/18 was left blank, meaning he did not receive the PPD. On 3/1/18 and 3/4/18 were left blank. The DNS and the ADON stated they were in the process of making a check list system to ensure all residents received the PPD.</p> <p>3. Resident #6 was admitted to the facility on 1/24/18 with multiple diagnoses, including polyneuropathy and venous insufficiency.</p> <p>The admission MDS assessment, dated 2/2/18,</p>	F 842	<p>reported in the monthly QAPI meeting for review and suggestions. Results of the DNS or designee audits of neuro checks being documented completely will be reported in the Monthly QAPI meeting for review and suggestions. DNS and Administrator or responsible for ongoing monitoring.</p>		

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F 842	<p>Continued From page 90</p> <p>documented Resident #6 was not "up to date" and was "not offered" the Pneumococcal Vaccination.</p> <p>On 3/22/18 at 5:30 PM, the Infection Control Nurse provided Resident #6's Pneumococcal Vaccine Consent Form, dated 1/25/18, which documented Resident #6 gave the facility permission to administer the vaccine.</p> <p>Resident #6's January 2018 MAR and TAR did not have documentation that Resident #6 received the Pneumococcal Vaccine.</p> <p>On 3/22/18 at 5:40 PM, the Infection Control Nurse was unable to provide documentation Resident #6 received the Pneumococcal Vaccine.</p> <p>The facility's Admission Check List for Resident #6 documented, "List must be completed within 24 hours of admission. Please initial once item is completed. When list is finished, place in DNS box." The list included, "Complete and have resident sign the Flu and Pneumovac consent sheets whether they consent or decline. If they would like the immunization, write the order and put in the doctor's box to be signed."</p> <p>4. Resident #19 was admitted to facility on 1/29/18 with multiple diagnoses including cognitive communication deficit.</p> <p>An admission MDS assessment, dated 2/5/18, documented Resident #19 was moderately cognitively impaired and required extensive assistance of 1 to 2 staff members for cares.</p>	F 842			

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F 842	<p>Continued From page 91</p> <p>On 3/21/18 at 7:30 AM, the DNS provided a copy of a fully completed Neurological Assessment related to Resident #19's unwitnessed fall which was documented on an Incident Report dated 3/15/18.</p> <p>On 3/23/18 at 9:30 AM, Resident #19's clinical record contained a scanned incomplete Neurological Assessment, dated 3/19/18, related to an unwitnessed fall noted on an Incident Report dated 3/15/18. The 3/15/18 neurological assessment was missing 6 of 24 entries and 2 of 24 entries were incomplete, lacking documentation of Resident #19's motor response, speech, level of consciousness, eye response, and pupil response. There was no reason given for the missing or incomplete entries.</p> <p>On 3/23/18 at 9:45 AM, the DNS stated she was unsure why the Neurological Assessments were inconsistent with each other. She could not explain why the copy provided to the surveyors was complete and the scanned 3/19/18 copy in Resident #19's clinical record was incomplete.</p> <p>On 3/23/18 at 10:00 AM, the Medical Records Director stated she scanned Resident #19's Neurological Assessment on 3/19/18 with a pile of other documents for other residents. The Medical Records Director stated she would later go back and stamp the documented scanned in with a date, and the date stamped on Resident #19's Neurological Assessment was 3/21/18. The Medical Records Director stated she was unable to recall if the document was completed or not when it was originally scanned in on 3/19/18.</p>	F 842			

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F 842	Continued From page 92 On 3/23/18 at 10:20 AM, the DNS was unable to explain how the neurological assessment was completed for Resident #19. The DNS was unable to identify the nurse's signature on the assessment.	F 842			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining	F 849		4/27/18	

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F 849	Continued From page 93 the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the	F 849			

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F 849	<p>Continued From page 94</p> <p>terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is</p>	F 849			

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F 849	Continued From page 95 responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F 849			

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F 849	<p>Continued From page 96</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to coordinate with the hospice provider to ensure a resident's needs were met. This was true for 1 of 2 residents (#16) sampled for hospice care. Lack of communication and coordination created the potential for Resident #16 to receive inadequate care. Findings include:</p> <p>Resident #16 was admitted to the facility on 1/16/18 with diagnoses which included dementia, repeat falls, and fractured femur.</p> <p>A significant change MDS assessment, dated 2/19/18, documented Resident #16 had a moderate cognitive impairment and documented she did not experience constipation. The MDS documented Resident #16 required extensive assistance of one to two staff members for all cares.</p> <p>Resident #16's 2/13/18 hospice agency and facility Care Coordination form documented the hospice agency and the facility would develop a joint care plan and coordinate care and services.</p> <p>Resident #16's physician orders, dated 1/26/18, documented an order for hospice services.</p>	F 849	<p><b>CORRECTIVE ACTION FOR THOSE AFFECTED:</b> Resident #16-No longer resides in the facility.</p> <p><b>OTHERS WITH THE POTENTIAL TO BE AFFECTED:</b> Other residents that are residing in the facility and receiving hospice services have the potential to be affected. No other residents are currently receiving hospice services.</p> <p><b>SYSTEMIC CHANGES:</b> Hospice company on 4/12/18 has provided a notebook book that includes contact information for the staff to reference and lists what tasks the Hospice will provide, and when/how to contact the Hospice company. DNS and LSW were in serviced on 4/13/18 that all future hospice companies nurse will need to meet with facility staff 1:1 on day of admit to co-ordinate services, and delineation of tasks, and to provide a care plan that clearly designates what services they will be providing and have contact information for</p>		

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F 849	<p>Continued From page 97</p> <p>An undated care plan, documented Resident #16 had a terminal diagnosis related to Alzheimer's disease. The care plan documented the facility would cooperate with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. The care plan documented nursing staff would provide comfort to Resident #16.</p> <p>a. An undated care plan documented Resident #16 had an altered elimination and bladder function related to activity intolerance, confusion, dementia, and impaired mobility. The care plan documented staff were to administer bowel medications as ordered.</p> <p>Resident #16's physician's orders included:            * Milk of Magnesia- 30 cc if no bowel movement in three days.            * If no results: then provide a 10 mg Bisacodyl suppository - if no bowel movement within four days;            * If no results: then provide a Fleet enema - one enema if no bowel movement within five days; and            * If no bowel movement within six days contact the provided, ordered 12/1/17.</p> <p>Resident #16's Bowel Movement Records, dated 2/20/18 through 3/21/18, documented Resident #16's bowel movements. Resident #16's bowel records documented she did not have a bowel movement between 3/13/18 and 3/20/18 (8 days).</p> <p>Resident #16's clinical record did not contain a note documenting the hospice provider was</p>	F 849	<p>the staff, on the day of admit. LSW was in serviced on 4/13/18 to inform hospice company of the requirement to attend facility care plan conferences to coordinate the plan of care. Administrator will audit all new hospice residents weekly x4 weeks, then random hospice resident monthly x 3 months to ensure that hospice notebook is received and joint care plan meeting scheduled.</p> <p><b>ONGOING COMPLIANCE:</b>            Administrator will report the results of the notebook audit and joint care plan meeting, in the monthly QA meeting for review and suggestions. Administrator and LSW is responsible for ongoing monitoring and compliance.</p>		

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F 849	<p>Continued From page 98</p> <p>notified when she went six, seven, or eight days without a bowel movement between 3/17/18 through 3/19/18.</p> <p>A 3/21/18 Health Status progress note documented, Resident #16 had not had a bowel movement for ten days, a suppository was administered and hospice was notified.</p> <p>b. An undated care plan, documented Resident #16 would receive two showers a week on Mondays and Thursdays. The care plan did not document who was responsible for providing showers.</p> <p>Resident #16's Facility Bathing Records for 2/28/18 through 3/21/18 documented Resident #16's showers. The bathing records documented Resident #16 was to receive a shower on Monday and Thursday evenings and PRN. Resident #16 did not receive a shower between 3/7/18 and 3/12/18 (6 days).</p> <p>Resident #16's Hospice Bathing Records between 2/16/18 through 3/20/18 documented Resident #16's showers. The bathing records did not include a shower between 3/7/18 and 3/12/18 (6 days).</p> <p>The facility and the hospice bathing records both documented Resident #16 was bathed on 3/2/18, 3/6/18, 3/13/18, and 3/16/18, which meant Resident #16 was bathed twice on those days. There was no documentation of why a second bath was given, needed, or if it was requested.</p> <p>Resident #16's record did not contain a comprehensive, integrated plan of care that</p>	F 849			

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F 849	Continued From page 99 reflected the services needed and who was to provide those services such as bathing requirements and when to contact hospice for changes to Resident #16's status.  On 3/20/18 at 11:12 AM, LPN #3 stated she was not sure what the delineation of duties were, and based on Resident #16's care plan it was difficult to identify who provided Resident #16's cares such as bathing and when to notify hospice of changes. LPN #3 stated the staff in the facility provided cares and documented the cares they provided and not what hospice provided.  On 3/20/18 at 4:12 PM, the DNS stated the facility staff provided care of the residents such as showers and hospice did as well. The DNS stated the facility staff documented cares they provided and not cares provided by the hospice staff. The DNS was unable to provide answers for why the shower was not completed for Resident #16 for 6 days by either the facility or hospice. The DNS stated the communication between the hospice provider was not always the best and it was something the facility was working on.	F 849			
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 867	CORRECTIVE ACTION FOR THOSE	4/27/18	

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F 867	<p>Continued From page 100</p> <p>interview, and review of clinical records and policies and procedures, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to take actions to identify and resolve systemic problems. These failed practices directly impacted 20 of 20 sample residents (#1-#12, #14, #16, #19, #21-#23, #75, and #121) and had the potential to impact the other 3 residents residing in the facility. The deficient practice resulted in insufficient direction and control necessary to ensure residents' rights were maintained and residents' quality of life and quality of care needs were met. The lack of supervision resulted in harm to Resident #11 (fractured rib) and Resident #16 (head laceration).The lack of an effective QAA process also placed residents at risk of harm due to inadequate care and services. Findings include:</p> <p>a. The QAA committee failed to provide sufficient monitoring and oversight to sustain regulatory compliance as evidenced by the following citations:</p> <ul style="list-style-type: none"> <li>* Please refer to F600 as it pertains to the facility's failure to ensure residents were free from abuse and neglect.</li> <li>* Please refer to F604 as it pertains to the facility's failure to ensure residents were free from physical restraints.</li> <li>* Please refer to F606 as it pertains to the facility's failure to ensure employee reference checks were completed prior to employment dates.</li> <li>* Please refer to F607 as it pertains to the</li> </ul>	F 867	<p><b>AFFECTED:</b> Residents #1-#12, #14, #16,#19, #21-#23, #75, and #121- Please refer to Plan of correction for F600, F604, F607, F609, F610, F684, F689.</p> <p><b>OTHERS POTENTIALLY AFFECTED:</b> Residents residing in the SNF have the potential to be affected. Please refer to plan of correction for tags F600,F604, F607, F609, F610, F684, F689.</p> <p><b>SYSTEMIC CHANGES:</b> QAA members were re educated by the Administrator, 4/24/18, on required audits and reporting the results of audits, and steps taken to resolve concerns to QAA team. QAA team was educated on root cause analysis and how to identify systemic concerns. QAA meeting will include audits from IDT for the Ftags listed above, corrective actions taken to resolve any concerns, and other topics of systemic concern. QAA members will be required to report the following month on the status of the areas the audits showed needed improvement, and what corrective changes had been made. Team will discuss if they were effective and or if they need further revision.</p> <p><b>ONGOING COMPLIANCE:</b> In the monthly QAA meeting, the</p>		

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F 867	<p>Continued From page 101</p> <p>facility's failure to ensure the current abuse and neglect policy was updated with the current regulations and was followed.</p> <p>* Please refer to F609 as it pertains to the facility's failure to ensure injuries of unknown sources were reported to the State Survey Agency.</p> <p>* Please refer to F610 as it pertains to the facility's failure to ensure injuries of unknown sources were investigated as potential abuse and /or neglect.</p> <p>* Please refer to F684 as it pertains to the facility's failure to ensure services provided met professional standards.</p> <p>* Please refer to F689 as it pertains to the facility's failure to ensure residents were free of accidents and were provided adequate supervision. Lack of supervision resulted in harm to Resident #11 when staff failed to provide adequate supervision while the resident was in his room and he fell and sustained a rib fracture. Resident #16 was harmed when she sustained a head laceration in her room falling from her bed.</p> <p>* Please refer to F700 as it pertains to the facility's failure to ensure residents were thoroughly assessed for the risk of entrapment prior to the placement of bed rails.</p> <p>* Please refer to F835 as it pertains to the facility's failure to ensure effective administration.</p> <p>* Please refer to F880 as it pertains to the facility's failure to ensure staff were trained to</p>	F 867	<p>Administrator will report the previous months action plans and help determine if area of concern is resolved, with the steps taken, or if additional systemic changes are needed.</p> <p>Administrator and Executive Director are responsible for ongoing monitoring and compliance.</p>		

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F 867	Continued From page 102 complete residents' laundry in a manner to avoid cross-contamination.  * Please refer to F883 as it pertains to the facility's failure to ensure implementation of an immunization tracking system for pneumococcal vaccines.  * Please refer to F909 as it pertains to the facility's failure to ensure maintenance conducted regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment.  b. On 3/23/18 at 3:31 PM, the Administrator stated the QAA committee met monthly and the QAA committee performed audits and projects on various topics. The Administrator stated the QAA committee had not recently identified abuse, physical restraints, accurate clinical records, maintenance inspections, falls, neurological assessments, and standards of practice concerns identified during the current 3/23/18 survey, as resident care concerns.	F 867			
F 880 SS=F	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.	F 880		4/27/18	

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F 880	<p>Continued From page 103</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 880			

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F 880	<p>Continued From page 104</p> <p>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.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 observation, staff interview, and policy review, it was determined the facility failed to ensure staff handled, processed, and transported linens for all residents to prevent the spread of infection. This failure created the potential for the residents to develop infection from cross contamination. Findings include:</p> <p>The facility's policy for laundry, dated 7/27/15, documented, "It is the standard to deliver all clean linens in a timely manner as to adequately stock clean linens for Resident use and to prevent the spread of infections and minimize microbial dissemination into the environment."</p> <p>The facility's policy did not include step by step directions how nursing staff was to handle, process, and transport linens to prevent the spread of infection from cross contamination.</p>	F 880	<p><b>CORRECTIVE ACTION FOR THOSE AFFECTED:</b> No residents were found to be effected</p> <p><b>THOSE POTENTIALLY AFFECTED</b> Residents residing in the SNF and have personal laundry washed by the staff have the potential to be affected On 3/22/18 the yellow clean linen cart was replaced in Redwood Village. On 3/22/18 a trash can was provided in each SNF on the dirty side of the laundry room. On 3/22/18 Waterproof universal apron, was placed in both SNF's in the laundry room on the clean side.</p> <p><b>SYSTEMIC CHANGES:</b></p>		

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F 880	<p>Continued From page 105</p> <p>On 3/20/18 at 3:30 PM, CNA #3 stated the CNAs were responsible to do residents' personal clothing laundry. CNA #3 was observed wearing gloves when taking bagged dirty laundry to be washed. CNA #3 stated the facility did not provide gowns to prevent cross contamination. CNA #3 wore gloves to remove the wet, clean clothes to place in the dryer. CNA #3 stated if there was a clean cart, she would have put the wet clean clothes in the cart to transport to the dryer to prevent cross contamination. CNA #3 would wear gloves to remove the residents' clothes out of the dryer and place on the table to fold. CNA #3 stated she was not trained on laundry procedures.</p> <p>On 3/20/18 at 3:50 PM, CNA #4 was observed wearing gloves and walking with arms straight out in front of her from the washer to the dryer, one item at a time, to prevent dropping the wet clean clothes on the floor or cross contamination. CNA #4 stated she had not been trained on laundry procedures.</p> <p>There was not a clean cart to transport wet clean laundry to the dryers in the Redwood building.</p> <p>On 3/21/18 at 1:30 PM, CNA #2 was observed wearing gloves to place dirty laundry into the washer. CNA #2 stated she should have been wearing a gown, but there was not one to put on. CNA #2 stated, she had not been trained on laundry procedures.</p> <p>On 3/21/18 at 3:10 PM, the Housekeeping Manager stated the expectations for the nursing staff on how to complete residents' personal</p>	F 880	<p>On 4/19/18 step by step procedures for handling, transporting, and processing personal laundry were posted and mounted in the laundry rooms. By 4/19/18, Nursing staff and housekeeping staff were re in-serviced on handling, transporting, and processing resident specific laundry procedures to prevent potential cross contamination issues. Starting 3/23/18, Housekeeping supervisor will randomly audit staff performing the personal laundry process and ensuring all necessary equipment is present, and proper steps followed 3x a week a 4 weeks, then weekly x 4 weeks then Monthly there after. Concerns or non compliance will be reported to the facility infection control specialist immediately.</p> <p><b>ON GOING COMPLIANCE:</b> Results of the housekeeping audits will be reviewed in the monthly QAPI meeting. Housekeeping supervisor and Infection control specialist will be responsible for ongoing compliance.</p>		

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F 880	<p>Continued From page 106</p> <p>laundry were as follows. The Housekeeping Manager stated the dirty clothes should be stored in bags in a gray cart. She stated the staff should wear a gown, gloves, and a mask to transport dirty laundry to the washer, then remove gloves, gown, and mask into a small garbage can next to the washer, then remove the bag into a bigger garbage can to be disposed of later, and lastly wash hands. The Housekeeping Manager stated after the clothes were cleaned, the nursing staff should apply gown, gloves, and mask and place in yellow clean cart to transport to the dryer. The Housekeeping Manager stated after the clothes were placed into the dryer, the nursing staff should remove gown, gloves, mask next to garbage can by the dryer, then wash hands. The Housekeeping Manager stated after the clothes were dry, the nursing staff should wear gown and gloves to fold clothes.</p> <p>On 3/21/18 at 3:45 PM, the Housekeeping Manager stated the Maple building did not have masks for the staff to wear and there was one reusable apron that was folded up in the drawer and appears it was never used. She stated in the Redwood building there was not a yellow clean cart to transport the clean clothes to the dryer and to be folded.</p> <p>On 3/21/18 at 4:00 PM, the Housekeeping Manager stated the nursing staff were not trained in laundry procedures only laundry staff. The Housekeeping Manager stated she had not observed the nursing staff competency for residents' personal laundry. The Housekeeping Manager stated she needed to have a nursing staff inservice on policy and procedures for residents' personal laundry.</p>	F 880			

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F 883 SS=F	<p>Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)</p> <p>§483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <ul style="list-style-type: none"> <li>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</li> <li>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</li> <li>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</li> <li>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following: <ul style="list-style-type: none"> <li>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</li> <li>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</li> </ul> </li> </ul> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <ul style="list-style-type: none"> <li>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</li> <li>(ii) Each resident is offered a pneumococcal</li> </ul>	F 883		4/27/18	

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F 883	<p>Continued From page 108</p> <p>immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, the facility failed to implement an immunization program to ensure residents' pneumococcal vaccines were being tracked with receiving or declining the pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later. This was true of 4 of 5 residents (#2, #6, #9, and #19) reviewed for vaccination. These failed practices represented a systemic failure which increased residents risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage. Findings include:</p> <p>The CDC website, updated 11/22/16, documented recommendations for pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older:</p>	F 883	<p><b>CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED:</b></p> <p>Resident#2,- Received PCV13 on 4/15/18 Resident #6, Received PCV13 on 4/15/18 Resident #9, Received PCV13 on 4/12/18 Resident #19, Received PCV13 on 4/12/18</p> <p><b>OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED:</b></p> <p>Current residents residing in the skilled facility have the potential to be affected. On, 4/20/18 an audit was completed by DNS or designee of current residents to ensure they have received receiving pneumococcal immunization, initial and/or second dose of PPSV23.</p>		

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F 883	<p>Continued From page 109</p> <p>* "Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23."</p> <p>* "If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23."</p> <p>The facility's policy for Pneumococcal vaccine, undated, documented, "The type of pneumococcal vaccine (PCV13, PPSV23/PPSV) offered will depend upon recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations." The policy did not document a tracking system for all immunizations.</p> <p>The facility's Pneumococcal Polysaccharide Vaccine (PPSV23) Consent Form documented, "Administer PCV13 first then in 1 year administer PPSV23 to adults 65 and older who have never received a pneumococcal vaccine. A second dose is recommended for adults 65 years or older if the first dose was received prior to age 65. A second dose of PPSV23 vaccine should be administered 1 year from the PCV13 dose and 5 years from the first PPSV23 dose." The resident or responsible party was to mark on the consent form as follows:</p> <p>* "I have received the information regarding pneumococcal infections and have been educated on the benefits and risks associated with the pneumococcal polysaccharide vaccine (PPSV23). I hereby give permission and request</p>	F 883	<p><b>SYSTEMIC CHANGES TO PREVENT REACCURANCE:</b> on 4/16/18 DNS revised electronic documentation program to flag staff of when the pneumococcal vaccine is due to be administered. On 4/12/18 staff were re inserviced on the documentation of vaccine consents or those declining of immunizations upon admission. LS re in-serviced 4/12/18 on completing and documenting immunizations tasks in the MAR, and also on the immunization sheets. On 4/12/18 staff were inserviced on PCV13 and PPSV23, and the need for a second dose one year later of the PCV13 if 65 years or older. Starting 4/16/18 the DNS or designee, will audit all new admissions daily x 2 weeks, then 2 new admissions weekly x 4 weeks, then 2 new admissions monthly x3 months to ensure immunizations are administered and documented timely. MDS nurse or designee will audit immunization records of those residents that have an Annual MDS due, to ensure 2nd Pneumococcal vaccine has been consented or declined, and that there is documentation of which immunization given.</p> <p><b>ONGOING MONITORING AND COMPLIANCE:</b> Results of the DNS immunization audits will be reported and reviewed in the monthly QAPI meeting. In monthly QAPI meeting the MDS nurse</p>		

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F 883	<p>Continued From page 110</p> <p>the vaccine be administered to me or the person named for whom I am authorized to sign."</p> <p>* "I have received the information on pneumococcal infections and have been educated on the benefits and risks associated with the pneumococcal polysaccharide vaccine (PPSV23). I hereby decline my permission to receive the vaccine for A. Medical Contraindication or B. Personal Reason."</p> <p>1. Resident #6 was admitted to the facility on 1/24/18 with multiple diagnoses, including polyneuropathy and venous insufficiency.</p> <p>The admission MDS assessment, dated 2/2/18, documented Resident #6 was not "up to date" and was "not offered" the Pneumococcal Vaccination.</p> <p>Resident #6's January 2018 MAR and TAR did not have documentation that Resident #6 received the Pneumococcal Vaccine.</p> <p>On 3/22/18 at 5:30 PM, the Infection Control Nurse provided Resident #6's Pneumococcal Vaccine Consent Form, dated 1/25/18, documented Resident #6 gave the facility permission for the vaccine to be administered. The Infection Control Nurse was unable to provide documentation Resident #6 received the pneumococcal vaccine and which type of vaccine, the PCV13 vaccine or PPSV23 vaccine in his clinical record.</p> <p>2. Resident #2 was admitted to the facility on 4/18/16 with multiple diagnoses, including diabetes mellitus.</p>	F 883	<p>will report results of those residents requiring a yearly MDS and the completion and documentation of the immunizations in the medical file. DNS and MDS responsible for ongoing monitoring and compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 883	<p>Continued From page 111</p> <p>A quarterly MDS assessment, dated 12/18/17, documented Resident #2 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 3/22/18 at 5:30 PM, the Infection Control Nurse provided Resident #2's Pneumococcal Vaccine Consent Form, dated 4/19/16, which documented Resident #2 "already received" the vaccination. The consent form did not document if the vaccine was the PCV13 vaccine, the PPSV23 vaccine, or when Resident #2 was to receive the next vaccine.</p> <p>3. Resident #19 was admitted to the facility on 1/29/18 with multiple diagnoses, including coronary artery disease and hypertension.</p> <p>The admission MDS assessment, dated 2/5/18, documented Resident #19 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 3/22/18 at 5:45 PM, the Infection Control Nurse provided Resident #19's Pneumococcal Vaccine Consent Form, dated 1/29/18, documented Resident #19 "already received in 2017". The consent form did not document if the vaccine was the PCV13 vaccine, the PPSV23, or tracking documentation when Resident #19 was to receive the next vaccine.</p> <p>4. Resident #9 was admitted to the facility on 2/5/16 with multiple diagnoses, including cancer and Parkinson's Disease.</p> <p>An annual MDS assessment, dated 1/30/18, documented Resident #9 was "up to date" with the Pneumococcal Vaccination.</p>	F 883			

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F 883	Continued From page 112  On 3/22/18 at 5:50 PM, the Infection Control Nurse provided Resident #9's Pneumococcal Vaccine Consent Form, dated 2/6/16, documented Resident #9 "received one in 2013- no need another." The consent form did not document if the vaccine was the PCV13 vaccine, the PPSV23, or tracking documentation when Resident #19 was to receive the next vaccine.  On 3/22/18 at 6:00 PM, the Infection Control Nurse was unaware of the most current CDC recommendations for the Pneumococcal Vaccination PCV13 and PPSV23, which included tracking all the resident's receiving the pneumococcal vaccination PCV13 dose first, followed by the PPSV23 one year later.	F 883			