



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 4, 2018

Ronald Barnes, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Mr. Barnes:

On **August 10, 2018**, a survey was conducted at Prestige Care & Rehabilitation - The Orchards 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.

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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 **September 14, 2018**. Failure to submit an acceptable PoC by **September 14, 2018**, may result in the imposition of civil monetary penalties by **October 7, 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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

Civil Monetary Penalty

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Denial of payment for new admissions effective November 11, 2018

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 10, 2019**, if substantial compliance is not achieved by that time.

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.

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:

<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 **September 14, 2018**. If your request for informal dispute resolution is received after **September 14, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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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,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style with a large, prominent 'D' at the beginning.

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

dr/lj
Enclosures

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

PRINTED: 09/21/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2018
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501
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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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from August 6, 2018 through August 10, 2018.</p> <p>The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Presie Billington, RN Teri Hobson, RN</p> <p>Survey Abbreviations:</p> <p>ADL = Activities of Daily Living AROM = Active Range of Motion BID = Twice a day BUE = Bilateral Upper Extremities C&S = Culture and Sensitivity (A culture is a test to find germs, such as bacteria or a fungus, that can cause infection. A sensitivity test checks to see what kind of medicine, such as an antibiotic, will work best to treat the illness or infection.) cm = Centimeter CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing Services I&A = Incident and Accident L = Left LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record mcg = micrograms MDRO = Multiple Drug Resistant Organism MDS = Minimum Data Set assessment mg = milligrams ml = milliliter POST = Physician Orders for Scope of Treatment,</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/14/2018
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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 000	Continued From page 1 PROM= Passive Range of Motion PRN = as needed RCM = Resident Care Manager RNCM = Registered Nurse Care Manager ROM = Range of Motion RSN = Regional Support Nurse SDC = Staff Development Coordinator TAR = Treatment Administration Record UA = Urinalysis UTI = Urinary Tract Infection X = times	F 000			
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		9/20/18	

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F 561	<p>Continued From page 2</p> <p>participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, record review, resident and staff interview, it was determined the facility failed to allow residents to make choices regarding their smoking schedule. This was true for 1 of 4 (#15) residents sampled for resident rights. This deficient practice created psychosocial harm for Resident #15 when she felt discriminated against for not being allowed to smoke with other residents and her choices were not honored. Findings include:</p> <p>The Smoking policy, revised June 2018, documented all residents who wished to smoke would be assessed and evaluated for safety. The policy documented "An established set of criteria will be used to evaluate safety risk. Residents who do not meet the established criteria to smoke independently will be provided assistance/supervision during all smoking activities."</p> <p>Resident #15 was admitted to the facility on 2/16/18 with diagnoses which included, multiple sclerosis, quadriplegia, and nicotine dependence.</p> <p>A quarterly MDS assessment, dated 5/24/18, documented Resident #15 was cognitively intact. The MDS assessment documented Resident #15 was totally dependent or required extensive assistance of one to two staff members for all cares.</p>	F 561	<p>F561</p> <ol style="list-style-type: none"> 1. Resident #15 is being allowed to smoke with other residents and her choices are being honored. A smoking device was purchased to aide in her smoking safely. 2. An audit of current resident who wish to smoke was conducted to ensure they do not feel discriminated against in their smoking preference. No other residents felt discriminated against. 3. Re-education provided to staff on the smoking policy and to ensure if a resident needs supervision or assistance we need to investigate all options available, so they do not feel discriminated against. Education provided by the DON and/or Administrator/designee by 9/20/18 4. Social Services Dept. will perform weekly audits of 3 random residents who smoke to ensure they do not feel discriminated against. Audits will be weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month. 5. Administrator/designee will report the results of these audits to the facility 		

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F 561	<p>Continued From page 3</p> <p>The care plan area addressing Resident #15's smoking, initiated 7/16/18, documented her family members were the "only authorized individuals to assist with smoking."</p> <p>Smoking Evaluations and Care Conferences notes documented the following:</p> <p>* 4/27/18 - Care Conference Note - "Resident requested care conference to discuss smoking concerns. Resident voices concerns of wanting to smoke. Resident states that she feels she has been discriminated against D/T [due to] being unable to smoke. RNCM states that D/T the fact she is unable to hold her cigarette it is not safe for her to smoke... [RSN] stated that family ONLY can administer cigarettes after a smoking assessment has been done and care plan it. Facility cannot assist with smoking D/T her inability to hold a cigarette."</p> <p>* 4/27/18 and 6/11/18 - Smoking Evaluations - The evaluations documented Resident #15 was unable to light, hold, or extinguish her smoking material and she required supervision with smoking. The evaluations documented the following summary, "[Resident #15] will be supervised smoker with family, staff are not to supervise her smoking. [Resident #15] and her family are aware of the risks of her smoking and they accept responsibility as IDT (Interdisciplinary Team) does not feel resident is safe to smoke with staff supervision. Resident is to wear a smoking apron..."</p> <p>Resident #15's unsigned consent, current Smoking Policy, dated June 2018, documented the Resident #15 was unable to sign the</p>	F 561	<p>monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 561	<p>Continued From page 4 document and the LSW had signed the consent on 8/9/18.</p> <p>On 8/6/18 at 3:20 PM, a facility sign was on a wall next to the exit door by the smoking area. The sign documented smoking times were 7:00 AM, 9:30 AM, 11:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, and 8:30 PM.</p> <p>On 8/6/18 at 4:14 PM, Resident #15 stated she was a smoker when she could and the facility stopped her from smoking. Resident #15 stated she felt "discriminated" against because of her condition of being a quadriplegic. Resident #15 stated smoking was one of the last joys in life where she enjoyed socialization with other people, and she felt she was missing this by being "segregated" in her room and in bed all day. Resident #15 stated the facility told her the staff would not assist her smoking because of insurance reasons which she did not understand. Resident #15 stated she could hold the cigarette in her mouth and she was willing to wear a smoking apron. Resident #15 stated her family was responsible for assisting her with smoking and they did not always visit daily. Resident #15 stated she wanted the option to smoke at minimum 1-2 times a day with other residents. Resident #15 stated the only way the facility would let her smoke was to agree with her family assisting her even if it did not make her happy.</p> <p>On 8/7/18 at 9:57 AM, Resident #15 was observed in the smoking area wearing a smoking apron and a family member accompanied her. The family member was sitting in a chair next to Resident #15 talking with her and another resident with his arm crossed in his lap. Resident</p>	F 561			

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F 561	<p>Continued From page 5</p> <p>#15 had a cigarette in her mouth and her right arm was positioned on top of the smoking apron. The ash cup was observed on the table next to Resident #15.</p> <p>On 8/9/18 at 10:30 AM, the Business Office Manager stated she went over the smoking policy with residents on admit and informed residents that they had to be assessed to as supervised or independent smokers. The Business Office Manager stated she had residents document that they understood the smoking policy.</p> <p>On 8/9/18 at 11:18 AM, RCM #2 stated Resident #15 was not able to smoke independently and she required 1:1 supervision. RCM #2 stated staff would be required to hold the ash cup under the cigarette for the duration of the cigarette. RCM #2 stated currently there was only one staff member assigned to monitor all residents during the smoke breaks and she would require 1:1. RCM #2 stated the family had wanted to take the responsibility for providing this 1:1 supervision. RCM #2 was unable to answer if the facility was understaffed and unable to provide the 1:1 supervision. RCM #2 stated Resident #15's family should be holding Resident#15's ash cup up for the duration of her cigarette and if it was not done, this was not adequate supervision.</p> <p>On 8/9/18 at 11:27 AM, the DNS stated Resident #15's family agreed during a care plan meeting to supervise her during smoking. The DNS stated Resident #15 should be allowed to smoke during the regular supervised times and the family times should be a extra time in addition to this. RCM #3 stated Resident #15 was allowed to smoke only</p>	F 561			

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F 561	Continued From page 6 when her family was present. The DNS stated a resident should not feel discriminated against. The DNS stated Resident #15 should be allowed to visit with other residents during the smoking breaks. The DNS stated the facility had staff to assist Resident #15 1:1 during smoke breaks in addition to the scheduled personnel assigned. The RSN stated the facility would complete a new smoking evaluation for Resident #15. The DNS stated they could provide assistance for her to smoke during the supervised smoke breaks. On 8/9/18 at 1:34 PM, when asked why it was determined facility staff could not safety assist Resident #15 to smoke, the DNS stated the staff was competent to monitor her safety while smoking. The DNS stated she was not sure of the reason Resident #15's smoking evaluation stated staff could not safely assist her. The DNS stated staff were still working on reassessing Resident #15.	F 561			
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and	F 572		9/20/18	

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F 572	<p>Continued From page 7</p> <p>responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of the facility's Admission Agreement, and staff interview, it was determined the facility failed to ensure the Admission Packet fully informed 15 of 15 (#5, #8, #9, #13, #14, #15, #17, #18, #21, #28, #33, #41, #45, #50, and #204) sampled residents residing in the facility and the other 42 residents who lived in the facility, prior to, or at the time of admission, of their rights in the facility. This deficient practice created the potential for residents' rights to be violated without the residents' knowledge.</p> <p>Findings include:</p> <p>The facility's Admission Agreement, undated, did not include all residents' rights, as follows:</p> <p>a. CFR 483.10(e)(4)-(6) [F559] states residents have, "...the right to share a room with his or her roommate of choice when practicable..."</p> <p>The facility's Admission Agreement did not document this resident right.</p> <p>b. CFR 483.10(f)(9)(i)-(iv) [F566] states, "The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement</p>	F 572	<p>F572</p> <ol style="list-style-type: none"> 1. Resident #5, #8, #9, #13, #14, #15, #17, #18, #21, #28, #33, #41, #45, #50, and # 204, have received a copy of the updated resident rights. If the resident had cognitive deficits their POA was provided a written copy. 2. Other current residents received a copy of the updated resident rights from the business office. If the resident had cognitive deficits their POA/guardian was provided a written copy. 3. The admission packet has been updated to include all the updated resident rights. The resident rights have been updated to include: <ol style="list-style-type: none"> a. Residents have the right to share a room with his or her roommate of choice when practicable b. The plan specifies the nature of the services performed and whatever the services are voluntary or paid, compensation for paid services is at or above prevailing rates and the resident agrees to the work arrangement described in the plan of care, 		

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F 572	<p>Continued From page 8 described in the plan of care."</p> <p>The facility's Admission Agreement did not document this resident right.</p> <p>c. 42 CFR 483.10(g)(2) [F573] states, "The facility must provide the resident with access to personal and medical records....within 24 hours and upon request and must allow the resident to obtain a copy of the records...upon request and 2 working days advanced notice to the facility."</p> <p>The facility's Admission Agreement documented the facility would "usually" provide residents copies of their medical records "within 30 days."</p> <p>d. CFR 483.10(g)(6) - (9) [F576] states, "The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research..."</p> <p>The facility's Admission Agreement did not document this resident right.</p> <p>e. CFR 483.10(g)(10)(11) [F577] states, "The facility must...have reports with respect to any surveys, certifications, and complaints investigations made...during the 3 preceding years...and post notice of the availability of such reports in areas...prominent and accessible..."</p> <p>The facility's Admission Agreement did not document residents and their guardians had the right to examine the facility's most recent survey results.</p> <p>f. Transfer and Discharge:</p>	F 572	<p>c. The facility you must provide the resident with access to personal and medical records within 24 hours and upon request and must allow the resident to obtain a copy of the records upon request and 2 working days advanced notice to the facility.</p> <p>d. The facility must have reports with respect to any surveys, certifications, and complaints investigations made during the 3 preceding years and post notice of the availability of such reports in areas prominent and accessible.</p> <p>e. Transfer and discharge: States residents have, "the right to refuse transfers to another room in the facility if the purpose is to relocate solely for the convenience of staff.</p> <p>f. States "the facility may not transfer or discharge the resident while the appeal is pending.</p> <p>g. The facility must send a copy of the notice to a representative of the office of the long-term care ombudsman.</p> <p>New admissions to the facility are being informed in writing of the rights of the residents. Business Office Manager has been educated by the Administrator/designee by 9/20/2018</p> <p>4. Administrator/designee will audit 2 random new admissions weekly to ensure the resident received the updated resident rights. Audits will be weekly x 4 weeks, then bi-weekly x 1 month, then monthly x 1 month.</p>		

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F 572	Continued From page 9 * CFR 483.10(e)(7) (i)-(iii)(8) [F560] states, residents have, "the right to refuse transfers to another room in the facility, if the purpose...is to relocate...solely for the convenience of staff..." * CFR 483.15(c)(1) [F622] states, "The facility may not transfer or discharge the resident while the appeal [to the transfer or discharge] is pending..." * CFR 483.15(c)(3)-(6)(8) [F623] states, "The facility must... send a copy of the notice to a representative of the Office of the Long-Term Care Ombudsman." The facility's Admission Agreement documented residents were transferred and discharged only in accordance with transfer or discharge rules. The facility's Admission Agreement documented if residents were delinquent on payments the residents was subject to transfer from the facility upon "legal required notice." The Admission Agreement did not specifically identify residents' transfer and discharge rights. On 8/9/18 at 10:16 AM, the Administrator stated the facility's admission packet had not been updated since he was hired as administrator. He said he could see where the admission packet did not inform the residents of their rights.	F 572	5. Administrator/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		9/20/18	

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F 578	<p>Continued From page 10 to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 578			

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F 578	<p>Continued From page 11</p> <p>by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a) residents were provided information regarding advance directives upon admission and if necessary, assisted to formulate advance directives, and b) the residents' medical records included documentation of this process, a copy of the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 10 of 15 residents (#8, #9, #14, #15, #18, #28, #33, #41, #45 and #50) whose records were reviewed for advance directives. These failures increased the risk of residents not having their decisions documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The facility's Advance Directives policy, revised 6/2018, documented:</p> <p>*An Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. An advance directive is not a medical order for care, but should be taken into account when orders for care are given.</p> <p>*During the admission process, the facility will identify if the resident has an advance directive or medical orders related to life sustaining treatment. If the resident does, a copy will be requested and kept in the resident's medical chart, accessible to the physician and care staff.</p>	F 578	<p>F578</p> <ol style="list-style-type: none"> 1. Resident #41 is no longer a resident of the facility. Resident's #8, #9, #14, #15, #18, #28, #33, #45, and #50 have received information on advance directives. The residents electronic record now includes either a copy of the residents advance directive or documentation of their decision not to formulate the advanced directive. 2. Other current residents were audited for documentation of an advance directive. If the resident did not have documentation of an advance directive they were provided information on advanced directives. The residents electronic record now includes either a copy of the residents advanced directive or documentation of their decision not to formulate the advance directive. 3. Re-education provided Social Service Director and Resident Care Managers on the Advance Directive Policy and Procedure. On admission a resident will receive information on advanced directives and if necessary, assisted to formulate advance directive, and the residents' medical records to include documentation of this process, a copy of the residents advance directives or documentation of their decision not to formulate advance directives. Education 		

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F 578	<p>Continued From page 12</p> <p>*During the admission process, if it is determined that the resident does not have an advance directive and wishes to formulate one, assistance will be provided, using the state specific advance directive forms. This will be documented in the medical chart along with a copy of the advance directive.</p> <p>*During the admission process, the facility will provide a copy of this policy that governs the exercise of these rights.</p> <p>The above policy was not followed.</p> <p>1. The records of Residents #8, #9, #14, #15, #18, #28, #33, #41, #45 and #50, were reviewed. None of the residents' records included advanced directives or documentation they declined establishing advance directives. The residents' records also lacked documentation that information regarding advanced directives and the facility's Advance Directives policy were provided to the residents and/or their representatives.</p> <p>On 8/8/18 at 11:55 AM, the DNS, together with the RSN, said she was aware the residents' records did not include documentation that information about advance directives was provided to the residents and/or their representatives. The DNS said they were adding advance directives information to the facility's admission packet and would discuss it with residents upon admission. The DNS and the RSN stated the facility was in the process of completing advanced directives for all residents in the facility or having the residents sign when</p>	F 578	<p>provided by DON and/or Administrator/designee by 9/20/18</p> <p>4. Administrator/designee will perform 3 random new admission audits to ensure the advance directive policy and procedure was followed. Audits will be weekly x 4 weeks, then monthly x 2 months.</p> <p>5. Administrator/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 578	Continued From page 13	F 578			
F 580 SS=D	they refused to establish advance directives. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		9/20/18	

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F 580	<p>Continued From page 14 update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure a resident's physician was notified of her increased pain and consistent refusal of medications and treatments. This was true for 1 of 1 (#41) resident reviewed for timely physician notification. This placed Resident #41 at risk of experiencing increased pain and unmanaged medical conditions. Findings include:</p> <p>Resident #41 was readmitted to the facility on 7/6/18, with diagnoses which included hypertension, chronic non-pressure ulcer of the lower leg, unspecified open wound to the right and left lower legs, chronic pain, cellulitis (potentially serious bacterial skin infection), and osteoarthritis.</p> <p>An admission MDS assessment, dated 7/13/18, documented Resident #41 had severe cognitive impairment. The MDS assessment documented she required extensive assistance from 1 to 2 staff members for all cares. The MDS</p>	F 580	<p>F580</p> <ol style="list-style-type: none"> 1. Resident #41 is no longer a resident of the facility. 2. Other current residents audited for consecutive refusal of medications and treatments. The resident's MD was notified of consecutive refusals of medications and/or treatments. Current residents were assessed for adequate pain control, if pain not controlled MD was notified with new orders if warranted. 3. Re-education provided to Licensed Nurses (LN's), and Resident Care Managers (RCM's). Education provided on when a resident is consecutively refusing medications and treatments the MD is to be notified. New behavior monitors put into place to monitor for refusals when a pattern of consecutive 		

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F 580	<p>Continued From page 15</p> <p>assessment documented she experienced frequent pain and her pain was rated at an 8 out of 10.</p> <p>The care plan area addressing Resident #41's pain, initiated 7/25/18, documented staff were to administer medications as ordered and anticipate Resident #41 for pain relief and respond to her complaints of pain.</p> <p>Resident #41's physician's orders included Norco 5-325 mg by mouth three times a day as needed for chronic pain, ordered 7/6/18.</p> <p>A Care Conference Report, dated 7/13/18, documented Resident #41 refused to get out of bed and she was admitted with multiple pressure ulcers and poor skin integrity.</p> <p>Resident #41's refusals interfered with her care as follows:</p> <p>* Resident #41's 7/9/18 through 8/8/18 MAR documented her Lisinopril (to treat high blood pressure) was not administered due to her refusals of the medication related to complaints of pain from 7/14/18 through 7/22/18, 7/27/18 through 7/29/18, 8/4/18, and 8/5/18.</p> <p>* Resident #41's 7/9/18 through 8/8/18 MAR documented her weight was not assessed related to complaints of pain with movement from 7/7/18 through 7/9/18, 7/11/18 through 7/16/18, 7/20/18 through 7/24/18, and 7/27/18 through 8/8/18.</p> <p>* Resident #41's 7/9/18 through 8/8/18 MAR documented her bordered foam dressing to the</p>	F 580	<p>refusals occur. Pain assessments have been implemented on residents q shift documented in the electronic medical administration record (EMAR). DON and/or Administrator/designee provided education by 9/20/18.</p> <p>4. RCM's/designee will audit 5 random residents weekly for adequate pain control, if pain is not controlled the MD was notified. SS/designee will audit 5 random residents weekly for consecutive refusals of medication and or treatments with MD notification and behavior monitors in place. Audits will be weekly x 4 weeks then bi-weekly x 1 month, and monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 580	<p>Continued From page 16</p> <p>mid and upper back, right ankle, and right shin was not changed due to Resident #41 refusing due to complaints of pain on 7/23/18, 7/28/18, 7/29/18, 8/1/18, 8/3/18, 8/4/18 and 8/6/18.</p> <p>Resident #41's 7/9/18 through 8/8/18 MAR documented her daily measurements of her bilateral ankles, bilateral calves, and bilateral insteps were not assessed due to Resident #41 refusing due to complaints of pain on 7/11/18, 7/12/18, 7/16/18, 7/17/18, 7/20/18 through 7/24/18, and 7/26/18 through 8/8/18.</p> <p>* Resident #41's 7/9/18 through 8/8/18 MAR documented staff were to apply skin moisturizer to her legs twice daily and it was not completed due to Resident #41 refusing due to complaints of pain on 7/13/18, 7/14/18 x 2, 7/15/18, 7/16/18 x 2, 7/17/18, 7/20/18 x 2, 7/21/18 x 2, 7/22/18 x 2, 7/23/18, 7/24/18, 7/27/18 x 2, 7/28/18 x 2, 7/29/18 x 2, 7/30/18, 7/31/18, 8/3/18 x 2, 8/4/18 x 2, 8/5/18 x 2, and 8/6/18.</p> <p>On 8/7/18 at 12:11 PM, Resident #41 stated she was not always provided pain medications prior to dressing changes and when she was not provided the medications she would refuse related to pain.</p> <p>On 8/8/18 at 5:45 PM, DNS stated the facility monitored residents for the first 72 hours for pain and then determined the residents pain control plan based on the 72 hour pain assessments. The DNS stated nurses should be monitoring residents for the effectiveness of the pain control plan and notify the physician if new pain presents. The DNS stated she was not aware of Resident #41's refusals of treatments and</p>	F 580			

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F 580	Continued From page 17 medications due to pain and she was not aware of her increased pain. Resident #41's clinical record did not contain documentation of refusals of cares on behavior monitoring flowsheets or in her care plan, or notification to the physician when she continually refused medications and treatments due to pain. The DNS stated the staff should have notified the physician about Resident #41's increased pain and increased refusals.	F 580			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		9/20/18	

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F 583	<p>Continued From page 18</p> <p>of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</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 a resident's privacy was maintained during a shower. This true for 1 of 15 residents (#28) observed for privacy. This failure in practice had the potential to cause psychosocial harm if the resident experienced feelings of embarrassment when his body was exposed to others unnecessarily. Findings include:</p> <p>Resident #28 was admitted to the facility 3/14/18 with diagnoses which included abnormalities of gait and mobility, cognitive communication deficit, and dementia with lewy bodies (abnormal proteins which attack brain tissue).</p> <p>An MDS assessment dated 6/21/18, documented Resident #28 was moderately cognitively impaired and he required one-person physical assistance with all ADL's.</p> <p>On 8/8/18 at 8:54 AM, Resident #28's incontinence brief was exposed to the main hall way, when the blanket around his waist caught on the wheel of his shower chair as CNA #9 rolled him down the hall to the shower room.</p> <p>On 8/8/18 at 9:03 AM, CNA #9 did not draw the</p>	F 583	<p>F583</p> <ol style="list-style-type: none"> 1. Resident #28 is receiving privacy during his shower. 2. Other current residents audited for privacy during showers. Privacy was provided. 3. Re-education provided to CNA's to ensure privacy is provided during showers. CNA's will attempt to dress and undress residents in their room if possible. A new privacy robe was purchased for residents who require to be transported to and from the shower undressed. Curtains to be pulled around the resident when providing personal cares. DON and/or Administrator/designee provided education by 9/20/18. 4. RCM/designee will audit 5 random residents for privacy provided during a resident's showers. Audits will be weekly x 4 weeks then bi-weekly x 2 months. 5. DNS/designee will report the results of 		

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F 583	Continued From page 19 shower curtain near the shower room exit door, thereby exposing Resident #28 twice when staff came in the door to the shower room. On 8/8/18 at 10:17 AM, CNA #9 stated she should have pulled the curtain to provide privacy for Resident #28 during the shower. CNA #9 stated she should have draped Resident #28 with the blanket like a tent, on the way to the shower room. On 8/8/18 at 5:04 PM, the DNS stated she expected the staff to cover a resident thoroughly to prevent exposure or leave their clothes on until they reached the shower. The DNS stated staff were expected to pull the shower curtain to provide privacy and prevent exposure to the hallway if the shower room door was opened.	F 583	these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.		
F 604 SS=D	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		9/20/18	

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F 604	<p>Continued From page 20 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, staff interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints by assessing bed and chair alarms and obtaining physicians orders for the alarms. This was true for 1 of 7 (#28) residents sampled for restraints. This failure in practice had the potential to cause psychosocial harm if the resident experienced feelings of being restricted in movement. Findings include:</p> <p>Resident #28 was admitted to the facility 3/14/18 with diagnoses which included COPD, dementia with lewy bodies (abnormal proteins which attack the brain tissue).</p> <p>An MDS assessment dated 6/21/18, documented Resident #28 was moderately cognitively impaired, required physical assistance with transfers, and bed and chair alarms were used daily. The MDS assessment did not include assessment of the alarms as potential restraints, including assessment of potential adverse</p>	F 604	<p>F604</p> <ol style="list-style-type: none"> 1. Resident #28 no longer requires alarms to his bed or w/c. 2. Other current residents were re-assessed for the use of bed and/or chair alarm. If warranted MD orders were obtained. 3. A new observation was created to include the following to be assessed for alarm use: Reason for alarm, Does the resident exhibit fear, anxiety or agitation related to the sound of the alarm, Does the resident demonstrate decreased mobility, Does the resident experience sleep disturbance due to the sound of the alarm, is there an infringement on their freedom of movement, fear of moving will set the alarm off, is there an infringement on the resident dignity and privacy related 		

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F 604	<p>Continued From page 21</p> <p>outcomes. Further assessment of the alarms and their impact on Resident #28 was not completed to determine potential negative impacts on him, including:</p> <ul style="list-style-type: none"> * Whether he exhibited fear, anxiety, or agitation related to the sound of the alarm * Demonstrated decreased mobility * Experienced sleep disturbance due to the sound of the alarm * Infringement on his freedom of movement, if he was fearful of moving as doing so would set off the alarm * Infringement on his dignity and privacy related to the sound of the alarms <p>A Care Plan, dated 6/22/18, documented Resident #28 was to have an alarm to his wheelchair and bed to alert staff of his attempts to self-transfer.</p> <p>A Physician's Order Report, dated from 8/1/18 to 8/31/18, did not include physician orders for the bed or chair alarms since Resident #28's admission on 3/14/18.</p> <p>On 8/8/18 at 8:54 AM, Resident #28 was observed to have a pressure alarm on his wheelchair.</p> <p>On 8/9/18 at 11:03 AM, the DNS stated there were no assessments for alarms for Resident #28. She stated she expected the nursing staff to perform assessments and obtain orders for all alarms.</p> <p>On 8/9/18 at 11:38 AM, 35 minutes after the above interview, a Restraint/Adaptive Equipment</p>	F 604	<p>to the sound of the alarm, Other less restrictive interventions trialed prior to alarm use.</p> <p>Re-education provided to LN's on the updated alarm assessment and obtaining an MD order for the use of an alarm. Alarms will be used as a last resort. Education provided by DON and/or Administrator/designee by 9/20/18.</p> <p>4. RCM/designee will audit 3 random residents who use a bed or chair alarm to ensure an assessment has been completed and an MD order is present. Audits will be weekly x 4 weeks, bi-weekly x 1 month, then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 604	Continued From page 22 Assessment related to the use of Resident #28's chair and bed alarms was completed by the facility. The assessment did not include evaluation of the above mentioned potential negative impacts to determine if the alarms constituted a restraint for Resident #28. The reason for the alarms was identified as "Weakness and Cognition" and stated therapy was being used to treat the medical conditions that required the use of the alarms. The assessment did not identify less restrictive interventions that had been tried and found to be unsuccessful, prior to the initiation of the alarms.	F 604			
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 - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		9/20/18	

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F 656	<p>Continued From page 23</p> <p>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 staff and resident interview, it was determined the facility failed to ensure person-centered comprehensive care plans were developed and implemented to address residents' needs and resuscitation code status, such as DNR (Do Not Resuscitate) and Full Code. This was true for 14 of 15 residents (#5, #8, #9, #13, #14, #15, #17, #18, #21, #28, #33, #41, #45 and #50) whose care plans were reviewed. Resident #13's care plan did not address her portacath (venous access), Resident #18's care plan did not address the fracture of her left thigh secondary to a fall, the functional brace on her left leg, removal of the functional brace to check her skin every shift, and pain in her left leg. Resident #21 did not have a care plan for her chronic obstructive pulmonary disease. The care plans for Residents</p>	F 656	<p>F656</p> <p>Resident #41 is no longer a resident of the facility.</p> <p>Resident's #5, #8, #9, #13, #14, #15, #17, #18, #28, #33, #45 and #50 have had their care plan updated to include their code status and an MD order present addressing the code status.</p> <p>#13 has had her care plan updated to include the care of her Port-a-cath.</p> <p>#18 has had her care plan updated to include the fracture of her left thigh and the functional brace on her left leg removal of the functional brace to check her skin every shift, and pain in her left leg.</p> <p>#21 has had her care plan updated to</p>		

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F 656	<p>Continued From page 24</p> <p>#5, #8, #9, #13, #14, #15, #17, #18, #28, #33, #41, #45 and #50, did not include their code status. These failures created the potential for residents to receive inappropriate or inadequate care with subsequent decline in health, and for their resusciation code status wishes to not be honored. Findings include:</p> <p>1. Resident #18 was admitted to the facility on 5/18/2015, with multiple diagnoses which included chronic pain and fracture of the lower end of the left femur (thigh bone).</p> <p>An annual MDS assessment, dated 5/27/18, documented Resident #18 was cognitively intact, experienced occasional pain, received routine and PRN (as necessary) pain medications. The MDS assessment also documented Resident #18's pain did not limit her day to day activities.</p> <p>Resident #18's current care plan documented Resident #18 had left shoulder pain as evidenced by her verbalization of pain. Interventions included in the care plan were:</p> <ul style="list-style-type: none"> * will ask for pain medication for breakthrough pain * pain assessment on admission and as necessary * monitor pain until effective pain management plan established * position resident for comfort <p>An Incident and Accident report dated 7/14/18, documented Resident #14 fell out of bed while trying to reach her call light.</p> <p>A 7/16/18, X-ray result, documented a fracture</p>	F 656	<p>include her chronic obstructive pulmonary disease.</p> <p>2. Other current residents have been reviewed to ensure their code status is added to their care plan and an MD order present addressing the residents code status. Other current residents have port-a-Cath have been reviewed to ensure the care for their port-a-Cath has been added to their care plan. Other current residents with fractures have been reviewed for a care plan addressing the fracture, pain, and any brace/splint being used as well as ensuring the LN is checking under the skin of the brace/splint for breakdown every shift. Other current residents with a DX of COPD were reviewed to ensure their care plan addresses the treatment of COPD.</p> <p>3. Re-education provided LN's to ensure when a resident has a brace/splint the residents skin needs to be assessed every shift for potential breakdown. Education provided to RCM's to ensure care plans address code status, how to care for a Port-a-Cath, fractures, pain r/t fractures, any braces/splints used for fractures included checking under the brace/splint for skin breakdown. Re-education to Medical Records to include Code status in the MD orders, residents with braces/splints r/t fractures has an order to check the skin under the brace/splint every shift for breakdown. DON and/or Administrator/designee</p>		

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F 656	<p>Continued From page 25 involving Resident #18's left supracondylar femur without displacement (fracture of the thigh bone near the knee).</p> <p>A Physician Note, dated 7/20/18, documented "I contacted [physician name] for phone consult and outlined my opinion that pt [patient] is not an operable candidate. We will place her in L [left] knee brace extension. Pain Meds [medication] modified see orders."</p> <p>A Physical Therapy Evaluation and Treatment, dated 7/19/18, documented "fit resident with a functional brace for supercondylar fracture on left..."</p> <p>On 8/8/18 at 2:53 PM, the Physical Therapist said Resident #18 had a functional brace on her left leg and he gave an in-service training to the staff on how to remove and put the resident's left leg brace back on. The Physical Therapist said he would expect the nurses to check Resident #18's skin every shift by removing her left leg brace.</p> <p>Resident #18's care plan did not document she:</p> <ul style="list-style-type: none"> * fractured her left leg when she fell out of her bed * had pain in her left leg * had a functional left leg brace * needed to have her functional left leg brace removed every shift to check her skin. <p>On 8/8/18 at 2:53 PM, Resident #18 said her left leg brace was not removed every day.</p> <p>On 8/8/18 at 3:47 PM, RCM #3 said Resident</p>	F 656	<p>provided education by 9/20/2018</p> <p>4. DNS/designee will audit 3 random residents charts weekly for an MD order to include the residents code status along with a care plan addressing their code status. Audits will be weekly x 4 weeks then bi-weekly x 1 month, then monthly x 1 month. DNS/designee will audit 3 random residents care plans who have a DX of COPD is addressed in the residents' care plan. 3 random residents care plans are assessed for fractures and ensure how to care for the fracture, pain interventions, and any brace/splint is addressed on the care plan. DNS/designee will audit 3 random residents care plans to ensure if they have a port-a-Cath this is addressed in their care plan. Audits will be weekly x 4 weeks then bi-weekly x 1 month, then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 656	<p>Continued From page 26</p> <p>#18's left leg brace should be removed at least once every shift to check on her circulation, movement, and skin. The RCM reviewed Resident #18's care plan and said she did not see where it addressed Resident #18's fractured left leg, left leg pain, and removal of the functional left leg brace every shift to check her skin.</p> <p>2. Resident #21 was admitted to the facility on 5/24/18, with multiple diagnoses which included chronic obstructive pulmonary disease (COPD) and that she received hospice care. COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus production, and wheezing.</p> <p>Resident #21's admission MDS assessment, dated 5/31/18, documented she was cognitively intact and required assistance of one staff member for all ADLs.</p> <p>Resident #21's August 2018 recapitulated physician's orders included the following medications related to her breathing difficulties:</p> <ul style="list-style-type: none"> * Prednisone 10 mg tablet once a day * Mucinex 600 mg tablet once a day * Ipratropium-albuterol solution 2.5 mg/3 ml for nebulization every 6 hours and every 6 hours PRN * Ventolin HFA (Hydrofluoroalkane) inhaler, 90 mcg/actuation, 2 puffs PRN every 6 hours * Oxygen 2-5 l (liters), titrate to patient's report of increased ease of breathing, continuous. <p>Resident #21's care plan did not address her</p>	F 656			

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F 656	<p>Continued From page 27</p> <p>COPD.</p> <p>On 8/9/18 at 3:25 PM, the DNS reviewed Resident #21's care plan and said she did not see where it addressed her COPD.</p> <p>3. Resident #13 was readmitted to the facility on 7/24/18, with an initial admission of 9/12/17, with diagnoses which included portal hypertension, hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction affecting the left non-dominant side, and muscle weakness.</p> <p>A quarterly MDS assessment, dated 5/20/18, documented Resident #13 was cognitively intact. The MDS assessment documented she required supervision with bed mobility and transfers.</p> <p>A History and Physical Note, dated 2/9/18, documented Resident #13 had a Port-a-Catheter on her left side. The note documented Resident #13's Port-a-Catheter had a "malfunction" and it would not flush. The note documented the left-sided catheter was placed in December of 2017 and it was her 2nd catheter due to her first catheter on the right-side developed an infection in December of 2017.</p> <p>A Progress Note, dated 8/7/18, documented Resident #13 was out of the facility for a Port-a-Catheter flush appointment.</p> <p>Resident #13's physician's orders did not include the Port-a-Catheter, its care, or why she had it.</p> <p>Resident #13's care plan did not contain an area addressing Resident #13's Port-A-Catheter.</p>	F 656			

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F 656	<p>Continued From page 28</p> <p>On 8/9/18 at 2:10 PM, the DNS and RCM #2 stated Resident #13 had poor veins and required the Port-a-Catheter for blood draws. RCM #2 stated the facility and the lab did not access the Port-a-Catheter and an outside agency maintained it.</p> <p>On 8/9/18 at 4:01 PM, RCM #2 stated the facility completed weekly skin assessment on Resident #13 and would look at the Port-a-Catheter. RCM #2 stated she understood including the catheter on Resident #13's care plan would alert staff to watch for signs of infection.</p> <p>4. Residents' care plans did not include their resuscitation code status. Examples include:</p> <p>a. Resident #5 was readmitted to the facility on 7/24/15 with diagnoses, including candidiasis (yeast infection), and benign prostatic hyperplasia without lower urinary tract symptoms.</p> <p>A quarterly MDS assessment, dated 5/14/18, documented Resident #5 was cognitively intact.</p> <p>Resident #5's Advanced Directive, dated 7/21/15, documented he wished to be DNR.</p> <p>Resident #5's care plan did not include Resident #5's code status.</p> <p>Resident #5's physician's orders did not contain an order with his wishes for DNR.</p> <p>b. Resident #13 was readmitted to the facility on 7/24/18, with an initial admission date of 9/12/17, with diagnoses which included portal</p>	F 656			

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F 656	<p>Continued From page 29</p> <p>hypertension, hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, and muscle weakness.</p> <p>A quarterly MDS assessment, dated 5/20/18, documented Resident #13 was cognitively intact.</p> <p>Resident #13's physician's orders did not include orders for her code status.</p> <p>Resident #13's care plan did not address Resident #13's code status.</p> <p>c. Resident #15 was admitted to the facility on 2/16/18 with diagnoses which included, multiple sclerosis, quadriplegia and nicotine dependence.</p> <p>A quarterly MDS assessment, dated 5/24/18, documented Resident #15 was cognitively intact.</p> <p>Resident #15's POST, dated 2/16/18, documented her resuscitation code status was DNR.</p> <p>Resident #15's physician's orders did not contain an order with her wishes for DNR.</p> <p>Resident #15's care plan did not address Resident #15's code status.</p> <p>d. Resident #41 was readmitted to the facility on 7/6/18, with diagnoses which included chronic non-pressure ulcer of the lower leg, unspecified open wound to the right and left lower legs, chronic pain, cellulitis (potentially serious bacterial skin infection), and osteoarthritis.</p>	F 656			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 30</p> <p>An admission MDS assessment, dated 7/13/18, documented Resident #41 had severe cognitive impairment.</p> <p>Resident #41's POST, dated 5/24/17, documented she her code status was DNR.</p> <p>Resident #41's physician's orders did not contain an order with her wishes for DNR.</p> <p>Resident #41's care plan did not address Resident #41's code status.</p> <p>e. Resident #45 was readmitted to the facility on 7/5/17 with diagnoses which included severe intellectual disability, muscle weakness, dizziness, and convulsions.</p> <p>An annual MDS assessment, dated 7/13/18, documented Resident #45 had a severe cognitive impairment.</p> <p>Resident #45's POST, dated 2/7/17, documented she wished to be full code.</p> <p>Resident #45's care plan did not address Resident #45's code status.</p> <p>Resident #45's physician's orders did not contain an order with her wishes for Full code.</p> <p>f. Resident #8 was admitted to the facility on 8/22/17, with multiple diagnoses which included heart failure.</p> <p>Resident #8's quarterly MDS assessment, dated 5/5/18, documented he had moderate cognitive impairment.</p>	F 656			

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F 656	Continued From page 31 Resident #8's POST, dated 10/16/17, documented he chose a code status of DNR with limited interventions. The resident's August 2018 recapitulated physician's orders documented "(DNR)" following his name. The "DNR" was not in the list of his orders. Resident #8's care plan did not document his code status. g. Resident #14 was admitted to the facility on 6/12/17 and was readmitted on 1/29/18, with multiple diagnoses which included dementia with behavioral disturbances. A quarterly MDS assessment dated 5/8/18, documented she was severely cognitively impaired. Resident #14's POST, dated 6/12/17, documented she chose a code status of DNR with comfort measures. The resident's August 2018 recapitulated physician's orders documented "(DNR)" following her name. The "DNR" was not in her list of orders. Resident #14's care plan did not include her code status. h. Resident #18 was admitted to the facility on 5/18/15, with multiple diagnoses which included cerebrovascular accident (stroke) and nondisplaced fracture of lower end of left femur	F 656			

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F 656	<p>Continued From page 32 (thigh bone).</p> <p>A quarterly MDS assessment, dated 5/27/18, documented she was cognitively intact.</p> <p>The resident's August 2018 recapitulated physician's orders documented "(DNR)" following her name. The "DNR" was not in the list of her orders</p> <p>Resident #18's care plan did not include her code status.</p> <p>i. Resident #17 was admitted to the facility on 4/21/06 and was readmitted on 8/23/13 with multiple diagnoses which included Parkinson's disease.</p> <p>A quarterly MDS assessment dated 2/23/18 and 5/26/18, documented Resident #17 was cognitively impaired, required extensive assistance of two staff members for all his ADLs.</p> <p>A Living Will signed by the resident on 9/1/98 was in his clinical record.</p> <p>Resident #17's POST, dated 3/22/12, documented a code status of DNR with comfort measures and limited interventions.</p> <p>The resident's August 2018 recapitulated physician's orders documented "(DNR/DNI)" [do not intubate]" following his name. The "DNR/DNI" was not in the list of his orders.</p> <p>Resident #17's care plan did not address his code status.</p>	F 656			

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F 656	<p>Continued From page 33</p> <p>j. Resident #9 was admitted to the facility on 7/27/16 with diagnoses which included acute pancreatitis, diabetes type 2, and tobacco use.</p> <p>A Physicians Order for Scope of Treatment (POST) dated 9/7/16, documented Resident #9 was a DNR with comfort measure only. She may have IV fluids, antibiotic and blood products.</p> <p>A care plan dated 7/27/16, did not document Resident #9's wishes regarding code status.</p> <p>k. Resident #28 was admitted to the facility 3/14/18 with diagnoses which included COPD, dementia with lewy bodies (abnormal proteins which attack the brain).</p> <p>An MDS assessment dated 6/21/18, documented Resident #28 was moderately cognitively impaired.</p> <p>A POST dated 3/14/18, documented Resident #28 was a full code with aggressive interventions.</p> <p>Resident #28's care plan did not document his wishes regarding code status.</p> <p>l. Resident #33 was readmitted to the facility 2/28/18 with diagnoses which included adult failure to thrive, peripheral vascular disease, and anxiety disorder.</p> <p>An MDS quarterly assessment dated 7/3/18, documented Resident #33 was moderately cognitively impaired</p> <p>A POST dated 10/26/16, documented Resident</p>	F 656			

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F 656	Continued From page 34 #33 was a full code with limited additional interventions (no intubation, or advanced airway and do not admit to intensive care). A care plan dated 1/23/18, did not include Resident #33's wishes regarding code status. m. Resident #50 was admitted to the facility 1/12/18 with diagnoses which included respiratory failure, hypoxia, and schizophrenia. An MDS quarterly assessment dated 7/22/18, documented Resident #50 was severely cognitively impaired. A care plan dated 1/26/18, did not address Resident #50's wishes regarding her code status. On 8/8/18 at 10:16 AM, RCM #3 stated she was not aware the care plan was required to include residents' code status. On 8/8/18 at 11:55 AM, the DNS together with the RSN said she was aware the residents' care plans did not include their code status.	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.	F 657		9/20/18	

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F 657	<p>Continued From page 35</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</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 for 2 of 15 residents (#5 and #41) reviewed for care plan revisions. This created the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include:</p> <p>1. Resident #41 was readmitted to the facility on 7/6/18, with diagnoses which included chronic non-pressure ulcer of the lower leg, unspecified open wound to the right and left lower legs, chronic pain, cellulitis, and diabetes.</p> <p>An admission MDS assessment, dated 7/13/18, documented Resident #41 had severe cognitive impairment. The MDS assessment documented</p>	F 657	<p>F657</p> <p>1. Resident #41 is no longer a resident of the facility. Resident #5 is currently free from a urinary tract infection.</p> <p>2. Other current residents have had a full body skin assessment performed to address any alteration in skin integrity. Any skin alteration has been added to the care plan. Other current residents were reviewed for current UTI's and to ensure a care plan is present addressing the UTI.</p> <p>3. Re-education provided to LN's when a resident has been diagnosed with a UTI a temporary care plan will be implemented to address the UTI and interventions to</p>		

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F 657	<p>Continued From page 36</p> <p>she required extensive assistance from 1 to 2 staff members for all cares. The MDS assessment documented she had 3 unstageable pressure ulcers and 3 Stage III pressure ulcers present upon admission. The MDS assessment documented one of the pressure ulcers was 5.7 cm by 3.5 cm by 0.4 cm with eschar (dead tissue). The MDS documented Resident #41 had pressure reducing devices to her chair and bed, nutrition, and pressure ulcer care.</p> <p>The care plan area addressing Resident #41's pressure ulcers, initiated 7/18/18, documented Resident #41 had alterations in her skin integrity and she was admitted with a Stage III pressure ulcer to her right outer ankle and an arterial ulcer to her right outer shin. The care plan did not include the other 2 Stage III pressure ulcers or the 3 unstageable pressure ulcers documented in the MDS admission assessment for Resident #41. The care plan also did not include the locations of the unstageable pressure ulcers.</p> <p>On 8/6/18 at 5:47 PM, Resident #41 was observed with bruises on her hands and arms and an undated bandage on her right forearm.</p> <p>Resident #41's care plan did not include the injury to Resident #41's right forearm or the eschar on her right second toe.</p> <p>On 8/8/18 at 7:08 PM, RCM #1 stated she was unaware Resident #41 had an injury to her second toe on her right foot. RCM #1 stated she was unaware of an injury to Resident #41's right forearm and the need for a bandage.</p> <p>2. Resident #5 was readmitted to the facility on</p>	F 657	<p>treat. Re-education provided to the RCM's to ensure if a resident has pressure ulcers these are documented in their comprehensive care plan. Education provided by DON and or Administrator/designee by 9/20/18</p> <p>4. RCM/designee will audit 3 random residents with a UTI to ensure an acute care plan has been developed. RCM/designee will audit 3 random residents skin integrity to ensure a care plan has been initiated. DNS/designee will audit 3 random residents care plans to ensure if a resident has a pressure ulcer, the ulcer has been documented in the care plan. Audits will be weekly x 4 weeks then bi-weekly x 1 month, then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 657	<p>Continued From page 37</p> <p>7/24/15, with diagnoses including candidiasis (a yeast infection) and benign prostatic hyperplasia (enlargement of the prostate gland) without lower urinary tract symptoms.</p> <p>A quarterly MDS assessment, dated 5/14/18, documented Resident #5 was cognitively intact and required limited assistance of one staff member with toileting and bathing.</p> <p>The care plan area addressing Resident #5's urinary incontinence, initiated 6/25/18, documented staff were to provide incontinence care after each incontinent episode and provide medication as directed by the physician.</p> <p>Resident #5's Progress Note, dated 8/6/18, stated he came back from a urology appointment with orders for an antibiotic of cephalexin 500 mg BID for 10 days. The first dose was to be administered on 8/6/18.</p> <p>A temporary care plan addressing Resident #5's antibiotic use related to a UTI, was initiated on 8/6/18. The care plan documented staff were to monitor for side effects of antibiotic use and efficacy of the medication. The care plan did not include Resident #5's diagnosis of a UTI.</p> <p>On 8/8/18 at 11:29 AM, the SDC who was also the infection control nurse was not aware Resident #5 had a current UTI and was on an antibiotic.</p> <p>On 8/9/18 at 1:53 PM, the DNS stated Resident #5's temporary care plan should have been created when his symptoms presented, and he should have a care plan for his UTI.</p>	F 657			

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F 657	Continued From page 38	F 657			
F 677 SS=D	<p>Resident #5's record did not contain a care plan for his current UTI.</p> <p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation, review of a procedure for hand care, and staff interview, it was determined the facility failed to maintain residents' dignity when toenails and fingernails were not kept cleaned and trimmed for 2 of 15 residents (#8 and #28) reviewed for grooming and hygiene. This created the potential for a negative effect on the residents' self-esteem and possible skin injury due to untrimmed nails. Findings include:</p> <p>1. Resident #8 was admitted to the facility on 8/22/17, with multiple diagnoses which included heart failure.</p> <p>Resident #8's quarterly MDS assessment, dated 5/5/18, documented he had moderate cognitive impairment and required extensive assistance of one staff member for most of his ADLs.</p> <p>The resident's July 2018 and August 2018 recapitulated Physician's Orders included "Please clip fingernails at least once a week to prevent resident from scratching arms and especially his nose. Once a day on Monday..." There was no order to trim or cut Resident #8's</p>	F 677	<p>F677</p> <ol style="list-style-type: none"> 1. Resident #8 and #28 have had their fingernails and toenails trimmed and cleaned. 2. Other current residents have had their fingernails and toenails cleaned and or trimmed. If the resident had difficult nails to trim a Podiatry consult was made. 3. Re-education provided to CNA's and LN's to ensure fingernails and toenails are clean and trimmed. LN's will trim nails if the resident is a Diabetic. CNA's will trim and clean nails during the resident's shower. A new entry has been created on the resident's treatment record for weekly checking of fingernails and toenails for needing cleaning or trimming. Education provided by DON and/or Administrator/designee by 9/20/2018 4. RCM/designee will audit 3 random residents weekly to ensure their fingernails and toenails are clean and 	9/20/18	

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F 677	<p>Continued From page 39 toenails.</p> <p>An ADL care plan initiated on 9/19/17, documented Resident #8 required extensive assistance with his ADLs. Interventions, dated 8/8/18, included "Staff to continue to encourage the resident to allow staff to provide nail care and assist him with shaving. He often times refuses nail care."</p> <p>Resident #8's July 2018 and August 2018 TAR, documented "Please clip fingernails at least once a week to prevent resident from scratching arms and especially his nose." Resident #8's July 2018 and August 2018 TAR did not include an order to trim or cut his toenails.</p> <p>On 8/7/18 at 3:54 PM, Resident #8's toenails were observed to have an opaque color with a yellow tinge. Resident #8's toenails were long, thick, and curved downward.</p> <p>On 8/9/18 at 10:27 AM, RN #4 removed Resident #8's compression garment, and said she was aware of his long toenails. RN #4 said whenever she tried to cut Resident #8's toenails, he never allowed her to them. RN #4 said she thought Resident #8 needed a Podiatry consult due to the condition of his toenails.</p> <p>On 8/9/18 at 11:44 AM, RCM #2 said only nurses could cut the nails of residents who were diabetic, and for the other residents, CNAs should do the nail care once a week and as needed during showers or baths. RCM #2 said she would refer Resident #8 to a Podiatrist.</p> <p>On 8/10/18 at 10:30 AM, the DNS said the</p>	F 677	<p>trimmed. Audits will be weekly x 4 weeks, then bi-weekly x 2 months.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 677	<p>Continued From page 40</p> <p>physician order should say clipping of the toenails once a week.</p> <p>2. Resident #28 was admitted to the facility on 3/14/18, with diagnoses which included cognitive communication deficit and dementia with lewy bodies (abnormal proteins which attack the brain tissue).</p> <p>A Procedure for Hand Care, undated, documented soft, smooth skin and trimmed, filed fingernails were important for overall health and comfort. If the facility allowed, staff was to use nail clippers to cut the person's fingernails. If the person's nails needed to be trimmed, and was outside of the aides scope of practice, they were to report this need to the nurse.</p> <p>An MDS assessment, dated 6/21/18, documented Resident #28 was moderately cognitively impaired and he required one-person physical assistance with all ADLs.</p> <p>A CNA Competency on nail care and foot care form, undated, documented the expectations of the facility was for CNA's to be competent in providing nailcare. CNAs were to clip fingernails straight across with the nail clippers and shape the nails with an emery board or nail file so they were smooth.</p> <p>On 8/8/18 at 9:04 AM, Resident #28's nails were observed to be approximately 3 cm in length and some nails were missing pieces in the middle of the nail tip which created sharp edges. Resident #28's left hand was contracted and marks were noted on his left palm from contracted finger nails, which appeared to discolor the skin.</p>	F 677			

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F 677	Continued From page 41	F 677			
F 684 SS=E	<p>On 8/8/18 at 5:15 PM, the DNS stated nail care should be performed weekly. She stated cleaning under nails should be done weekly and PRN.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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 policy and record review, it was determined the facility failed to ensure professional standards of practice were followed for 7 of 15 sampled residents (#5, #17, #18, #33, #41, #45, and #205) reviewed for standards of practice. Resident #5's lab results were not followed up in a timely manner resulting in a delay in treatment. Resident #17 was missing skin assessments of the left ear. Resident #18's leg brace was not removed for skin assessments. Resident #33 and #41 had treatments for wounds without orders. Resident #45's neurological assessments were incomplete after unwitnessed falls. Resident #205's medication was left of the bedside table without supervision. 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>	F 684	<p>F684</p> <p>1. Resident #5's labs have been addressed by the MD. Resident #17 has a current skin assessment with documentation of the wound to his left ear. Resident #18's leg brace is being removed for skin assessments. Resident #33 has current treatments with orders for wounds. Resident #41 is no longer a resident of the facility. Resident #45 has not had any recent falls. Resident #205 does not have medications left on the bedside table.</p> <p>2. Other current residents who have had labs drawn in the last 30 days were assessed to ensure any abnormal lab was followed up in a timely manner. Other current residents have had a full</p>	9/20/18	

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F 684	<p>Continued From page 42</p> <p>1. Resident #18 was admitted to the facility on 5/18/15, with multiple diagnoses which included cerebrovascular accident (stroke) and nondisplaced fracture of lower end of left femur (thigh bone).</p> <p>A quarterly MDS assessment, dated 5/27/18, documented Resident #18 was cognitively intact and required extensive assistance of two staff members for all her ADLs.</p> <p>An Incident and Accident Report, dated 7/14/18, documented Resident #18 had an unwitnessed fall from her bed at 6:30 AM that day. The report documented "initial nurse in room found rsdt [resident] on the floor with one leg still up on the side of the bed tangled in a blanket..." The activity Resident #18 was engaged in at the time of the fall was documented as "Looking for call light or reaching for call light, rsdt [resident] stated both. Call light was attached to her covers per usual."</p> <p>A 7/16/18 X-ray result, documented a fracture involving Resident #18's left supracondylar femur (thigh) without displacement.</p> <p>A Physician Order, dated 7/18/18, documented Resident #18 was to have a brace on her left knee and physical therapy was to evaluate the brace and provide treatment.</p> <p>A Physician Note, dated 7/20/18, documented "I contacted [physician name] for phone consult and outlined my opinion that pt [patient] is not an operable candidate. We will place her in L [left] knee brace extension. Pain Meds [medications]</p>	F 684	<p>body skin assessment performed noting any new skin injuries, MD was notified, and new treatment orders were obtained. Skin injuries will be monitored weekly with measurements and a description. Other current residents with a brace/splint will have the brace removed to assess the skin under the brace/splint. Current residents reviewed who have had an unwitnessed fall in the last 7 days to ensure a neurological test was performed according to the policy and procedure. Other current residents have been assessed to having medications left at bedside. No other residents were found with this practice.</p> <p>3. Re-education provided to LN's: a. Medication pass policy; The LN who prepares medications will observe the resident ingest the medication. b. When a new skin injury is identified MD notification of the issue, MD order for treatment, Weekly skin monitoring of the injury, an acute care plan entry, c. Any brace/splint on a resident's body a visual check under the brace/splint for skin breakdown d. Unwitnessed falls must have a Neurological check done per policy and procedure. Education provided by DON and/or Administrator/designee by 9/20/2018.</p> <p>4. RCM/designee will audit 3 random residents to ensure the LN observes the resident ingest the poured medication.</p>		

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F 684	<p>Continued From page 43 modified see orders."</p> <p>A Nurses' Note dated 7/22/18 at 12:55 PM, documented Resident #18's left knee immobilizer (brace) was opened and a skin inspection was completed. The note documented Resident #18 requested the therapy department, specifically the Physical Therapist, reapply the brace, stating "I don't trust any one else."</p> <p>A Nurses' Note, dated 7/29/18 at 10:34 AM, documented Resident #18's brace was in place and the skin underneath was intact.</p> <p>On 8/6/18 at 5:10 PM, Resident #18 was observed in bed lying on her back. Her left leg had a brace from her thigh to her ankle. Resident #18 said she had a fall about 3 weeks ago and was told she had a fracture.</p> <p>On 8/8/18 at 2:53 PM, the Physical Therapist said Resident #18 had a functional brace on her left leg and he gave an in-service training to the staff on how to remove and put the brace back on Resident #18's leg. The Physical Therapist said he would expect the nurses to check Resident #18's skin every shift by removing the left leg brace.</p> <p>On 8/8/18 at 2:53 PM, Resident #18 said her left leg brace was not removed every day.</p> <p>On 8/8/18 at 3:02 PM, CNA #4 said she did not know whether Resident #18's left leg brace had to be removed or not.</p> <p>On 8/8/18 at 3:06 PM, LPN #3 checked the Resident #18's medical record and said there</p>	F 684	<p>Medications are not found at bedside. RCM/designee will audit 3 random residents skin to ensure skin injuries have MD notification with current treatment orders present. RCM/designee will audit 3 random residents who have a brace/splint in use has their skin assessed under the brace/splint. RCM/designee will audit 3 random unwitnessed falls to ensure neurological checks are completed per policy. Audits will be done weekly x 4 weeks then bi-weekly x 1 month, then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 684	<p>Continued From page 44</p> <p>was no order to remove Resident #18's left leg brace.</p> <p>On 8/8/18 at 3:47 PM, RCM #3 said there was no order for Resident #18's left leg brace to be removed every shift to check her skin. RCM #3 said Resident #18's left leg brace should be removed at least once every shift to check her circulation, movement, and skin.</p> <p>2. Resident #17 was admitted to the facility on 4/21/06, with multiple diagnoses including an unspecified open wound on his left ear.</p> <p>A quarterly MDS assessments, dated 2/23/18 and 5/26/18, documented Resident #17 was cognitively impaired and required extensive assistance of two staff members for all his ADLs.</p> <p>Resident #17's Physician's orders and TAR for August 2018 documented an order dated 7/12/17, directing staff to clean the scabbed area on his left ear with normal saline and apply Bacitracin daily and as needed.</p> <p>Resident #17's care plan documented he was at risk for impaired skin integrity. The care plan included the following approaches:</p> <ul style="list-style-type: none"> * Cleanse left ear with normal saline and apply Bacitracin (topical antibiotic) daily and as needed * Conduct a systematic skin inspection per facility protocol, paying particular attention to the bony prominences, and report any signs of skin breakdown * Staff were to be cautious when repositioning Resident #17 to prevent friction and skin impairment 	F 684			

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F 684	<p>Continued From page 45</p> <p>On 8/7/18 at 11:24 AM, CNA #5 and CNA #11 were providing nursing cares to Resident #17. Resident #17 was observed to have a blackened area located about midway on his left outer ear. CNA #11 said Resident #17 had the blackened area on his left ear for quite a while and it was not healing.</p> <p>On 8/8/18 at 2:50 PM, RCM #1 looked at Resident #17's left ear and said she was not aware he had a blackened area on his left ear. RCM #1 said she would look at Resident #17's record to see if there was an order to treat his ear wound.</p> <p>On 8/8/18 at 4:26 PM, RCM #2 measured the blackened area on Resident #17's left ear, and it was 2 cm by 1.5 cm, with the depth unknown. When asked how the measurement compared to the previous measurement, RCM #2 said she would look for the Skin Grid for Resident #17's left ear.</p> <p>On 8/9/18 at 3:40 PM, RCM #2 said skin assessments were done weekly and it will be documented on the TAR with a plus sign if there was a skin issue. RCM #2 said a plus sign would trigger the staff to do a Skin Grid, which was a more detailed skin assessment. RCM #2 said she was unable to find a Skin Grid related to Resident #17's left ear wound. She said it was an oversight because it was an ongoing issue.</p> <p>Resident #17's wound on his left ear was not monitored to determine progress toward healing.</p> <p>3. Resident #41 was readmitted to the facility on</p>	F 684			

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F 684	<p>Continued From page 46</p> <p>7/6/18, with diagnoses which included chronic non-pressure ulcer of the lower leg, an unspecified open wound to the right and left lower legs, chronic pain, cellulitis (potentially serious skin infection), and diabetes.</p> <p>An admission MDS assessment, dated 7/13/18, documented Resident #41 had severe cognitive impairment. The MDS assessment documented she required extensive assistance from 1 to 2 staff members for all cares. The MDS assessment documented she had 3 unstageable pressure ulcers and 3 Stage III pressure ulcers present upon admission. The MDS documented one of the pressure ulcers was 5.7 cm by 3.5 cm by 0.4 cm with eschar. The MDS documented she had pressure reducing devices to her chair and bed, increased nutritional needs, and required pressure ulcer care.</p> <p>Johns Hopkins Medicine, website accessed on 8/30/18, stated "A pressure ulcer is the result of damage caused by pressure over time causing an ischemia (restriction in blood supply to tissues) of underlying structures. Bony prominences are the most common sites and causes." The website stated an assessment of the wound should be done weekly and used to drive treatment decisions. A Stage III pressure ulcer is described as full thickness skin loss which may include undermining/tunneling. An unstageable pressure ulcer is full thickness skin loss which is covered by slough (dead tissue usually cream or yellow in color) or eschar (dry, thick, leathery dead tissue tissue that is often tan, brown or black).</p> <p>A Care Conference Report, dated 7/13/18,</p>	F 684			

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F 684	<p>Continued From page 47</p> <p>documented Resident #41 refused to get out of bed and she was admitted with multiple pressure ulcers and poor skin integrity.</p> <p>The care plan area addressing Resident #41's pressure ulcer, initiated 7/18/18, documented Resident #41 had alterations in her skin integrity and she was admitted with a Stage III pressure ulcer to her right outer ankle and an arterial ulcer to her right outer shin. The care plan documented she had poor skin integrity related to poor circulation and diabetes.</p> <p>Resident #41's physician's orders included:</p> <ul style="list-style-type: none"> * Skin moisturizing to legs twice daily, ordered 7/13/18. * Bordered foam to right lower extremity as needed, ordered 7/20/18. * Bordered foam to right ankle once every three days, ordered 7/20/18. * Bordered foam to wound on right outer shin once every three days, ordered 7/20/18. * Bordered foam dressing to open areas on the upper and mid back as need, ordered 7/25/18. * Bordered foam dressing to open area on the upper and mid back once every three days, ordered 7/25/18. <p>On 8/6/18 at 5:47 PM, Resident #41 was observed laying in bed with a pillow under her back on her left-side. Resident #41 was observed with bruises on her hands and arms and an undated bandage on her right forearm.</p> <p>On 8/7/18 at 4:11 PM, LPN #2 stated he was not sure what the bandage on Resident #41's right forearm was covering and that there was no date</p>	F 684			

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F 684	<p>Continued From page 48</p> <p>on the bandage. LPN #2 stated he would follow up about the bandage on Resident #41's right forearm.</p> <p>On 8/8/18 at 1:18 PM, LPN #2 stated he was not aware what was under the bandage on Resident #41's right forearm because there was no date on the bandage. LPN #2 stated he had not followed up regarding the bandage to Resident #41's right forearm.</p> <p>On 8/8/18 at 1:20 PM, LPN #4 stated there were no orders for the bandage on Resident #41's right forearm or when to change it.</p> <p>On 8/8/18 at 1:44 PM, LPN #2 stated the right forearm injury appeared to be a skin tear and was healed as of 8/8/18.</p> <p>On 8/8/18 at 7:08 PM, RCM #1 stated she was unaware of an injury to Resident #41's right forearm and the need for a bandage.</p> <p>4. The facility's Neurological Assessments - Post Accidents policy, dated 2/2018, documented residents' neurological status should be assessed following head injury or suspected head injury. The policy documented neurological assessments were to be completed every 15 minutes x (times) 4, then every 30 minutes x 4, then every hour x 4, followed by every 4 hours x 4, then every shift for 48 hours. The policy documented staff were to assess for changes in levels of responsiveness, pupillary changes, hand grasp, pain, vitals, restlessness, headaches, vomiting, forced breathing, and purposeful movement.</p>	F 684			

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F 684	<p>Continued From page 49</p> <p>Resident #45 was readmitted to the facility on 7/5/17, with diagnoses which included severe intellectual disability, muscle weakness, dizziness, and convulsions.</p> <p>Resident #45's Fall Risk Assessments, dated 1/17/18, 4/14/18, and 7/19/18 documented she was at high risk for falls.</p> <p>An annual MDS assessment, dated 7/13/18, documented Resident #45 had severe cognitive impairment and experienced multiple non-injury falls. The MDS assessment documented Resident #45 did not use a bed alarm or chair alarm. The MDS assessment documented Resident #45 required extensive assistance of one to two staff members for all cares except eating.</p> <p>The care plan area addressing Resident #45's falls, initiated 12/12/17, documented she was at risk for falls related to a history of falls and generalized weakness. The care plan interventions were documented as follows:</p> <ul style="list-style-type: none"> * Staff were to provide frequent checks on Resident #45 and keep her door ajar. * Staff were to keep her snacks at a higher level where Resident #45 could reach them easily. * Resident #45 was to wear non-skid foot wear at all times. * Resident #45's room was near the nurses' station for better visibility. * Staff were to answer her call light promptly to help prevent falls. * Resident #45's call light was to be within reach at all times. 	F 684			

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F 684	<p>Continued From page 50</p> <p>Resident #45's clinical record documented she experienced 4 falls in her room between 4/14/18 and 6/4/18.</p> <p>The I&A Reports documented the following:</p> <ul style="list-style-type: none"> * An I&A Report, dated 4/14/18 at 10:45 PM, documented Resident #45 experienced an unwitnessed fall from her wheelchair. She was attempting to transfer from her wheelchair into her bed and confirmed she hit her head. * An I&A Report, dated 4/30/18 at 11:15 AM, documented Resident #45 experienced an unwitnessed fall from bed. She was found on her back with her head towards the door and her feet under the bed. The I&A documented Resident #45 was wearing normal socks and not non-skid foot wear. The I&A documented Resident #45 sustained an injury of a small bruise to her left hand and possibly one under her left eye. The I&A documented neurological assessments were initiated. * An I&A Report, dated 5/24/18 at 5:25 AM, documented Resident #45 experienced a fall from her wheelchair. * An I&A Report, dated 6/4/18 at 2:30 PM, documented Resident #45 experienced an unwitnessed fall from her bed. <p>Neurological Records documented Resident #45's neurological status was not consistently evaluated per the facility's policy, after the unwitnessed falls on 4/14/18, 4/30/18, 5/24/18, and 6/4/18, as follows:</p>	F 684			

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F 684	<p>Continued From page 51</p> <p>* The 4/14/18 assessment was not completed on 4/15/18 from 12:15 AM through 4:45 AM because Resident #45 was sleeping. On the 4/16/18, night and evening shifts Resident #45's level of consciousness, pupil response, and motor response were not assessed.</p> <p>* The 4/30/18, assessment was incomplete on 4/30/18 between 1:50 PM and 2:50 PM and 4:50 PM and 10:20 PM as Resident #45's vital signs were not assessed. On 5/2/18 and 5/3/18, the evening and night shift staff did not assess her level of consciousness, pupil response, motor response, and vital signs.</p> <p>* The 5/24/18 assessment was not complete from 12:45 PM to 3:00 PM as it was missing Resident #45's level of consciousness, pupil response, and motor response. On the same day, from 3:30 PM to 7:30 PM, her vital signs were not assessed. On the night shift for 5/26/18 and 5/27/18, Resident #45 was sleeping and her neurological assessments were not completed.</p> <p>* The 6/4/18 assessment was not complete from 2:30 PM through 7:15 PM as Resident #45's level of consciousness, pupil response, and motor response were not assessed. Beginning at 9:15 PM through 9:15 AM the assessment was missing level of consciousness, pupil response, motor response, and vital signs. On the 6/8/18 day and evening shift the assessments were missing level of consciousness, pupil response, motor response, and vital signs.</p> <p>On 8/9/18 at 4:11 PM, the DNS and RCM #1 stated neurological assessments were incomplete. The DNS stated if the resident was</p>	F 684			

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F 684	<p>Continued From page 52</p> <p>sleeping the staff should attempt to wake the resident to ensure there was not a change in neurological status. The DNS stated the level of consciousness, pupil response, motor function, vital signs, and pain responses should be assessed.</p> <p>5. Resident #5 was readmitted to the facility on 7/24/15 with diagnoses, including candidiasis (yeast infection) and benign prostatic hyperplasia (enlargement of the prostate gland caused by a benign overgrowth) without lower urinary tract symptoms.</p> <p>A quarterly MDS assessment, dated 5/14/18, documented Resident #5 was cognitively intact and required limited assistance of one staff member with toileting. The assessment noted Resident and bathing and was continent of bowel and bladder.</p> <p>Resident #5's Progress note dated 8/1/18, documented Resident #5's urine specimen was collected on 7/30/18 and was waiting for the laboratory service to pick up the specimen.</p> <p>Resident #5's Progress note dated 8/6/18, documented he returned from the urologist with an order for an antibiotic.</p> <p>Resident #5's urinalysis and C&S dated 8/3/18 was received by the facility via fax on 8/8/18 at 1:48 PM.</p> <p>Nursing staff failed to follow up with the lab on the results of the urinalysis and C&S in a timely manner.</p>	F 684			

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F 684	<p>Continued From page 53</p> <p>On 8/9/18 at 1:53 PM, the DNS stated the nurses should have followed with the lab regarding the C&S results as soon as possible.</p> <p>6. Resident #205 was readmitted to the facility on 8/3/18, with multiple diagnoses which included liver failure, ascites (fluid in the abdomen), and shortness of breath.</p> <p>An MDS assessment, dated 7/25/18, documented Resident #205 was cognitively impaired.</p> <p>A Medication Administration Policy, undated, stated the person who prepared the dose for administration was the person who administered the medication. The policy also stated the resident was always observed after administration to ensure the dose was completely ingested.</p> <p>On 8/9/18 at 9:52 AM, a CNA approached LPN #3 and stated Resident #205 would like some of her pills broken to help her swallow them. LPN #3 and the surveyor entered Resident #205's room and a medication cup with multiple pills in it was observed on the bedside table. LPN #3 assisted Resident #205 with her pills by breaking them in half. Resident #205 stated she had a tough time with the large pills.</p> <p>On 8/9/18 at 10:11 AM, LPN #3 stated she did not wait for Resident #205 to take her pills, because Resident #205 did not like to be rushed. She stated she knew she should have supervised Resident #205 while she took her medications.</p>	F 684			

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F 684	<p>Continued From page 54</p> <p>On 8/9/18 at 11:00 AM, the DNS stated she would expect nurses to supervise residents while taking medications.</p> <p>7. Resident #33 was admitted to the facility on 2/28/18, with diagnoses which included peripheral vascular disease.</p> <p>An MDS assessment, dated 7/25/18, documented Resident #33 was cognitively impaired.</p> <p>A Skin at Risk/Skin Breakdown policy, dated 2/2018, stated upon discovery of a newly identified skin impairment (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc.) the licensed nurse should document the skin impairment including measurements of size, color, presence of odor, any exudate, and if the resident experienced pain. The policy also stated an incident report in the risk management tool needed to be completed and a physician should be notified.</p> <p>On 8/7/18 at 11:57 AM, LPN #1 removed a 2x2 bandage from Resident #33's left knee. The wound under the bandage was approximately 4 cm in diameter, several skin layers deep, wet, and sticky. LPN #1 stated Resident #33 had scratched off the scab on his knee on 8/6/18. There was no date on the bandage.</p> <p>On 8/8/18 at 2:44 PM, RN #6 stated she was not aware there was a wound to Resident #33's left knee. She pulled the left pant leg up and the wound was open to air with no bandage.</p>	F 684			

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F 684	Continued From page 55 Resident #33's record did not include documentation of an injury to his left knee. On 8/9/18 at 4:59 PM, the DNS stated she would expect a nurse to complete documentation and obtain an order for a new wound. She expected nurses to add the new wound to the alert charting, which ensured the information would pass to the next nurse.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and review of a skin assessment spreadsheet, it was determined the facility failed to prevent the worsening of identified pressure ulcers and the development of new pressure ulcers. This was true for 1 of 3 residents (#41) reviewed for pressure ulcers. This failure resulted in harm to Resident #41 when her pressure ulcers worsened and she developed new pressure ulcers. Findings include:	F 686	F686 1. Resident #41 is no longer a resident of the facility. 2. Other current residents were assessed for at risk for skin breakdown using the BRADEN assessment. Moderate to high risk residents were reviewed for preventative interventions in place.	9/20/18	

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F 686	Continued From page 56 Resident #41 was readmitted to the facility on 7/6/18, with diagnoses which included chronic non-pressure ulcer of the lower leg, unspecified open wound to the right and left lower legs, chronic pain, cellulitis (potentially serious skin infection), and diabetes. An admission MDS assessment, dated 7/13/18, documented Resident #41 had severe cognitive impairment. The MDS assessment documented she required extensive assistance from 1 to 2 staff members for all cares. The MDS assessment documented she had 3 unstageable pressure ulcers and 3 stage three pressure ulcers present upon admission. The MDS documented one of the pressure ulcers was 5.7 cm by 3.5 cm by 0.4 cm with eschar. The MDS documented she had pressure reducing devices to her chair and bed, increased nutritional needs, and required pressure ulcer care. Johns Hopkins Medicine, website accessed on 8/30/18, stated "A pressure ulcer is the result of damage caused by pressure over time causing an ischemia of underlying structures. Bony prominences are the most common sites and causes." The website stated an assessment of the wound should be done weekly and used to drive treatment decisions. A Stage III pressure ulcer is described as full thickness skin loss which may include undermining/tunneling. An unstageable pressure ulcer is full thickness skin loss which is covered by slough (dead tissue usually cream or yellow in color) or eschar (dry, thick, leathery dead tissue tissue that is often tan, brown or black).	F 686	Current residents with pressure ulcers were reviewed for healing interventions and preventative measures for further skin breakdown. 3. Re-education provided LN's on ensuring skin breakdown preventative measures are in place and carried out. Re-education provided to RCM's on weekly documentation of pressure ulcers when a pressure ulcer worsens and or has not changed in 2 weeks the MD will be notified for new treatment. Education provided by DON and/or Administrator/designee by 9/20/2018 4. DON/designee will audit 3 random residents with pressure ulcers to ensure weekly documentation is completed and the ulcer is not improving in 2 weeks MD was notified and ensure current interventions for healing and preventing further breakdown are being followed. Audits will be weekly x 4 weeks, then bi-weekly x 2 months. 5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.		

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F 686	<p>Continued From page 57</p> <p>A Care Conference Report, dated 7/13/18, documented Resident #41 refused to get out of bed and she was admitted with multiple pressure ulcers and poor skin integrity.</p> <p>The care plan area addressing Resident #41's pressure ulcers, initiated 7/18/18, documented Resident #41 had alterations in her skin integrity and she was admitted with a Stage III pressure ulcer to her right outer ankle and an arterial ulcer to her right outer shin. The care plan documented she had poor skin integrity related to poor circulation and diabetes. The care plan did not include the other 2 Stage III pressure ulcers or the 3 unstageable pressure ulcers documented in Resident #41's 7/13/18 admission MDS assessment for Resident #41.</p> <p>Resident #41's physician's orders included:</p> <ul style="list-style-type: none"> * Bordered foam to right lower extremity as needed, ordered 7/20/18. * Bordered foam to right ankle once every three days, ordered 7/20/18. * Bordered foam to wound on right outer shin once every three days, ordered 7/20/18. * Bordered foam dressing to open areas on the upper and mid back as need, ordered 7/25/18. * Bordered foam dressing to open area on the upper and mid back once every three days, ordered 7/25/18. <p>The Weekly Skin Alteration Reports documented the following:</p> <p>a. The Weekly Skin Alteration Report of Resident #41's outside right ankle documented Resident #41 had a stage three pressure ulcer, first</p>	F 686			

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F 686	<p>Continued From page 58</p> <p>observed upon admission. The report documented the measurements were:</p> <p>* On 7/6/18, 7/10/18, and 7/17/18 the wound was documented as 2 cm by 1 cm with clear drainage and 100% slough.</p> <p>* On 7/20/18 the wound was documented as 2 cm by 0.7 cm with serous drainage and slough.</p> <p>* On 7/27/18 and 8/3/18 the wound was documented as 2 cm by 2 cm with white and yellow drainage and slough. The wound worsened with increased size and slough covering the wound base remained.</p> <p>On 8/7/18 at 4:11 PM, LPN #2 stated the bandage on Resident #41's ankle was changed earlier in the day on 8/7/18. LPN #2 found the soiled bandage from her ankle dressing and the bandage appeared to have a 5 cm round shaped lime green and yellow discharge on the bandage.</p> <p>b. Resident #41 developed 2 new skin impairment areas on her back, as follows:</p> <p>The Weekly Skin Alteration Report of Resident #41's middle back documented Resident #41 had an excoriated area, first observed on 7/25/18. The report documented the measurements were:</p> <p>* On 7/25/18 and 7/27/18 the wound was documented as 2 cm by 1 cm.</p> <p>* On 8/3/18 the wound was documented as resolved.</p> <p>The Weekly Skin Alteration Report of Resident</p>	F 686			

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F 686	<p>Continued From page 59</p> <p>#41's upper back documented Resident #41 had an excoriated area, first observed on 7/25/18. The report documented the measurements were:</p> <ul style="list-style-type: none"> * On 7/25/18 the wound was documented as 3 cm by 5 cm with 100% granulation. * On 7/27/18 the wound was documented as 2.5 cm by 5 cm with granulation. * On 8/3/18 the wound was documented as resolved. <p>c. Resident #41 developed a new pressure ulcer area on her right second toe.</p> <p>On 8/6/18 at 5:47 PM, Resident #41's second toe was observed with a 1 cm eschar area on her right foot.</p> <p>On 8/7/18 from 9:47 AM through 4:11 PM, Resident #41's second toe was observed with a 1 cm eschar area on her right foot.</p> <p>On 8/7/18 at 4:11 PM, LPN #2 stated he had not noticed Resident #41's second toe before then.</p> <p>Resident #41's 7/9/18 through 8/8/18 MAR documented she refused wound treatments multiple times due to pain. Examples include:</p> <ul style="list-style-type: none"> * Bordered foam dressing to the mid and upper back, right ankle, and right shin was not changed on 7/23/18, 7/28/18, 7/29/19, 8/1/18, 8/3/18, 8/4/18 and 8/6/18. <p>Resident observation and interviews:</p>	F 686			

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F 686	<p>Continued From page 60</p> <p>On 8/6/18 at 5:47 PM, Resident #41 was observed laying in bed with a pillow under her back on her left-side.</p> <p>On 8/7/18 from 9:47 AM through 4:11 PM, Resident # 41 was observed on her back with a pillow under her right arm and her legs flush on the bed. Resident #41's right ankle and right calf were positioned flat against the mattress.</p> <p>On 8/7/18 at 10:42 AM, Resident #41's bilateral legs were observed with flaking skin and her toenails were observed yellow and thick. Resident #41's right leg was observed with a bandage on the outside of her right ankle and an ACE bandage on her right shin.</p> <p>On 8/7/18 at 12:11 PM, Resident #41 stated she was not always provided pain medications prior to dressing changes and when she was not provided the medications she would refuse related to pain. Resident #41 stated when she was provided pain medications the dressing changes could be managed.</p> <p>On 8/7/18 at 4:11 PM, LPN #2 stated Resident #41's feet should be floated on a pillow.</p> <p>On 8/8/18 from 8:37 AM to 5:56 PM, Resident #41's right ankle and her right calf were observed positioned flat against the mattress.</p> <p>On 8/8/18 at 1:12 PM, Resident #41 was observed during a dressing change to her right shin. Resident #41's leg was positioned back on the mattress after LPN #4 completed the dressing change. Resident #41 cried out during the dressing change saying, "Ow."</p>	F 686			

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F 686	Continued From page 61 On 8/8/18 at 1:44 PM, LPN #2 stated he did not document the injury to Resident #41's second toe and he provided report of the second toe injury to the on-coming nurse. On 8/8/18 at 5:56 PM, the DNS stated wounds with eschar and slough in the base would be considered unstageable. The DNS observed Resident #41's right ankle and right shin on the bed and stated her ankle and shin should be floated and off the bed. On 8/8/18 at 7:08 PM, RCM #1 stated she was unaware Resident #41 had an injury to the second toe on her right foot. RCM #1 stated Resident #41 refused a foot cradle on the bed and she could not provide documentation of this conversation occurring prior to 8/8/18. RCM #1 stated Resident #41 would refuse to float her right leg and she could not provide documentation of this prior to 8/8/18.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		9/20/18	

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F 688	<p>Continued From page 62</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure a restorative nursing program to prevent functional decline in Range of Motion (ROM), was provided for 3 of 5 (#17, #18 and #28) residents reviewed for ROM. This deficient practice had the potential to cause harm if residents experienced a decline in ROM. Findings include:</p> <p>1. Resident #17 was admitted to the facility on 4/21/06, with multiple diagnoses which included Parkinson's Disease.</p> <p>A quarterly MDS assessment, dated 2/23/18 and 5/26/18, documented Resident #17 was cognitively impaired, required extensive assistance of two staff members for all his ADLs, and received a RNA program of PROM (passive range of motion) 5 days a week for at least 15 minutes a day.</p> <p>Resident #17's August 2018 recapitulated physician's orders included:</p> <p>*PROM: Gently pull each finger from side to side of joints; Extend bilateral wrists; pronate (turn downward) and supinate (turn upward) bilatera] forearms, extend bilateral elbows; abduct (move away from the center of the body) bilateral</p>	F 688	<p>F688</p> <p>1. Resident #17, #18 and #28 have been assessed by OT to evaluate their upper and lower extremities for contractures and review for an appropriate RNA restorative nursing program if warranted. LN assessed resident #17, #18 and #28's pain control when providing the RNA program to aide in participation.</p> <p>2. Other current residents were assessed for contractures. If contractures were noted PT/OT evaluations performed for an appropriate RNA program, if not already currently on an RNA program. Residents pain assessed to aide in participation of a RNA program.</p> <p>3. Re-education provided to CNA staff to ensure they are performing the resident's programs as ordered, if a resident is having pain and is unable to participate a communication must be made to the LN and the RCM.</p> <p>Communicate with your LN if a resident complains of pain often let the LN know so the resident can be pre-medicated prior to you working with them.</p>		

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F 688	<p>Continued From page 63</p> <p>shoulders, flex and extend bilateral knees, dorsal (upper side) and plantar flex bilateral ankles. Special instructions were stated as "Restorative Program".</p> <p>*Restorative Plan: PROM, Splint or Brace assistance: Goals: Prevent further contractures of bilateral upper (BLU) extremities and hands. Approaches included gentle PROM with tone inhibition techniques for BLU extremities all planes, a therapeutic carrot (carrot shaped hand orthodic) along Resident #17's fingers of the left hand and a palm protector in right hand daily.</p> <p>A care plan dated 12/14/12, documented Resident #17 had limited voluntary movement related to advancement of Parkinson's disease. The care plan included the following:</p> <p>* Restorative plan: PROM, Splint or Brace assistance * Goals: Prevent further contractures of BUEs and hands * Approaches: Gentle PROM with tone inhibition techniques for BUEs on all planes, therapeutic carrot along fingers Resident #17's fingers on the left hand and a palm protector in the right hand daily.</p> <p>On 8/6/18 at 2:44 PM, Resident #17 was observed sitting in his Broda chair. Resident #17's right hand was flexed at the wrist, and all his fingers were flexed. Resident #17 did not have therapeutic carrot othodic, palm protector, splint or brace on his upper extremities.</p> <p>On 8/7/18 at 3:37 PM, Resident #17 was observed lying in bed on his back. Both of his</p>	F 688	<p>LN's and RCM's education; if a restorative nurse's aide communicates to you that a resident is unable to participate in their RNA program a pain assessment must be done, administer pain medication as directed, if pain continues to not be relieved MD notification is warranted. A premed may be warranted so the resident will participate in their RNA program. Education provided by DON and/or Administrator/designee by 9/20/2018</p> <p>4. DON/designee will audit 3 random residents who participate in a RNA program to ensure no consecutive refusals have occurred, and pain is being controlled for resident to participate. DON/designee will audit 3 random residents Minimum Data Set assessments for upper and lower extremities ROM</p> <p>deficits to ensure a decline has not occurred in the past 3 months and ensure if a decline occurred PT/OT received a referral. Audits will be weekly x 4 weeks then bi-weekly x 2 months.</p> <p>5. DNS/designee will report the results of these audits to</p> <p>Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 688	<p>Continued From page 64</p> <p>arms were both flexed to his chest. Resident #17 did not have therapeutic carrot, palm protector, splint or brace on his upper extremities.</p> <p>On 8/8/18 at 8:45 AM, Resident #17 was observed lying in bed on his back and his eyes closed. Both of his arms were flexed to his chest. Resident #17 did not have therapeutic carrot, palm protector, splint or brace on his upper extremities.</p> <p>Resident #17 was observed in the same position and he did not have therapeutic carrot, palm protector, splint or brace on his upper extremities on 8/8/18 at 10:45 AM, 8/8/18 at 2:11 PM, and 8/8/18 at 3:00 PM.</p> <p>On 8/8/18 at 5:20 PM, RCM #2 and the surveyor went to Resident #17's room. He was in the same position and did not have therapeutic carrot, palm protector, splint or brace on his upper extremities. RCM #2 said Resident #17 was on an RNA program and used to have a therapeutic carrot in his hands.</p> <p>A Restorative Nursing Report documented Resident #17 did not receive his RNA program for:</p> <p>*19 days in June 2018 *22 days in July 2018</p> <p>On 8/10/18 at 10:43 AM, RNA #1 said Resident #17 did not have a therapeutic carrot, splint or brace on his upper extremities because of pain. RNA #1 said he reported it to the nurse whenever Resident #17 was in pain and whenever he refused his RNA program.</p>	F 688			

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F 688	Continued From page 65 Resident #17's Nursing Notes, dated 6/1/18 through 8/8/18, did not include documentation of his refusals of the RNA program or why he did not have a therapeutic carrot, palm protector, splint or brace on his upper extremities. Resident #17's had contractures and the facility failed to provide the necessary RNA program as ordered by the physician. 2. Resident #18 was admitted to the facility on 5/18/15, with multiple diagnoses which included cerebrovascular accident (stroke) and nondisplaced fracture of lower end of left femur (thigh bone). A quarterly MDS assessment, dated 5/27/18, documented she was cognitively intact, required extensive assistance of two staff members for all her ADLs, and received an RNA program for AROM (active range of motion) and PROM six days a week. Resident #18's August 2018 recapitulated physician's orders included a Restorative Nursing Program as: *Assistive AROM per therapy recommendations to maintain functional ROM to right shoulder. Must be at least 6 days/week for 15 minutes ordered on 10/27/15. *PROM per therapy recommendations to maintain flexibility to left shoulder. Must be at least 6 days/week for 15 minutes ordered on 10/27/15. *Follow FMP (functional maintenance program)	F 688			

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F 688	<p>Continued From page 66</p> <p>per therapy recommendations to BLE (bilateral lower extremities) and UE (upper extremities) to decrease pain, 6 times a week, 15 minutes a day, ordered on 1/23/18.</p> <p>Resident #18's care plan documented she had restorative nursing program for both AROM and PROM. The care plan included the following approaches: 10-15 reps (repetitions) each, flexion, abduction, IR (internal rotation), ER (external rotations), follow FMP per therapy recommendations.</p> <p>On 8/8/18 at 9:02 AM, Resident #18 was observed lying in bed on her back. The surveyor asked if she could raise her arms. Resident #18 raised her right upper arm but was unable to raise her left upper arm. Resident #18 said she had a stroke and since then she was unable to use or move her left upper arm. She said she was not having any exercise on her left upper arm because of the pain in her left shoulder and pain in her left leg.</p> <p>Restorative Nursing Report documented Resident #18 did not received her RNA program from 7/17/18 to 8/8/18.</p> <p>On 8/8/18 at 9:48 AM, RNA #2 said Resident #18 did not have her RNA program since she fell in July 2018. RNA #2 said Resident #18 always refused her RNA program due to severe pain. She said whenever Resident #18 refused her RNA program she would ask the nurse if Resident #18 was due for her pain medications, and would approach the resident again at least three times. RNA #2 said if she was unsuccessful in encouraging Resident #18 to do her RNA</p>	F 688			

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F 688	<p>Continued From page 67</p> <p>program, then she would tell the nurse Resident #18 did not have her RNA for that day.</p> <p>On 8/8/18 at 10:52 AM, RN #4 said she was not aware Resident #18 was refusing her RNA program. She said if she had known the resident was refusing her RNA program, she would talk and educate the resident, and if the resident continues to refuse she would report it to the RCM.</p> <p>On 8/8/18 at 11:08 AM, RCM #2 said it was the responsibility of the RNAs to report to the nurses if a resident was refusing an RNA program. RCM #2 said if a resident had continued refusals, she would talk to the resident and find out the reason for the refusals.</p> <p>On 8/8/16 at 11:16 AM, RCM #3 said she was not aware Resident #18 had been refusing her RNA program since she had a fall. She said if she had known Resident #18 was refusing her RNA program, she would talk and educate the resident, and if needed, she would refer the resident to her physician.</p> <p>3. Resident #28 was admitted to the facility on 3/14/18, with diagnoses which included COPD, dementia with lewy bodies (abnormal proteins which attack the brain).</p> <p>An MDS assessment, dated 6/21/18, documented Resident #28 was moderately cognitively impaired and required one-person maximum assistance with all ADLs.</p> <p>On 8/8/18 at 8:54 AM, Resident #28's care was observed during a shower. CNA #9 washed</p>	F 688			

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F 688	Continued From page 68 Resident #28's hands. She was able to slightly pry Resident #28's left hand open to wash the inside of his fingers and palm with a washcloth. She did not perform ROM exercises during the shower. On 8/8/18 at 9:04 AM, Resident #28's nails were observed to be 3 cm in length. Some fingernails were missing sharp pieces in the middle of the tips which created sharp edges. Resident #28's left hand was contracted into a fist and fingernail marks were observed in his left palm. Resident #28's medical record did not include communication or documentation regarding Resident #28's left hand contracture. A physician's order for weekly skin checks, dated 3/29/18, required staff to follow the skin at risk policy. There was no mention of the potential skin break down related to the contracture of the left hand and his long fingernails pressing against the palm. On 8/9/18 at 11:24 AM, the Rehabilitation Director stated she was the occupational therapist back in May when Resident #28 was receiving restorative therapy. She stated Resident #28 was not assessed for contractures of the left hand in the occupational therapy evaluation. She stated he was not receiving therapy now for the left-hand contracture.	F 688			
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		9/20/18	

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F 689	<p>Continued From page 69 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 2 residents (#18 and #45) reviewed for supervision and accidents. Resident #18 was harmed when staff failed to provide sufficient supervision while the resident was in her room and she fell and sustained a femur (thigh bone) fracture. Resident #45 was harmed when she sustained a wrist fracture in her room when she fell from her bed. Findings include:</p> <p>1. Resident #45 was readmitted to the facility on 7/5/17 with diagnoses which included severe intellectual disability, muscle weakness, dizziness, and convulsions.</p> <p>Resident #45's Fall Risk Assessments, dated 1/17/18, 4/14/18, and 7/19/18 documented she was at high risk for falls.</p> <p>An annual MDS assessment, dated 7/13/18, documented Resident #45 had a severe cognitive impairment and had experienced multiple non-injury falls. The MDS assessment documented Resident #45 did not use a bed alarm or chair alarm. The MDS assessment documented Resident #45 required extensive assistance of one to two staff members for all cares except eating.</p>	F 689	<p>F689</p> <p>1. Resident #18's care plan has been updated to include increased supervision, ensure personal items are within reach, ensure her call light is within reach when she is in her room, staff are asking resident before leaving her room if she has any other needs. Resident #45 has had a new fall risk assessment completed, care plan reviewed and updated to reflect current interventions to reduce the risk of a fall.</p> <p>2. Other current residents have had a new fall risk assessment. Resident who scored as a high fall risk were reviewed for new interventions which may include increased supervision, care plans updated as well.</p> <p>3. Re-education provided to staff on increased supervision to high fall risk residents, what does this mean. When a resident is calling out help help staff is not to walk by the resident's room without checking on the resident. Staff to ensure residents call lights are within reach, along with their personal items. Re-education provided to LN's during the investigation process after a resident</p>		

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F 689	<p>Continued From page 70</p> <p>The care plan area addressing Resident #45's falls, initiated 12/12/17, documented she was at risk for falls related to a history of falls and generalized weakness. The care plan interventions were documented as follows:</p> <ul style="list-style-type: none"> * Staff were to provide frequent checks on Resident #45 and keep her door ajar. * Staff were to keep her snacks at a higher level where Resident #45 could reach them easily. * Resident #45 was to wear non-skid foot wear at all times. * Resident #45's room was near the nurses' station for better visibility. * Staff were to answer Resident #45's call light promptly to help prevent falls. * Resident #45's call light was to be within reach at all times. <p>Resident #45's clinical record documented she experienced 4 falls in her room between 4/14/18 and 6/4/18.</p> <p>Resident #45's I&A Reports documented the following:</p> <ul style="list-style-type: none"> * An I&A Report, dated 4/14/18 at 10:45 PM, documented Resident #45 experienced an unwitnessed fall from her wheelchair. Resident #45 was attempting to transfer from her wheelchair into her bed and confirmed she hit her head. The I&A documented Resident #45 was trying to eat snacks and the facility moved her snacks to a higher drawer and she was educated to use her call light. The clinical management team review of the fall documented Resident #45 was cognitively impaired and the immediate 	F 689	<p>fall, you need to determine the cause of the fall (the root cause) and include the new intervention on the care plan. Re-education provided to RCMs on the completion of the root cause analysis of residents fall the new intervention to prevent the resident from repeating the same action a new intervention needs to be put into place and placed on a resident care plan. Education provided by DON and/or Administrator/designee by 9/20/2018</p> <p>4. DNS will audit 3 random resident incident reports for new interventions placed on the resident care plan. Administrator/designee will audit 3 random high fall risk residents to ensure staff are providing increased supervision and ensure staff are not walking by a resident's room that is calling out help, help. Audits will be weekly x 4 weeks then bi-weekly x 1 month, then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 689	<p>Continued From page 71</p> <p>actions of reminding the resident to utilize her call light and moving her call light were the appropriate interventions.</p> <p>Resident #45's care plan was updated on 4/20/18 to reflect this change.</p> <p>* An I&A Report, dated 4/30/18 at 11:15 AM, documented Resident #45 experienced an unwitnessed fall from bed. Resident #45 was found on her back with her head towards the door and her feet under the bed. The I&A documented Resident #45 was wearing normal socks and not non-skid foot wear. The I&A documented Resident #45 sustained an injury of a small bruise to her left hand and possibly one under her left eye. The I&A documented neurological assessments were initiated. The I&A documented Resident #45 was attempting to transfer from her bed into her wheelchair. The I&A documented the facility received orders for physical therapy to evaluate Resident #45 for education on strengthening related to transfers. The clinical management team review of the fall documented Resident #45 was cognitively impaired and Resident #45 transferred without the non-skid foot wear and she was refusing cares, was impulsive and did not wait for assistance at times.</p> <p>Resident #45's care plan was not updated after the 4/30/18 fall to reflect the change of refusal of cares and impulsiveness.</p> <p>* An I&A Report, dated 5/24/18 at 5:25 AM, documented Resident #45 experienced a fall from her wheelchair. The resident was attempting to transfer from her wheelchair into her bed. The</p>	F 689			

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F 689	<p>Continued From page 72</p> <p>I&A documented Resident #45 was wearing socks at the time of the fall. The I&A documented Resident #45 sustained an injury of small bruises to her left buttocks. The clinical management team review of the fall documented Resident #45 was cognitively impaired and Resident #45 was non-compliant with the care plan and attempted to self transfer without assistance. The recommendation of the team was to change the care plan to offer to assist Resident #45 to bed after meals.</p> <p>Resident #45's care plan was not updated after the 5/24/18 fall to reflect this change of assisting her to bed after meals.</p> <p>* An I&A Report, dated 6/4/18 at 2:30 PM, documented Resident #45 experienced an unwitnessed fall from her bed. Resident #45 was attempting to transfer from her bed into her wheelchair. The I&A documented Resident #45 was wearing not wearing any footwear at the time of the fall. The I&A documented Resident #45 sustained an injury of a right wrist fracture, bruising, and a skin tear. The clinical management team review of the fall documented Resident #45 was cognitively impaired and Resident #45 was "probably" attempting to self transfer and she was not wearing her non-skid foot wear. The care plan was updated to include keeping the door open to allow frequent checks.</p> <p>Resident #45's care plan was updated on 6/11/18 to reflect this change.</p> <p>On 8/6/18 at 5:24 PM, Resident #45 was observed calling out, "Help, help, help." Three staff personnel walked by the room before</p>	F 689			

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F 689	<p>Continued From page 73</p> <p>someone stopped to see what Resident #45's needs were.</p> <p>On 8/8/18 from 8:50 AM- 9:00 AM, Resident #45 was observed calling out, "Help, help, help, hi, hi." Resident #45's call light was activated. Resident #45 was assisted out of her bed at 9:00 AM by a staff member.</p> <p>On 8/9/18 at 4:11 PM, the DNS and RCM #1 stated Resident #45 was placed next to the nurses' station for increased supervision, her snacks were moved, and the open door policy initiated. RCM #1 stated Resident #45 preferred her belongings in a particular place and it was difficult for the facility to change things in her room. RCM #1 stated she hoped the care plan was updated with all the interventions following the falls.</p> <p>The facility failed to implement interventions, including increased supervision, to prevent Resident #45 from experiencing multiple falls in her room.</p> <p>2. Resident #18 was admitted to the facility on 5/18/15, with multiple diagnoses which including cerebrovascular accident (stroke) and generalized muscle weakness.</p> <p>A quarterly MDS assessment dated 2/26/18, documented Resident #18 was cognitively intact, had no history of falls, and required extensive assistance of two staff members for all cares except for eating and drinking.</p> <p>Resident #18's care plan initiated on 5/28/15, documented she was at risk for falls. The care</p>	F 689			

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F 689	<p>Continued From page 74</p> <p>plan approaches included a two-person Hoyer lift for all transfers, assessment for assistive devices, assessment of risk factors, and Resident #18's use of wheelchair for mobility with the assistance of one person.</p> <p>Resident #18's care plan initiated on 10/9/17, documented she was at risk for impaired vision due to diabetes mellitus. The care plan directed staff to report any unusual visual disturbances, blurred vision, halos, and double vision.</p> <p>The 10/9/17 care plan did not state Resident #18's commonly used items were to be placed within her reach.</p> <p>An I&A Report, documented Resident #18 had an unwitnessed fall from bed at 6:30 AM on 7/14/18. The report documented "initial nurse in room foun[d] rsdt [resident] on the floor with 1 leg still up on the side of the bed tangled in a blanket..." Activity engaged in at the time of the fall was documented as "Looking for call light or reaching for call light, rsdt [resident] stated both. Call light was attached to her covers per usual."</p> <p>A revised care plan dated 7/14/18, documented Resident #18 had a fall from bed. Approaches included in the care plan were to place a fall mat on the floor while Resident #18 was in bed, a bolster to be placed on the bed for safety per Resident #18's request, and staff were to encourage Resident #18 to keep her bed in the lowest position.</p> <p>A Nursing Note, dated 7/14/18 at 9:28 AM, documented licensed nurse entered Resident #18's room and observed her lying face down on</p>	F 689			

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F 689	<p>Continued From page 75</p> <p>the floor next to her bed. Resident #18's head was on the floor and her chest and lower extremities were on top of the metal legs of her bedside table. The Nursing Note documented further assessment of Resident #18's legs, knees and ribs found they were without deformities and there were no changes to her normal range of motion.</p> <p>A Nursing Note, dated 7/14/18 at 5:48 PM, documented Resident #18's left knee was swollen and painful to touch with no obvious deformity. Resident #18 also complained of pain in her ribs. A physician order was received to x-ray Resident #18's chest and left lower extremity. A family representative wanted Resident #18 sent to the hospital, but Resident #18 elected not to go to the emergency room. Resident #18 was aware her x-rays would be taken the following Monday.</p> <p>Resident #18's x-ray results, dated 7/16/18, documented an acute impacted supracondylar femur (thigh bone) fracture and a normal left shoulder.</p> <p>A Physician Note, dated 7/20/18, documented "I contacted [name of physician] for phone consult and outlined my opinion that pt [patient] is not an operable candidate. We will place her in L [left] knee brace in extension..."</p> <p>A Physical Therapy Evaluation and Treatment note, dated 7/19/18, documented "fit resident with a functional brace for supercondylar fracture on left..."</p> <p>On 8/8/18 at 9:08 AM, Resident #18 said she fell</p>	F 689			

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F 689	<p>Continued From page 76</p> <p>off her bed because she was trying to reach her call light. When asked where call light was, Resident #18 said over there, pointing to her bed side table to the right side of her bed. Resident #18 said it was early in the morning when it happened. She said she had felt cold and needed an extra blanket and could not reach her call light.</p> <p>On 8/8/18 at 2:55 PM, Resident #18 said she smoked cigarettes 2-3 times per day had not smoked for weeks now because her left leg hurts whenever she moves.</p> <p>On 8/8/18 at 5:35 PM, a surveyor entered Resident #18's room. Resident #18 was observed in bed, her bed was slightly raised and on her right side was the overbed table with two glasses of a juice. Resident #18 asked the surveyor to push her overbed table closer to her so she reach her drink. The surveyor asked Resident #18 how she would ask for help if the surveyor was not in her room. Resident #18 then pushed her call light as a response.</p> <p>On 8/9/18 at 10:00 AM, the Maintenance Director said he helped to deliver drinks to the residents the day before. He said he knew Resident #18 and forgot to ask her if she needed anything else when he put the glasses of juice on her overbed table. The Maintenance Director said he should have made sure Resident #18 could reach the juice before he left her room.</p> <p>On 8/9/18 at 2:47 PM, RCM #3 said Resident #18 rolled out of her bed while trying to reach her call light. RCM #3 said she was told by the nurse that Resident #18's call light was always within</p>	F 689			

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F 689	Continued From page 77 reach of the resident. RCM #3 said staff should ensure Resident #18's call light, television remote control, drinks, and other commonly used items were within her reach. RCM #3 said staff were to ask Resident #18 what else she needs before leaving her room.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		9/20/18	

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F 690	<p>Continued From page 78</p> <p>comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure residents' urinary care needs were met. This was true for 1 of 3 residents (#41) sampled for UTIs and / or indwelling urinary catheters. Resident #41 had the potential for harm when she did not have a diagnosis for the indwelling urinary catheter and the catheter care was not consistently provided. Findings include:</p> <p>1. Resident #41 was readmitted to the facility on 7/6/18, with diagnoses which included chronic kidney disease.</p> <p>An admission MDS assessment, dated 7/13/18, documented Resident #41 had a severe cognitive impairment. The MDS assessment documented she required extensive assistance from 1 to 2 staff members for all cares. The MDS assessment documented she had an indwelling catheter.</p> <p>The Admission Nursing Assessment, dated 7/6/18, documented Resident #41 was incontinent of urine and did not have a catheter.</p> <p>The Baseline Care plan addressing Resident #41's bladder incontinence, dated 7/6/18, did not include the use of a catheter.</p>	F 690	<p>1. Resident #41 is no longer a resident of the facility.</p> <p>2. Other current residents with urinary catheters were reviewed to ensure a medical diagnosis was present for the catheter use Catheter care is being done consistently as well as catheter care is now being documented on the resident's treatment record.</p> <p>3. Re-education provided to LN's to ensure a resident with a foley catheter has a medical diagnosis for the use of the catheter. LN's are to be documenting on the resident's treatment record the foley catheter care. CNA's re-educated on ensuring consistent catheter care is being provided. Education to Medical Records to ensure residents with a foley catheter has a medical diagnosis for the use. An entry will be made on the resident's treatment record to document foley catheter care. RCM's educated by DNS to ensure residents who receive new orders for a foley catheter has a medical diagnosis for the use and the resident has an entry on their treatment record for catheter care every shift. Education provided by the DON and/or Administrator/designee by 9/20/2018</p>		

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F 690	<p>Continued From page 79</p> <p>On 7/23/18 Resident #41's care plan was updated to address an indwelling catheter and stated Resident #41 required a catheter due to immobility and her skin integrity.</p> <p>Resident #41's physician's orders included a Foley catheter, ordered on 7/13/18 without a diagnosis attached.</p> <p>A Care Conference Report, dated 7/13/18, documented Resident #41 refused to get out of bed and she was admitted with multiple pressure ulcers and poor skin integrity.</p> <p>Resident #41's 7/13/18 through 8/8/18 MARs and TARs did not document catheter care was being completed for Resident #41.</p> <p>On 8/6/18 at 5:47 PM, Resident #41 was observed laying in bed with a catheter hanging on the bed.</p> <p>On 8/7/18 from 9:47 AM through 4:11 PM, Resident # 41 was observed with a catheter hanging on the bed.</p> <p>On 8/8/18 at 6:10 PM, the DNS stated there was not a diagnosis related to the use of Resident #41's catheter. The DNS also said she could not locate documentation catheter care was provided to Resident #41. The DNS stated documentation of the catheter care would be located on the MAR or TAR.</p>	F 690	<p>4. RCM/designee will audit 3 random residents with new orders for foley catheter to ensure a medical diagnosis is present for the use, as well as an entry for catheter care every shift. Audit 3 random resident to ensure consistent catheter care is completed. Audits will be weekly x 4 weeks, then bi-weekly x 1 month, then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		
F 697 SS=G	<p>Pain Management CFR(s): 483.25(k)</p> <p>§483.25(k) Pain Management. The facility must ensure that pain management is</p>	F 697		9/20/18	

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F 697	<p>Continued From page 80</p> <p>provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff and resident interview, and review of records, it was determined the facility failed to ensure physicians' orders were followed as directed to effectively manage residents' pain. This was true for 2 of 2 (#18 and #41) residents sampled for pain. Resident #18 and Resident #41 were harmed when they experienced increased pain during cares and a dressing changes. Findings include:</p> <p>1. Resident #41 was readmitted to the facility on 7/6/18, with diagnoses which included chronic non-pressure ulcer of the lower leg, unspecified open wound to the right and left lower legs, chronic pain, cellulitis (a potentially serious skin infection), and osteoarthritis.</p> <p>An admission MDS assessment, dated 7/13/18, documented Resident #41 had severe cognitive impairment. The MDS assessment documented she required extensive assistance from 1 to 2 staff members for all cares. The MDS assessment documented she experienced frequent pain and her pain was rated at an 8 out of 10.</p> <p>The care plan area addressing Resident #41's pain, initiated 7/25/18, documented staff were to administer medications as ordered and anticipate Resident #41's need for pain relief and respond</p>	F 697	<p>F697</p> <p>1. Resident #41 is no longer a resident of the facility. Resident #18's physician orders are being followed as directed. Non-pharmacological interventions are now included on the resident's care plan for shoulder pain. Her care plan addresses her left leg pain r/t fracture. Resident is currently participating in a RNA program.</p> <p>2. Other current residents were assessed for pain control, a review of the resident's current pain medication regimen for those with uncontrolled pain were assessed. Assessments were completed to ensure medications are administered as ordered by the physician. Other residents were assessed for non-pharmacological interventions that are effective for the resident, these will be added to the care plan as well.</p> <p>3. Re-education provided to LN's will perform a pain assessment every shift which is documented on the resident's medication record. LN's to ensure pain medications are administered according the Physicians orders, non-pharmaceutical interventions must be</p>		

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F 697	<p>Continued From page 81 to her complaints of pain.</p> <p>Resident #41's physician's orders included Norco 5-325 mg by mouth three times a day as needed for chronic pain, ordered 7/6/18.</p> <p>Resident #41 did not have orders for scheduled pain medications or daily pain monitoring.</p> <p>A Care Conference Report, dated 7/13/18, documented Resident #41 refused to get out of bed and she was admitted with multiple pressure ulcers and poor skin integrity.</p> <p>The Weekly Skin Alteration Reports documented the following:</p> <p>* Weekly Skin Alteration Reports, dated 7/6/18, 7/10/18, 7/17/18, 7/20/18, 7/27/18, and 8/3/18, documented Resident #41 had a stage three pressure ulcer on her outside right ankle, first observed upon admit.</p> <p>* Weekly Skin Alteration Reports, dated 7/6/18, 7/10/18, 7/17/18, 7/20/18, 7/27/18, and 8/3/18, documented Resident #41 had an arterial wound on her right outer shin with black area, first observed upon admit.</p> <p>Resident #41's 7/9/18 through 8/8/18 MAR documented she refused medications, treatments, and the application of skin moisturizer multiple times due to severe complaints of pain. Examples include:</p> <p>* Lisinopril was not administered from 7/14/18 through 7/22/18, 7/27/18 through 7/29/18, 8/4/18, and 8/5/18.</p>	F 697	<p>used in conjunction with the pharmaceutical orders to aid in pain control as well, care plans will include these. Education provided by the DON and/or Administrator/designee by 9/20/2018</p> <p>4. RCM/designee will audit 3 random residents to ensure they have adequate pain control, the LN is administering pain medication according the Physician orders, ensure non-pharmaceutical interventions are in place and being used, ensure a pain care plan is in place and being followed. Audits will be weekly x 4 weeks, then bi-weekly x 2 months.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 697	<p>Continued From page 82</p> <p>* Her weight was not assessed from 7/7/18 through 7/9/18, 7/11/18 through 7/16/18, 7/20/18 through 7/24/18, and 7/27/18 through 8/8/18.</p> <p>* Bordered foam dressing to the mid and upper back, right ankle, and right shin was not changed on 7/23/18, 7/28/18, 7/29/19, 8/1/18, 8/3/18, 8/4/18 and 8/6/18.</p> <p>* Her daily measurements of her bilateral ankles, bilateral calves, and bilateral insteps were not assessed on 7/11/18, 7/12/18, 7/16/18, 7/17/18, 7/20/18 through 7/24/18, and 7/26/18 through 8/8/18.</p> <p>* Skin moisturizer was not applied on 7/14/18, 7/16/18, 7/20/18, 7/21/18, 7/22/18, 7/27/18, 7/28/18, 7/29/18, 8/3/18, 8/4/18, and 8/5/18.</p> <p>* Skin moisturizer was applied once a day, instead of twice as a day as ordered on 7/13/18, 7/17/18, 7/15/18 7/23/18, 7/24/18 7/30/18, 7/31/18 and 8/6/18.</p> <p>On 8/6/18 at 5:47 PM, Resident #41 was observed laying in bed with a pillow under her back on her left-side.</p> <p>On 8/7/18 from 9:47 AM through 4:11 PM, Resident # 41 was observed on her back with a pillow under her right arm and her legs flush on the bed. Resident #41's right ankle and right calf was positioned flat against the mattress.</p> <p>On 8/7/18 at 10:42 AM, Resident #41's right leg was observed with a bandage on the outside of her right ankle and an ACE bandage on her right</p>	F 697			

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F 697	<p>Continued From page 83</p> <p>shin. CNA #1 and CNA #2 were observed assisting Resident #41 with changing her incontinence brief. CNA #1 removed the pillows under Resident #41's right arm and she cried out, "Ow, ow, ow, ow, ow, ow." CNA #1 and CNA #2 rolled Resident #41 onto her left-side and Resident #41 said, "Ow, ow, ohh God, ow, ow." CNA #1 stated sorry and he knew it was painful. Resident #41 stated, "Ow, ow, ow, oh, oh, oh my left leg, you are pulling on my hip." The CNAs rolled Resident #41 onto her back and then onto her right-side. She continued to cry and say "Ow, ow, ow, ow, ow, ohh, ohh, my arm, could you lift you have a hand on my arm, oh, oh, oh, oh, my arm, oh, oh, oh, oh, could you lift your arm, ow, ow, ow!" The CNAs completed changing Resident #41's incontinence brief and positioned Resident #41 up higher in bed. During the process Resident #41 continued to cry out, "Oh, oh, oh." CNA #2 was observed placing a pillow under her right side and she continued to express cries of pain. CNA #1 and #2 stated they had to replace the pillow under her back and she stated she was in too much pain to allow then to apply the pillow behind her back and to please wait a while.</p> <p>On 8/7/18 at 12:11 PM, Resident #41 stated she was not always provided pain medications prior to dressing changes and when she was not provided the medications she would refuse due to pain. Resident #41 stated when she was provided pain medications the dressing changes could be managed.</p> <p>On 8/8/18 from 8:37 AM to 5:56 PM Resident #41's right ankle and her right calf were observed positioned flat against the mattress.</p>	F 697			

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F 697	<p>Continued From page 84</p> <p>On 8/8/18 at 1:12 PM, Resident #41 was observed during a dressing change to her right shin. Resident #41's leg was positioned back on the mattress after LPN #4 completed a dressing change. Resident #41 cried out during the dressing change saying, "Ow."</p> <p>On 8/8/18 at 1:25 PM, Resident #41 was observed crying and complaining her right arm hurt "really bad." Resident #41 stated her pain was rated at an 8 out of 10.</p> <p>On 8/8/18 at 1:33 PM, LPN #2 was called for assistance and LPN #2 was observed attempting to reposition Resident #41's pillow under her right arm. Resident #41 started crying and stated, " I do not mean to cry, but it hurt really bad."</p> <p>On 8/8/18 at 1:34 PM, LPN #2 provided Resident #41 with a pain pill.</p> <p>On 8/8/18 at 5:45 PM, DNS stated the facility monitored residents for the first 72 hours for pain and then determine the residents pain control plan based on the 72 hour pain assessments. The DNS stated nurses should be monitoring residents for the effectiveness of the pain control plan and notify the physician if new pain presents. The DNS stated the facility also assessed residents quarterly for changes in pain to determine the effectiveness of the pain medications. The DNS stated she was not aware of Resident #41's refusals of treatments and medications due to pain and she was not aware of her increased pain. The DNS stated she could not see what non-pharmacological interventions were being utilized for Resident #41. Resident</p>	F 697			

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F 697	<p>Continued From page 85</p> <p>#41's clinical record did not contain documentation of notification to the physician when she continually refused medications and treatments due to pain. The DNS stated the staff should have notified the physician about Resident #41's increased pain and increased refusals.</p> <p>2. Resident #18 was admitted to the facility on 5/18/15, with multiple diagnoses which included chronic pain and fracture of lower end of femur (thigh bone).</p> <p>An annual MDS assessment, dated 5/27/18, documented Resident #18 was cognitively intact, experienced occasional pain, received routine and PRN (as necessary) pain medications. The MDS assessment also documented Resident #18's pain did not limit her day to day activities.</p> <p>Resident #18's August 2018 recapitulated physician's orders included:</p> <p>*Bio-freeze or generic equivalent PRN topically for pain, ordered 9/27/17. *Fentanyl patch 75 mcg/hour, every 72 hours, ordered 7/16/17. *Lidocaine Adhesive patch medicated, 5%: 1 patch topical once a day, ordered 7/22/2017, *Norco (hydrocodone-acetaminophen) 5/325 mg tablet, tablet PRN every 6 hours, ordered 6/20/16.</p> <p>Resident #18's care plan documented Resident #18 had left shoulder pain as evidenced by Resident #18's verbalization of pain. Interventions included in the care plan were:</p>	F 697			

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F 697	<p>Continued From page 86</p> <ul style="list-style-type: none"> * Resident #18 will ask for pain medication for breakthrough pain * Pain assessment on admission, and as necessary * Monitor pain until effective pain management plan is established * Position resident for comfort <p>Non-pharmacological interventions were not included in the care plan for Resident #18's shoulder pain.</p> <p>An I&A Report, dated 7/14/18, documented Resident #14 fell out of bed while trying to reach her call light.</p> <p>Resident #18's revised care plan, dated 7/14/18, documented Resident #18 had a fall from bed and she was at risk for falls. Interventions included in the care plan were to place a fall mat on the floor while Resident #18 was in bed, a bolster to be placed on the bed for safety per Resident #18's request, and staff were to encourage Resident #18 to keep her bed in the lowest position. The care plan did not address the left leg pain she was experiencing due to the thigh fracture.</p> <p>A Physical Therapy Evaluation and Treatment note, dated 7/19/18, documented "fit resident with a functional brace for supercondylar fracture on left..."</p> <p>A 7/16/18, X-ray result, documented a fracture involving Resident #18's left supracondylar femur (thigh) without displacement.</p> <p>A Physician Notes, dated 7/20/18, documented "I</p>	F 697			

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F 697	<p>Continued From page 87</p> <p>contacted [physician name] for phone consult and outlined my opinion that pt [patient] is not an operable candidate. We will place her in L [left] knee brace extension. Pain Meds [medication] modified see orders."</p> <p>A Physician Order dated 7/20/18, documented:</p> <ul style="list-style-type: none"> * Discontinue Norco 5/325 mg tablet, resident has high level of pain medication (PRN) for LLE fracture, * Norco 10/325 mg tablet, PRN every four hours, one tablet for 1-5 pain, two tablets for 6-10 pain, * May have floor mat next to bed for safety. <p>Resident #18's July 2018 PRN Medication Administration Pain Management Flow Sheet documented Resident #18 received one tablet of Norco 10/325 mg, instead of two tablets as ordered, for a pain rating of 6-10. Examples include:</p> <ul style="list-style-type: none"> * On 7/20/18 at 6:11 PM, Resident #18 rated her pain at "8" and received one tablet of Norco 10/325 mg. Resident #18's pain was reassessed and rated her pain at "3." * On 7/23/18 at 6:47 AM, Resident #18 rated her pain at "9" and received one tablet of Norco 10/325 mg. Resident #18's pain was reassessed and rated her pain at "4." * On 7/23/18 at 11:05 AM, Resident #18 rated her pain at "9" and received one tablet of Norco 10/325 mg. Resident #18's pain was reassessed and rated her pain at "2." * On 7/24/18 at 11:24 AM, Resident #18 rated her 	F 697			

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F 697	<p>Continued From page 88</p> <p>pain at "7" and received one tablet of Norco 10/325 mg. The resident's pain was reassessed and rated her pain at "2."</p> <p>*On 7/25/18 at 9:52 AM, Resident #18 rated her pain at "9" and received one tablet of Norco 10/325 mg. The resident's pain was reassessed and rated her pain at "2."</p> <p>*On 7/25/18 at 3:46 PM, Resident #18 rated her pain at "10" and received one tablet of Norco 10/325 mg. The resident's pain was reassessed and rated her pain at "1."</p> <p>*On 7/27/18 at 4:56 AM, Resident #18 rated her pain at "7" and received one tablet of Norco 10/325 mg. The resident's pain was reassessed and rated her pain at "4."</p> <p>A Nursing Note, dated 7/24/18 at 10:27 AM, documented Resident #18 showed aggressive behavior towards staff during nursing cares. She refused to be touched or moved afraid it would cause her pain.</p> <p>A Nursing Note, dated 7/31/18 at 6:16 AM, documented Resident #18 was tearful when turned in her bed to change her adult diaper.</p> <p>A Nursing Note, dated 7/31/18 at 1:57 PM, documented "...resident is only allowing staff to provide cares 1 x shift, and she is not allowing them to roll her over...Resident has extreme anxiety when attempting to look at areas..."</p> <p>On 8/7/18 at 3:41 PM, a surveyor entered Resident #18's room, where two CNAs and RN were observed providing nursing cares to</p>	F 697			

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

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F 697	<p>Continued From page 89</p> <p>Resident #18. The surveyor asked permission to observe the staff while they provide nursing cares to Resident #18. The RN asked Resident #18 and she said "No." As the surveyor was leaving the room, the surveyor heard Resident #18 saying in a loud voice "no no no my leg my leg."</p> <p>On 8/8/18 at 9:48 PM, CNA #2, who worked as a RNA, said Resident #18 had not received restorative nursing services since she fell because Resident #18 always refused due to severe pain.</p> <p>On 8/8/18 at 2:55 PM, Resident #18 said she smoked cigarettes 2-3 times per day but had not smoked for weeks now because her left leg hurt whenever she moved.</p> <p>On 8/9/18 at 10:12 AM, CNA #4 and CNA #6 were providing nursing cares to Resident #18. The CNAs changed Resident #18's soiled brief. While the two CNAs assisted Resident #18 with cares and rolled her from side to side she moaned and continued to moan throughout the process. Resident #18 was heard saying loudly "no no no, don't don't don't" as she was rolled from side to side.</p> <p>On 8/9/18 at 2:11 PM, RCM #3 confirmed Resident #18 pain medications were not consistently administered as ordered. She said it was a concern since Resident #18 was always in pain. RCM #3 said she was not sure whether the nurse had recognized the change in Resident #18's pain medication. RCM #3 said nurses should asked the residents at least once every shift if they are in pain or not. RCM #3 then</p>	F 697			

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F 697	Continued From page 90 looked at the nursing notes and said she did not find documentation regarding the reason Resident #18 received one tablet of Norco 10/325 for pain scale of greater than 5.	F 697			
F 700 SS=D	Resident #18 was harmed when she did not receive the right amount of pain medications ordered. She refused to smoke and participate her restorative nursing program because of the pain she experienced. 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, record review, and staff	F 700		9/20/18	
			F700		

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F 700	<p>Continued From page 91</p> <p>interview, it was determined the facility failed to ensure appropriate safety assessments were completed prior to the installation of bed rails for 3 of 3 residents (#13, #15, and #33) reviewed for bed rail use. This failure created the potential for harm if residents were to become entrapped in bed rails, experience falls, or were otherwise injured due to the use of bed rails. Findings include:</p> <p>1. Resident #13 was readmitted to the facility on 7/24/18, with an initial admission date of 9/12/17, with diagnoses which included portal hypertension, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, and muscle weakness.</p> <p>A quarterly MDS assessment, dated 5/20/18, documented Resident #13 was cognitively intact. The MDS assessment documented she required supervision with bed mobility and transfers.</p> <p>Resident #13's physician's orders documented she had a right-sided bedrail for bed mobility, ordered 9/14/17. The physician's order was not transcribed over onto Resident #13's order recapitulation the physician signed as of 8/7/18.</p> <p>The care plan area addressing Resident #13's falls, initiated 2/22/18, documented Resident #13 had the right-sided bedrail for bed mobility.</p> <p>Resident #13's Bedrail Assessment, dated 10/10/17, did not contain documentation her bed's dimensions were assessed based on her size and weight, she was assessed for risk for entrapment, and /or the assessment followed manufacturer's recommendations for installing</p>	F 700	<p>1. Resident #13, #15, and #33 have been assessed to ensure the dimensions of their bed is adequate for the resident based on the resident's height and weight, MD orders are present, and care planned.</p> <p>2. Other current residents who use side rails were assessed for entrapment, and the dimensions of the bed were assessed to ensure it is adequate for the resident based on the resident's height and weight. Residents DX's were reviewed for cognition deficits and movement disorders as well for safety. MD orders were reviewed and are present, as well as care planned.</p> <p>3. Re-education provided to the Maintenance Director to ensure each month he is logging which beds are assessed and how many beds are assessed and what residents are assessed. An addition added to the monthly report including which beds are assessed and how many beds are assessed, and what residents are assessed. LN's were re-educated on side rail use with using other interventions prior to initiating side rails. If side rails are warranted an MD order, consent and assessment for side rails are obtained prior to placing on bed. Education provided by the DON and/or Administrator/designee by 9/20/18</p> <p>4. Administrator/designee will audit 5</p>		

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F 700	<p>Continued From page 92 and maintaining bedrails.</p> <p>On 8/8/18 at 9:08 AM, Resident #13 was observed in bed close to the edge of the right side of the bed and her bedrail was in the upright position.</p> <p>2. Resident #15 was admitted to the facility on 2/16/18, with diagnoses which included multiple sclerosis and quadriplegia.</p> <p>A quarterly MDS assessment, dated 5/24/18, documented Resident #15 was cognitively intact. The MDS documented Resident #15 did not use bedrails. The MDS documented Resident #15 was totally dependent or required extensive assistance of one to two staff members for all cares.</p> <p>Resident #15's physician's orders documented she had bilateral bedrails for safety, ordered 2/18/18. The physician's order was not transcribed over onto Resident #15's order recapitulation the physician signed as of 8/8/18.</p> <p>Resident #15's care plan did not include an area addressing her bedrails.</p> <p>Resident #15's Bedrail Assessment, dated 5/30/18, did not contain documentation her bed's dimensions were assessed based on her size and weight, she was assessed for risk for entrapment, or the assessment followed manufacturer's recommendations for installing and maintaining bedrails.</p> <p>On 8/6/18 at 4:14 PM, Resident #15 was observed in bed with bilateral 1/2 bedrail upright.</p>	F 700	<p>random residents who use bedrails to ensure they have been assessed to ensure the dimensions of the bed is adequate for the resident based on the resident's height and weight, MD orders are present, and care planned. Audits will be weekly x 4 weeks then bi-weekly x 1 month, then monthly x 1 month. Administrator/designee will audit the Maintenance Director monthly side rail report to ensure it includes which beds are assessed and how many beds are assessed, and what residents are assessed. Audits will be monthly x 3 months.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 700	<p>Continued From page 93</p> <p>3. Resident #33 was readmitted to the facility on 2/28/18, with diagnoses which included abnormalities of gait and mobility, and peripheral vascular disease.</p> <p>A Care Plan, dated 4/12/18, documented Resident #33 was to have side rails to enable him to participate as much as possible in self-care.</p> <p>A Physician's Order Report, dated 7/1/18, documented Resident #33 may have side rails to help with bed repositioning.</p> <p>An MDS quarterly assessment, dated 7/3/18, documented Resident #33 was moderately cognitively impaired, and required one-person physical assistance with transfer and bed mobility.</p> <p>On 8/7/18 at 11:44 AM, Resident#33' s bed was observed to have ½ side rails up at the head of his bed.</p> <p>The Maintenance Director provided logbooks from January 2018 through July 2018, which documented in-house inspections of bed frames and mattresses were completed monthly and as part of the monthly inspections beds were inspected for risk of entrapment. The logbook did not identify what beds were assessed or how many beds were assessed, or what residents were assessed.</p> <p>On 8/9/18 at 2:45 PM, the Maintenance Director stated the report just identified the beds were inspected and did not identify what rooms were</p>	F 700			

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F 700	Continued From page 94 checked. The Maintenance Director stated he only placed bedrails after residents had orders in place for them and nursing had assessed them. The Maintenance Director stated all the beds and bedrails were compatible with each other as they were bought together.	F 700			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's Medication Administration General Guidelines, and staff interview, it was determined the facility failed to ensure it was free from medication error rates 5 percent or greater. This was true for 3 of 26 medications (11.54%) which affected 2 of 3 residents (#44 and #154) whose medication passes were observed. The failure created the potential for harm when residents received the wrong dose of a medication, and had the potential for subtherapeutic effects when residents did not receive their medications at the correct time and were not instructed to rinse their mouths after receiving inhaled medications. Findings include: The facility's undated Medication Administration General Guidelines documented the following "Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label...Medications are	F 759	F759 1. Resident #154 is receiving the prescribed Advair Diskus inhaler as directed by the Physician, the resident is rinsing their mouth after administration as well. Resident #44 is rinsing their mouth after the use of their Symbicourt inhaler. 2. Other current residents who receive an inhaler now have an entry in the medication record to rinse mouth after the use of an inhaler. The nurse will assist with this task if needed. Other current residents are receiving their inhaler medications as directed by the Physician. 3. Re-education provided to the LN□s on ensuring residents rinse their mouth after the using an inhaler. LN□s have been re-educated on the 6 rights of a medication pass. Education provided by	9/20/18	

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F 759	<p>Continued From page 95 administered in accordance with written orders of the attending physician..."</p> <p>The Nursing 2018 Drug Handbook instructions for the Advair Diskus and Symbicort (both are inhalers) stated "Instruct patient to rinse mouth after inhalation to prevent oral (mouth) candidiasis (yeast infection)." The instructions for the administration of Flomax (a medication used to treat an enlarged prostate) stated "Tell patient to take drug about 30 minutes after same meal each day."</p> <p>1. Resident #154 was admitted to the facility on 8/7/18, with multiple diagnoses which included COPD.</p> <p>Resident #154's August 2018 recapitulated Physician's Orders included Advair Diskus blister with device 250-50 mcg/dose, 1 puff twice a day. The order included special instructions for the resident to rinse the mouth out with water, swish, and spit after administration.</p> <p>On 8/8/18 at 4:30 PM, LPN #2 was observed when he administered Resident #154's medications, which included the inhaled medication Advair. Resident #154 was observed to take two puffs of the Advair, and then gave the Advair back to LPN #2. Resident #154 was not observed rinsing his mouth after taking the Advair inhalation.</p> <p>LPN #2 was interviewed immediately after the medication pass. After reviewing the physician's orders, LPN #2 said Resident #154 should have only taken one inhalation of Advair. When asked what instructions should have been given to</p>	F 759	<p>DON and/or administrator/designee by 9/20/2018</p> <p>4. DON/designee will audit 3 random LN□s weekly to ensure LN□s are following the 6 rights of a medication pass. DON/designee will audit 3 random LN□s administering an inhaler to a resident to ensure the resident is rinsing their mouth after use. Audits will be weekly x 4 weeks, then bi-weekly x 1 month then monthly x 1 month.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 759	Continued From page 96 Resident #154 after taking the Advair inhalation, LPN #2 said he would ask Resident #154 to drink water. 2. Resident #44 was admitted to the facility on 5/24/18, with multiple diagnoses which included COPD. Resident #44's August 2018 recapitulated Physician Orders included Flomax 0.4 mg capsule by mouth. The order included special instructions for the medication to be given with the evening meal. Resident #44 also had a physician order for Symbicort 160-4.5 mcg/actuation, 2 puffs twice a day. On 8/8/18 at 5:55 PM, RN #5 was observed as she administered Resident #44's oral medications which included Flomax 0.4 mg capsule and Symbicort. Resident #44 took his oral medications and drank the water RN #5 handed to him. Resident #44 then took one puff of Symbicort, and gave the Symbicort back to RN #5. Resident #44 was not observed rinsing his mouth after taking the puff of Symbicort. RN #5 was interviewed immediately after the medication pass. After reviewing the physician's orders, RN #5 said she should have told Resident #44 to take two puffs of Symbicort and asked him to rinse his mouth with water and spit it out. She said the Flomax should have been given with Resident #44's evening meal.	F 759			
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	F 761		9/20/18	

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F 761	<p>Continued From page 97</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</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 carts. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>On 8/8/18 at 6:27 PM, during the inspection of the Long Hall Medication Cart with RN #5, the following medications were found:</p> <p>*13 tablets of ondansetron (a nausea</p>	F 761	<p>F761</p> <ol style="list-style-type: none"> 1. The Long hall medication cart was reviewed for expired medications no other expired medications were found. 2. Other medications carts and medication rooms were audited for expired medications; any expired medications were discarded. 3. Re-education provided to the LN□s to ensure during the medication pass the LN 		

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F 761	Continued From page 98 medication) 8 mg which expired on 6/7/18. *9 capsules of oseltamivir phosphate (an anti-viral medication) which expired on 7/15/18. At the time of inspection RN #5 verified the expiration dates and said she would dispose of the expired medications.	F 761	is reviewing the expiration date of the medication prior to administering. When a resident is discharged from the facility, or when a medication is discontinued the medication is removed from the medication cart. Education provided by DON and/or Administrator/designee by 9/20/18 4. RCMs will audit the medication carts weekly for expired medications, audits will be weekly x 4 weeks then bi-weekly x 2 months. DON/designee will audit the medication room for expired medications on a monthly basis for expired medications. Audits will be monthly x 3 months. 5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.		
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. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/20/18	

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F 880	<p>Continued From page 99 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 contact with residents or their food, if direct contact will transmit the disease; and</p>	F 880			

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F 880	<p>Continued From page 100</p> <p>(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 observations, staff interviews, and policy review, it was determined the facility failed to ensure licensed nursing staff utilized proper hand hygiene practices during medication pass. This was true for 1 of 3 residents (#4) observed for medication pass. The facility failed to implement isolation precautions timely for 1 of 1 resident (#5) reviewed for infection. These deficient practices created the potential for the spread of infectious organisms from cross contamination which could harm all residents residing in the facility. Findings include:</p> <p>The facility's Transmission Based Precaution Policy, dated June 2017, documented contact precautions were used to prevent infections that spread from person to person and staff would wear gloves and a gown.</p> <p>The facility's MDRO Policy, dated June 2017, documented cleaning and disinfection of shared</p>	F 880	<p>F880</p> <ol style="list-style-type: none"> 1. Resident #5 no longer requires isolation, LN□s are following proper hand hygiene when preparing medications for resident #4. 2. Other current residents were audited for any current and pending Urinalysis to ensure follow-up has occurred and if isolation precautions are warranted. Other current residents were audited for LN□s preparing medications using proper hand hygiene. 3. Re-education provided to LN□s on proper hand hygiene for medication pass. LN is to use a spoon to remove a medication if other medications are present in the medication cup or use a 		

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F 880	<p>Continued From page 101</p> <p>bathrooms, dining rooms, and equipment was required and staff were required to use personal protective equipment, which included the use of gloves and a gown.</p> <p>1. Resident #5 was readmitted to the facility on 7/24/15, with diagnoses which included candidiasis (yeast infection) and benign prostatic hyperplasia (enlargement of the prostate gland caused by a benign overgrowth) without lower urinary tract symptoms.</p> <p>A quarterly MDS assessment, dated 5/14/18, documented Resident #5 was cognitively intact and required limited assistance of one staff member with toileting and bathing.</p> <p>The care plan area addressing Resident #5's urinary incontinence, initiated 6/25/18, documented staff were to provide incontinence care after each incontinent episode and provide medication as directed by the physician.</p> <p>A Progress Note, dated 7/31/18, documented Resident #5's physician ordered a urinalysis.</p> <p>A Progress Note, dated 8/1/18, documented a nurse collected Resident #5's urine specimen for the urinalysis and the facility was waiting on the laboratory service to pick up the specimen.</p> <p>A temporary care plan addressing Resident #5's antibiotic use related to a UTI, initiated on 8/6/18, documented staff were to monitor for side effects of antibiotic use and efficacy of the medication.</p> <p>Resident #5's Progress Note, dated 8/6/18, documented he came back from a urology</p>	F 880	<p>glove to discard the medication. Education provided by DON and/or Administrator/designee by 9/20/2018.</p> <p>4. RCM□s/designee will audit 3 random resident medication preparations to ensure the LN is following proper hand hygiene. DON/ designee will audit 3 random residents UA□s to ensure follow up results are obtained timely and ensure if isolation was required it was initiated timely. Audits will be weekly x4 weeks, then bi-weekly x 2 months.</p> <p>5. DNS/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee.</p>		

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F 880	<p>Continued From page 102</p> <p>appointment with orders for an antibiotic of cephalexin 500 mg BID for 10 days, the first dose to be administered on 8/6/18.</p> <p>Resident #5's 8/6/18 - 8/8/18 MAR documented he was administered the cephalexin 500 mg BID as ordered.</p> <p>On 8/8/18 at 11:29 AM, the SDC, who was also the infection control nurse, stated she was not aware Resident #5 had a current UTI and was on an antibiotic.</p> <p>Resident #5's C&S lab result, dated 8/3/18, was received at the facility via fax on 8/8/18 at 1:48 PM. The C&S documented the presence of proteus mirabilis and the organism was resistive to cefazolin. Both cephalexin and cefazolin are cephalosporin antibiotics and act in the same way to kill bacteria.</p> <p>On 8/8/18 at 4:07 PM, the SDC stated the presence of proteus mirabilis indicated the organism was an MDRO and she initiated contact precautions as of 8/8/18 (2 days after the antibiotic was ordered and 7 days after he was cultured). The SDC stated she was not sure how Resident #5's C&S results were not provided to the facility before 8/8/18, and why nursing did not follow up on the missing lab results. The SDC stated the bathrooms were shared between residents, Hoyer lifts were shared on the halls, and the shower rooms were shared. The SDC stated when a resident had an MDRO organism the staff was provided with a packet of wipes to clean the toilet after the infected resident used the restroom.</p>	F 880			

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F 880	Continued From page 103 On 8/8/18 at 6:19 PM, the SDC stated the nurses should have called the lab about the missing C&S results and any shift nurse could complete this task. The SDC stated lab results were usually completed within 24 hours and if staff had not received C&S results after the UA results then staff should call the lab to check on the status of the results. The SDC stated the nurses should have called the lab for the C&S results and once they knew the results, isolation precautions should have been implemented. The SDC stated the isolation precautions were not implemented timely. On 8/9/18 at 1:53 PM, the DNS stated the nurses should have followed up with the lab regarding the C&S results as soon as possible. The DNS stated the staff should have implemented isolation precautions earlier. 2. On 8/9/18 at 10:50 AM, LPN #1 was observed as she prepared Resident #4's medications. LPN #1 poured a ranitidine tablet (a medication used to treat ulcers) into the medication cup. LPN #1 then realized Resident #4 was taking a liquid form of ranitidine. LPN #1 then picked up the ranitidine tablet from the medication cup, which contained other medications for Resident #4, using her right hand and destroyed the medication. On 8/9/18 at 11:17 AM, LPN #1 said she should have put on a glove or used a spoon to pick up the ranitidine tablet from the medication cup.	F 880			
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control	F 925		9/20/18	

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F 925	<p>Continued From page 104</p> <p>program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility records, the facility failed to ensure it was free from pests. This effected 15 of 15 residents (#5, #8, #9, #13, #14, #15, #17, #18, #21, #28, #33, #41, #45, #50, and #204) and all residents who lived in the facility. Flies were observed on residents, resident care areas, cooking areas, and medication cart areas. This failure in practice had the potential for psychosocial harm from infestation of pests. Findings include:</p> <p>1. On 8/7/18 at 11:57 AM, LPN #1 was observed using a fly swatter to kill 3 flies in the (short hall) hallway, while at the medication cart.</p> <p>On 8/8/18 at 10:46 AM, Maintenance Staff #1 stated a pest control company came monthly and sprayed a solution in the smoking area that attracted flies and killed them. Maintenance Staff #1 stated the smoking area (at an exit door to the kitchen) was the worst area for flies.</p> <p>On 8/8/18 at 11:15 AM, Dietary Staff #1 stated flies' landed on the serving utensils hanging above the food. Dietary Staff #1 stated a pest control company sprayed in the kitchen last year. Dietary Staff #1 pointed at a bug light, to the right of the hall way entrance to the kitchen, close to the ceiling and then turned out the kitchen lights. When the kitchen was dark, it demonstrated the bug light was not working.</p> <p>On 8/8/18 at 1:25 PM, multiple flies were observed in the kitchen from the entrance door.</p>	F 925	<p>F925</p> <ol style="list-style-type: none"> 1. Currently there are not flies in resident #5, #8, #9, #13, #14, #15, #17, #18, #21, #28, #33, #41, #45, #50 and #204 rooms. 2. Other current resident rooms, resident care areas, cooking areas, and medication cart areas were audited for flies. 3. Pest Control will be coming to the facility to spray for flies every 2 weeks, fly traps will be added to the dumpster area changing out every 2 weeks as well. 4. Administrator/designee will do a random audit of facility areas for flies weekly x 4 weeks then bi-weekly x 2 months. 5. Administrator/designee will report the results of these audits to the facility monthly Quality Assurance meeting for 60 days or until substantial compliance has been achieved or sustained as determined by the committee. 		

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

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F 925	<p>Continued From page 105</p> <p>Flies were observed on 3 different meal cart handles, various silverware, on the plastic covers over the drink pitchers, on glasses sitting on the carts, and were flying around the room.</p> <p>On 8/8/18 at 1:28 PM, Dietary Staff #2 stated on average flies landed on the cold food approximately twenty times while they were preparing it. She stated she covered the food as soon as possible. Dietary Staff #2 stated she saw, on average, 50 flies a day. She stated flies were continually seen landing on the clean serving utensils hanging over the food.</p> <p>On 8/8/18 at 1:43 PM, a Pest Control Technician stated he was the person who completed the pest control for the facility during the past two years. He stated last year he sprayed the kitchen for flies when the kitchen was not in use, and the kitchen must be cleared for several hours. He stated he had not sprayed for flies in the facility this year.</p> <p>On 8/9/18 at 2:06 PM, CNA #11 stated the flies were a problem since it got hot.</p> <p>Invoices from the pest control company dated 5/9/18, 6/4/18, 7/10/18, and 8/8/18, documented fly bait spray was used outside of the kitchen.</p> <p>On 8/8/18 at 12:33 PM, during meal service 10 flies were observed crawling on the outside of dishes and utensil in the kitchen.</p> <p>2. On 8/7/18 at 9:47 AM, Resident #41 was observed with three flies on her body and she could not move her arms and legs to swat the flies off of herself. Resident #41 stated the flies</p>	F 925			

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F 925	<p>Continued From page 106</p> <p>were annoying and did not leave her alone.</p> <p>On 8/8/18 at 1:27 PM, Resident #41 was observed with the flies buzzing around her open wounds during a dressing change.</p> <p>3. Resident #18 was admitted to the facility on 5/18/15, with multiple diagnoses which included cerebrovascular accident (stroke) and nondisplaced fracture of lower end of left femur (thigh bone).</p> <p>On 8/8/18 at 9:08 AM, two flies were observed flying over Resident #18's bed.</p> <p>On 8/8/18 at 10:03 PM, Resident #18 was observed in bed sleeping and 3 flies were observed flying over her face.</p> <p>On 8/8/18 at 2:17 PM, Resident #18 said she just slapped two flies using her fly swatter. CNA #3 who was inside the Resident #18's room said flies had been a problem in the facility for about a week now. CNA #3 said they always kept the main door of the facility closed but the flies were still able to come in.</p> <p>On 8/9/18 at 9:57 AM, the Maintenance Supervisor said there are horses near the facility and flies were a problem in the facility every year, especially when it got hot. He said they were addressing the issues and asked the pest control to come every two weeks.</p>	F 925			