IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0009
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November 21, 2018

Dawn Meyer, Administrator
Lincoln County Care Center
PO Box 830
Shoshone, ID 83352-1502

Provider #: 135056

Dear Ms. Meyer:

On **October 26, 2018**, a survey was conducted at Lincoln County Care Center 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal 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) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of penalties by **December 24, 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 <u>in column (X5)</u>.

  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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 7, 2018, (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 26, 2019**. A change in the seriousness of the deficiencies on **December 10, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 26, 2019** includes the following:

Denial of payment for new admissions effective **January 26, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 26 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 26, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, 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 **December 3, 2018**. If your request for informal dispute resolution is received after **December 3, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

DR/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135056		**10/26/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN COUNTY CARE CENTER	**511 EAST FOURTH STREET** **SHOSHONE, ID 83352**

(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 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted October 22, 2018 to October 26, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Wendi Gonzales, RN Belinda Day, RN Abbreviations: ADL - Activities of Daily Living cm = centimeter CNA = Certified Nursing Assistant COPD =Chronic Obstructive Pulmonary disease DON = Director of Nursing I&A= Incident and Accident IDT = Interdisciplinary Team LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram ml = Milliliter RN = Registered Nurse RSM = Resident Services Manager PPE = Personal Protective Equipment PRN = As Needed TAR = Treatment Administration Record	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		11/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/30/2018

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 554	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer nebulizer treatments. This was true for 1 of 4 sample residents (#29) reviewed for respiratory care. The failure created the potential for adverse effects if Resident #29 self-administered nebulizer treatments inappropriately. Findings include: The facility's Administering Medications through a Small Volume (Handheld) Nebulizer Policy and procedure, dated 1/8/18, documented the facility utilized KeyMed's policy and procedure for nebulizer treatments. The KeyMed procedure documented staff were to stay with residents for the duration of the treatment unless the resident was assessed and authorized to self-administer the medications. Resident #29 was admitted to the facility on 5/5/16, with diagnoses which included COPD. A quarterly MDS assessment, dated 9/26/18, documented Resident #29 had a moderate cognitive impairment and was inattentive with disorganized thinking. The care plan area addressing Resident #29's COPD, initiated 5/5/16, documented she was a mouth breather and was reminded to breathe through her nose. The care plan documented she was to receive her nebulizer per orders. The care plan did not document she was assessed to self-administer the medication.	F 554	The rights to self administer medications, if the interdisciplinary team has determined that this practice is clinically appropriate. 1. This affects 1 of 32 residents. Resident #29 was reassessed for appropriateness of self medication. Changes were made to care plan to reflect the change in her use of Nebulizer treatments. 2. This has the potential to affect all residents with orders for Nebulizer treatments. All residents with orders for treatments were reviewed and care plans updated. 3. All License staff in-serviced on the policy and procedure for Nebulizer treatments. By DNS/Designee 4. Audits of License staff performing treatment will occur weekly for four weeks than monthly for three months. Audits will be performed by Director of Nursing or designee. All audits to be reviewed in QA/QI	

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F 554	Continued From page 2 Resident #29's Physicians Orders included the following: - DuoNeb Solution (inhaler used to treat wheezing and shortness of breath) 0.5-2.5 mg/3 ml vial inhaled twice daily for asthma, ordered 3/29/18. - DuoNeb Solution 0.5-2.5 mg/3 ml vial inhaled every 4 hours PRN for COPD and held per a hand-held device, ordered 6/13/17. Resident #29's 10/1/18 -10/23/18 MAR documented her scheduled DuoNeb treatment was provided per physician's orders. Resident #29's MAR documented she was provided a PRN nebulizer treatment on 10/23/18 at 10:54 AM. On 10/23/18 from 10:39 AM to 10:48 AM, Resident #29 was not feeling well and was experiencing episodes of emesis. On 10/23/18 at 10:52 AM, LPN #1 was observed as she set Resident #29's PRN DuoNeb treatment up and left the room. On 10/23/18 from 11:01 AM to 11:05 AM, Resident #29's DuoNeb hand held device was observed to be misting and the device was positioned next to her leg. Resident #29's head was bent over, and she appeared to be sleeping. On 10/23/18 at 11:05 AM, Resident #29 woke up and placed the hand-held device to her mouth and activated her call light.	F 554		

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F 554	Continued From page 3 On 10/2318 at 11:08 AM, LPN #1 entered the room and turned off the DuoNeb and asked Resident #29 what she needed. Resident #29 could not remember what she needed. LPN #1 turned the DuoNeb back on and left the room. On 10/23/18 from 11:14 AM to 11:17 AM, Resident #29's DuoNeb hand held device was observed to be misting and the device was positioned next to her leg. Resident #29's head was bent over, and she appeared to be sleeping. On 10/23/18 at 11:18 AM, LPN #1 entered Resident #29's room and removed the tubing from her hand. Resident #29's clinical record did not contain an assessment to self-administer medications. On 10/23/18 at 1:13 PM, LPN #1 stated when a resident needed a breathing treatment the process was to open a vial of the medicine and the process would take approximately 15 minutes to complete. LPN #1 stated it depended on what was going on in the facility during that time frame when she would check on residents. LPN #1 stated if a resident was using a hand-held device and it was not to her mouth she was not receiving the medicine. LPN #1 stated she thought the resident had been assessed to self-administer medications and she thought it was care planned.	F 554		
F 578 SS=F	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		11/30/18

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F 578	Continued From page 4 formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 578		

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F 578	Continued From page 5 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure the residents' medical records included a copy of the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 11 of 11 residents (#4, #6, #7, #8, #10, #12, #14, #23, #26, #29, #31) reviewed for advance directives. This failure created the potential for harm if an individual resident's wishes were not followed due to lack of direction and documentation in the record. Findings include: The facility's Advance Directives Policy, dated September 2014, documented prior to or upon admission of a resident to the facility, the Resident Services Director or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives contingent on either decision. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline. This policy was not followed. 1. Residents #4, #6, #7, #8, #10, #12, #14, #23, #26, #29, and #31's records did not include documentation of their advanced directives or documentation they declined establishing	F 578	The facility must inform and provide the resident with the choice to form a advanced directive or decline on admission to the facility. 1. This affected 11 of 32 residents. Residents #4,#6,#7,#8,#12,#14,#23,#26,#29, advanced directives were noted to be in a binder in RSD office. RSD in-serviced on placement of such documents, Medical records up loaded said documents to electronic file as well as hard copy placed in chart. Resident #10, was given a copy of a Living will and assisted by RSD to review and make choices toward his end of life cares. Resident #31 was informed of his right to form a Living Will and di fill one out with his choice of end of life care. 2. This has the potential to affect all new admissions to the facility, and remaining 21. The medical records were audited for compliance. Any medical records that were found to be deficient in practice were updated by RSD with resident or resident representative. A form was developed for resident or resident representative to sign showing that they have chosen or declined the choices of forming a living will. 3. Resident Serviced Director, Interdisciplinary team, and admission team, were in-serviced to offer resident or resident representative the option to formulate, or decline an advanced directive.	

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F 578	Continued From page 6 advance directives. The residents' records also lacked documentation information regarding advanced directives and the facility's Advance Directives policy were provided to the residents and/or their representatives. On 10/24/18 at 9:27 AM, the DON stated she could not locate the advanced directives in the residents' records and she would look for the location of the advanced directives. On 10/25/18 at 12:21 PM, the Administrator stated the advanced directives were found in a binder in the RSM office. The Administrator stated she provided instruction to the staff to upload the documents into each residents' medical record. a. Resident #10 was admitted to the facility on 3/16/16, with multiple diagnoses including schizophrenia bipolar disorder, anxiety, and depression. Resident #10's record did not include documentation or a copy of his advance directives, or his decision not to formulate advance directives. Resident #10's care plan, dated 8/9/17, documented he had a Do Not Resuscitate (DNR) code status, and he wanted his son to become his decision maker if he was no longer able to make decisions. The care plan directed staff to provide comfort care for end of life. Resident #10's annual MDS assessment, dated 8/7/18, documented the resident's cognition was intact, and family or representative did not	F 578	All new admissions medical records will be audit for the formulating or declining of advanced directives. The Administrator /Designee will complete audits to ensure that each person performing a Admission is correctly following task of offering advanced directives.	

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F 578	Continued From page 7 participate in the assessment. On 10/24/18 at 10:52 AM, the Administrator stated Resident #10 was his own person and did not have a living will. The Administrator stated he should have been offered assistance to develop a living will and resident's decision documented in the admission notes. On 10/24/18 at 12:20 PM, the RSM stated Resident #10 was his own person and wanted to have his son make the decisions for him, and there was not a living will. The RSM stated that she documented notes related to advance directives in the facility's computer system and advance directives should be in the resident's hard chart. The RSM was unable to provide Resident #10's advance directive from his medical records. b. Resident #31 was admitted to the facility on 9/8/18, with multiple diagnoses including right side hemiplegia and hemiparesis (paralysis and weakness) related to cerebral infarction (stroke), and depression. Resident #31's record did not include documentation or a copy of his advance directives, or his decision not to formulate advance directives. Resident #31's Physician Order for Scope of Treatment (POST), dated 9/12/18, documented he had a DNR code status, and requested comfort measures. Resident #31's admission MDS assessment, dated 9/15/18, documented his cognition was	F 578		

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F 578	Continued From page 8 intact. Resident #31's care plan, dated 9/25/18, documented he had a DNR code status, and his friend was his Power of Attorney (POA) for health care when he was no longer able to make decisions. The care plan directed staff to provide comfort measures for end of life care. On 10/24/18 at 12:20 PM, the RSM stated Resident #31 had a POA, there was record of a POA but not a living will, and notes were in the facility's computer system. On 10/23/18 at 9:04 AM, the Medical Records Personnel stated the advance directives should be located in the hard chart and the advance directives section of the facility's computer system.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		11/30/18

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F 600	Continued From page 9 by: Based on observation, record review, resident and staff interview, and review of facility policies it was determined the facility failed to ensure 1 of 1 (#29) resident who was observed for potential abuse were free from all forms of potential abuse, including verbal and mental abuse and neglect. This deficient practice created the potential for harm if the facility failed to prevent and protect residents from potential incidents of abuse and/or neglect. Findings include: The facility's Abuse Policy and procedure, dated 5/31/17, documented residents were to be free from abuse, neglect, and misappropriation of property. The policy documented verbal abuse was using willfully disparaging and derogatory terms to a resident. The policy documented neglect was not providing goods and services to a resident that prevents and avoids mental anguish, pain, physical harm, or emotional distress. Resident #29 was admitted to the facility on 5/5/16, with diagnoses which included major depression, abnormal posture, and chronic pain. Resident #29's care plan area addressing her cognition, initiated 5/5/16, and documented she had bouts of confusion which impaired her decision making skills. The care plan area also addressed Resident #29's risk for skin impairments, initiated 5/5/16, and documented she was dependent on staff to reposition her every two hours to prevent skin breakdown. A quarterly MDS assessment, dated 9/26/18, documented Resident #29 had moderate	F 600	The resident has the right to be free from abuse. staff must not use verbal abuse, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. 1. This affected 1 or 32 residents. Staff member #A was removed from contact with residents. Staff member A, was interviewed, and than placed on suspension, until investigation could be completed. Statements taken from all staff on duty. Resident was interviewed. Surveyor was interviewed and statement written. 2. This has the potential to affect all residents. 3. All staffed in-serviced on signs of burn out. All staff in-serviced on abuse, types of abuse, and steps on how to report abuse. Residents were interviewed for any concerns with staff being verbally harsh in tone, or rough with cares. Staff audited on interactions with residents. 4. Audits to be performed one time weekly for four weeks, then monthly for three months. All audits to be reviewed in QA/QI.The Administrator/Designee will complete a weekly/monthly focused round to ensure that all residents are free from harm or the potential for harm.	

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	135056		10/26/2018

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F 600	Continued From page 10 cognitive impairment and was inattentive with disorganized thinking. The MDS documented Resident #29 was totally dependent on two staff members for transfers and bed mobility. On 10/24/18 at 1:16 PM, Resident #29 was observed reading a paper in the activity room. On 10/24/18 at 2:22 PM, Resident #29 was observed sitting in her wheelchair in her room facing the window and pulling at her left leg. Resident #29 was crying and stated to Staff #A her leg was pinching, and she was hurting really bad. Staff #A's back was facing Resident #29 and Staff #A was near Resident #29's window adjusting her blinds and curtains when she said in a raised voice, "I don't know what you want me to do! I've tried everything, I just lifted you up, I've pulled you over, I don't know what else I can do! I guess I could try and take you to the bathroom." Staff #A left the room as she said this and entered another resident's room to assist with cares. Resident #29 continued to cry and pulled at her left leg. On 10/24/18 at 2:27 PM, Resident #29 was observed with tears in her eyes and pulled at her left leg and stated she was in pain because she had wrinkles on her leg. On 10/24/18 at 2:29 PM, a surveyor asked CNA #8 and CNA #1 to assist Resident #29 with her leg, CNA #8 stated she would come assist Resident #29. On 10/24/18 at 2:30 PM, Staff #A saw CNA #8 and CNA #1 entering Resident #29's room, and rolled her eyes and entered the room and Staff	F 600		

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F 600	Continued From page 11 #A stated to CNA #8 and CNA #1 she could explain what was going on with Resident #29. Staff #A stated Resident #29 was complaining about discomfort under her left leg and Staff #A had tried to reposition her, and nothing had helped. Staff #A stated she was going to obtain assistance with getting Resident #29 into the larger bathroom to see if they could figure out what was wrong. On 10/24/18 at 2:31 PM, Staff #A stated Resident #29 was crying and Staff #A said to Resident #29, "I've tried everything, I just lifted you up, I've pulled you over, I don't know what else I can do! I guess I could try and take you to the bathroom." On 10/24/18 at 2:34 PM, CNA #1 and Staff #A left Resident #29's room without assisting her to the bathroom. On 10/24/18 at 2:35 PM, The RSM entered Resident #29's room and provided Resident #29 with 1:1 attention and got her to stop crying. On 10/24/18 at 2:37 PM, the RSM stated Resident #29 was a difficult resident and did not know how to communicate her needs all the time. The RSM stated Resident #29 suffered from anxiety and she had provided 1:1 attention to see if she could get Resident #29 to stop crying and see if she would forget about her leg pain. The RSM stated staff should be speaking with Resident #29 in a calm soothing manner and they should not raise their voices at her. On 10/24/18 at 2:56 PM, Resident #29 was observed taken into the day room and Resident #29 was pulling at her left leg.	F 600		

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F 600	Continued From page 12 On 10/24/18 at 3:01 PM, Resident #29 was observed as RN #1 took her to her room to assess her leg for injury. On 10/25/18 at 3:12 PM, the Administrator, who was the abuse coordinator, stated staff were trained with how to deal with difficult residents such as Resident #29. The Administrator stated she had asked Staff #A to leave the building while she investigated this for potential abuse. The Administrator stated residents should not be left crying and staff should not raise their voices to residents if the staff member was frustrated. The Administrator stated she was in the process of investigating this allegation and she was interviewing staff and other residents.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		11/30/18

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F 657	Continued From page 13 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised as care needs changed for 3 of 14 residents (Resident #6, #7, and #8) whose care plans were reviewed. This failure had the potential for harm if care and services were not provided due to inaccurate information. Findings include: 1. Resident #6 was admitted to the facility on 5/5/16, with diagnoses which included syncope (fainting), lack of coordination, and muscle weakness. A quarterly MDS assessment, dated 10/12/18, documented Resident #6 was cognitively intact and had experienced one fall without injury. Resident #6 was observed to be assisted with ADLs such as transferring to and from her recliner chair from her wheelchair and or walker, applying oxygen, and using the restroom with the assistance of another resident [Resident #1]. Resident #1 was admitted to the facility on 7/10/18, with diagnoses which included dementia and macular degeneration. Resident #1 was	F 657	A comprehensive care plan must be reviewed and revised by interdisciplinary team after each assessment, and with each change in residents care. 1. This affected 3 of 32 residents. Resident #6 was informed in writing of risk and benefits, of performing own cares or allowing resident # 1 (husband) assisting with cares. Care plan reviewed and updated with changes. Resident # 7 Care plan was reviewed and updated to have her fall approach for repositioning, moved to falls care plan. Resident # 8 Care plan was updated to reflect current skin condition. 2. This has the potential to affect all residents with care plan updates prior to scheduled assessments. Interdisciplinary team reviewed all care plans to ensure that all approaches were correctly placed and updated, in care plan. Especially ones that involving falls, and skin issues. 3. Interdisciplinary team to review each week, the fall and skin concerns to make sure that care plan is appropriately	

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F 657	Continued From page 14 Resident #6's husband and they resided in the same room. a. The care plan area addressing Resident #6's falls, initiated 7/24/18, documented she was at risk for falls with major injury related to weakness and her history of syncope. The care plan documented Resident #6 attempted to ambulate without assistance and without assisted devices. The care plan documented staff were to ensure her belongings were put away so Resident #6 did not try and do this herself. The care plan documented Resident #6 used a wheelchair for locomotion and staff or Resident #1 would assist her with locomotion. Resident #6's care plan did not document Resident #6's preference for Resident #1 to assist her with cares and that the facility had discussed the risk verses benefits and educated Resident #6 on potential injuries. b. The care plan area addressing Resident #6's ADL, initiated 7/24/18, documented there were times Resident #1 would "push" Resident #6 into the bathroom and wait for her to finish using the restroom. Resident #6's care plan did not document the facility had discussed the risk verses benefits of having Resident #6 assist her with ADLs instead of facility staff. On 10/22/18 at 3:09 PM, Resident #6 was observed sitting in a recliner chair with her legs elevated on a pillow and the foot rest extended. Resident #6 stated Resident #1 assisted her with cares at the facility such as transfers, going to the bathroom, getting out of bed, and whatever she needed. Resident #6 stated staff would assist her when Resident #1 was busy or not in the room.	F 657	updated. MDS and all IDT members in-serviced to update care plans in a timely manner. All intervention that are safety related from falls or skin concerns need placed on care plan after event. 4. Audits to be performed one time weekly for four weeks, then monthly for three months. Director of Nursing/Designee will complete a weekly audits of IDT meeting and of new skin /fall incidents to be sure that all care plans were updated with appropriate interventions. All Audits to be reviewed in QA/QI	

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F 657	Continued From page 15 On 10/22/18 at 3:40 PM, Resident #1 assisted Resident #6 out of her recliner chair. Resident #6 removed her nasal cannula which was attached to her oxygen concentrator and Resident #1 pulled Resident #6 up by her hands to a standing position and walked her to her wheelchair. Resident #6 sat down hard into her wheelchair and the brakes were not locked. Resident #6's portable oxygen was not turned on and the nasal cannula was placed on her nose. Resident #1 wheeled Resident #6 outside the building on a walk. On 10/23/18 at 2:22 PM, Resident #6 and Resident #1 were observed leaving the bathroom together. Resident #6 stated she just finished using the restroom with her husband's assistance. Resident #6 was using a front wheeled walker to walk to and from her room. Resident #1 held on to Resident #6's elbow as he assisted Resident #6 back into her recliner chair. Resident #6 did not have a gait belt around her waist while she was walking. On 10/24/18 at 4:15 PM, the RSM and DON stated Resident #1 assisted Resident #6 with small things such as making the bed, assisting her with locomotion in her wheelchair, and notifying staff if she wasn't feeling well. The DON stated Resident #1 was not supposed to assist Resident #6 with going to the bathroom or transfers. The DON and the RSM stated they did not have documentation that a risk verses benefits discussion was completed with the couple, however, they would correct this on 10/24/18. The RSM and the DON stated the facility did not have a discussion with the couple	F 657		

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F 657	Continued From page 16 regarding their choices, which placed Resident #6 at increased risk for falling. The DON stated this information was missing in the care plan and she would add the missing pieces. 2. Resident #7 was admitted to the facility on 7/13/17, with diagnoses which included muscle weakness, Alzheimer's disease, and degenerative disease of the nerves. A quarterly MDS assessment, dated 8/3/18, documented Resident #7 had severe cognitive impairment and had experienced no falls. A 9/14/18 I&A report documented Resident #7 experienced an unwitnessed fall in her room, rolling out of bed. The I&A documented staff found Resident #7 sitting on the floor next to her bed with her head on her pillow at the edge of the bed and her back was facing her night stand. The IDT review of Resident #7's fall documented Resident #7 liked to sleep on the edge of her bed and she required verbal cueing and reminders for positioning while in bed. The IDTs plan was for staff to check on Resident #7 often and encourage her to sleep in the center of her bed. The care plan was updated on 9/18/18 after she fell out of bed, which documented staff were to check on her often and remind and encourage her to sleep towards the center of her bed before she fell asleep. However, this was documented under her risk for skin impairments and not her falls care area. Resident #7's intervention of encouraging her to sleep in the center of her bed was intended for fall prevention. On 10/22/18 at 11:24 AM, Resident #7 was	F 657		

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F 657	Continued From page 17 observed sleeping on her right side on the outer edge of bed. Resident #7's knees were bent at a 30-degree angle and were extended over the edge of the bed. Resident #7 was observed with stockings on her feet. Resident #7 was observed in the same position on 10/23/18 from 9:00 AM to 11:32 AM, and on 10/24/18 from 10:28 AM to 2:19 PM. On 10/25/18 at 8:45 AM, the DON stated Resident #7 was encouraged by staff to sleep in the center of her bed for her fall risk. The DON stated the fall care area should be updated with the current plan and should notify staff of the current interventions in place. 3. Resident #8 was admitted to the facility on 5/13/16, with diagnoses which included Parkinson's disease, neuromuscular dysfunction of the bladder, abnormal posture, and muscle weakness. The care plan was not updated when Resident #8 developed skin impairments as follows: The care plan area addressing Resident #8's Risk for Skin Breakdown, revised 5/31/16, documented staff were to reposition Resident #8 every 2 hours and staff were to do weekly skin assessments. A Nurse's Progress Note, dated 6/13/18, documented Resident #8 had an area of shearing on her left buttock which measured 1.3 cm by 0.6 cm and an area which measured 2.5 cm by 0.8 cm on her right buttocks. Resident #8's care plan was not updated or	F 657		

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F 657	Continued From page 18 revised to reflect the shearing to her buttocks. On 10/25/18 at 2:02 PM, the DON stated the areas should be monitored on the care plan.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 1 resident (Resident #26) sampled for quality of life concerns, and created the potential for residents to become bored or depressed when not provided with meaningful engagement throughout the day. Findings include: Resident #26 was readmitted to the facility on 8/22/18, with diagnoses which included spastic (muscle spasms) hemiplegia (paralysis) affecting the left side, unsteadiness on feet, dementia, and muscle weakness. A significant change MDS assessment, dated 9/5/18, documented Resident #26 had severe	F 679	The facility must provide based on assessment and preferences of each resident an ongoing program to support to support their choices of activities. 1. This affected 1 of 32 residents. Resident # 26 has been assessed for likes, and dislikes, in leisure and group program. When showing interest in a program resident assisted by staff to program of choice. 2. This has the potential to affect all residents that require assistance to programs of choosing. The activity staff will ask the residents if they would like to attend current program being offered. If they say yes then their name is placed on a list that then given to the Licensed nurse. The clinical team is	11/30/18

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F 679	Continued From page 19 cognitive impairment and required extensive assistance of two staff members with bed mobility and transfers. The care plan area addressing Resident #26's activities, revised 8/29/18, documented he enjoyed participating in activities with others but refused at times. On 10/23/18, from 9:06 AM through 11:54 AM, Resident #26 was observed in bed on his back watching TV. On 10/24/18 at 9:52 AM, Resident # 26 was observed in bed on his back watching TV. On 10/24/18 at 10:02 AM, the Activities Director entered Resident #26's room and asked him if he wanted to attend the activity in the dining room that started at 10:00 AM. Resident #26 stated he wanted to attend the activity. The Activity Director stated she would ask for assistance with getting him out of bed to attend the activity and left the room. The Activity Director was observed asking a CNA to please assist Resident #26 with getting out of bed. The CNA stated she was assisting a resident to the bathroom and would assist Resident #26 when she could. On 10/24/18 from 10:04 AM through 11:04 AM, Resident #26 was observed in his room. On 10/24/18 at 10:42 AM, CNA #8 and CNA #7 were asked to assist Resident #26 into his wheelchair by another CNA. On 10/24/18 at 11:00 AM, CNA #8 and CNA #7 were observed assisting Resident #26 into his	F 679	then responsible for assisting resident up for program. Activity staff is to then go around 15 minutes prior to program to make sure all interested resident are assisted to program. 3. The list will be kept in a binder in activity department and then compared to participation sheets to be sure residents are attending activity of choice. Activity staff and Clinical team were educated on the importance and quality of life that activities bring to the residents. Activities for the residents are as important as medications and all other clinical needs or concerns. 4.Administrator/Designee will complete weekly/monthly audits to ensure that the quality of life for residents through activities is met. Audits will be performed one time weekly for four weeks, then monthly for three months.. All audits to be reviewed in QA/QI	

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F 679	Continued From page 20 wheelchair and at 11:04 AM, Resident #26 was observed being wheeled out to the dining room by CNA #8. The Activities Assistant was in the process of cleaning the dining room from the activity and stated the activity had ended at 11:00 AM. On 10/24/18 at 11:09 AM, the Activities Director stated she had asked staff members to assist Resident #26 out of bed and it did not happen before the activity was completed. The Activities Director stated Resident #26 should have been allowed to attend the activity. The Activity Director stated Resident #26 preferred watching TV, telling stories, 1:1 interactions, wheeling around outside, and viewing pictures. On 10/25/18 at 8:40 AM, the DON stated Resident #26 should have been taken to the activity and she would look into why it did not occur.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		11/23/18

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F 686	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure residents were repositioned routinely to prevent skin breakdown for 2 of 3 residents (#8 and #26) who required positioning and/or had skin impairments. The failure to reposition residents placed them at risk of developing wounds. Findings include: The facility's undated Skin Impairment policy documented staff were to assess residents' wounds weekly and include measurements and documentation of the progression or regression of the areas. The policy defined excoriation as a wound. The facility's Repositioning Policy, dated 5/2015, documented residents were to be repositioned to prevent skin breakdown. The policy documented staff were to check in residents' care plans for resident-specific positioning needs to include, how often, how many staff were required to assist, and equipment needed. These policies were not followed. 1. Resident #8 was admitted to the facility on 5/13/16 with diagnoses, which included Parkinson's disease, neuromuscular dysfunction of the bladder, abnormal posture, and muscle weakness. A quarterly MDS assessment, dated 8/6/18, documented Resident #8 was cognitively intact and required limited to extensive assistance of one staff member with cares. The MDS documented she had no skin impairments and an	F 686	Skin integrity, which is based on the comprehensive assessment of a resident is to be consistent with professional standards of practice, to prevent pressure ulcers. 1. This affected 2 of 32 residents. Resident #8 skin was assessed and area of concern is now healed. She was assessed for her independence in repositioning, and care plan update with changes. Resident # 26 turning schedule was changed and updated to reflect resident's current needs for positioning. Care plan was updated with changes. 2. This has the potential to affect all residents with skin concerns and repositioning programs. All care plans were reviewed and updated to reflect any changes needed for residents. 3. Positioning form was reformatted to reflect the individual needs of residents. And to provide a more accurate documentation of residents position. All staff in-serviced on new form, and the importance of repositioning of residents. All Licensed staff trained and in-serviced on completion of weekly skin assessments. The skin assessment schedule was changed to match with residents bath schedule, for convenience. Skin assessment were also rescheduled to residents personal preference to occur weekly. 4. Director of Nursing/Designee will	

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F 686	Continued From page 22 indwelling catheter. The care plan area addressing Resident #8's Risk for Skin Breakdown, revised 5/31/16, documented staff were to do weekly skin assessments. a. Resident #8's Weekly Skin Assessments were not completed as directed in her care plan. The June 2018 through 10/26/18 Weekly Skin Assessments, documented staff were to assess Resident #8's skin weekly on Saturdays. Weekly Skin Assessments were not completed on 6/16/18, 8/11/18, 9/22/18, 10/13/18, and 10/20/18. The 6/2/18 through 10/3/18 Weekly Skin Assessments documented Resident #8's skin was intact until the 10/10/18 Weekly Skin Assessment. The assessment documented her buttock was red with dry flaky skin. On 10/25/18 at 2:02 PM, the DON stated she expected skin assessments to be completed weekly. The DON stated if a skin assessment was not completed the RN needed to document a reason in the resident's medical record. b. The care plan was not updated when Resident #8 developed skin impairments as follows: The care plan area addressing Resident #8's Risk for Skin Breakdown, revised 5/31/16, documented staff were to reposition Resident #8 every 2 hours and staff were to do weekly skin assessments. A Nurse's Progress Note, dated 6/13/18, documented Resident #8 had an area of	F 686	ensure that Skin assessments and the repositioning program forms are completed as directed. Director of Nursing/ Designee ensure that audited are completed one time per week for four weeks, then monthly for three months. All audits to be reviewed in QA/QI	

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F 686	Continued From page 23 shearing on her left buttock which measured 1.3 cm by 0.6 cm and an area which measured 2.5 cm by 0.8 cm on her right buttock. Resident #8's care plan was not updated to include the shearing to her buttocks. On 10/25/18 at 2:02 PM, the DON stated the areas should be monitored on the care plan or include revisions. c. Resident #8 had skin damage related to shearing which was not sufficiently monitored as follows: A Nurse's Progress Note, dated 6/13/18, documented Resident #8 had an area of shearing on her left buttock which measured 1.3 cm by 0.6 cm and an area which measured 2.5 cm by 0.8 cm on her right buttock. Resident #8' record did not include consistent weekly skin assessments of the 6/13/18 wounds to the left buttock. Resident #8's wounds were not measured after the initial nurses note and the progression of the wounds were not consistently completed as follows. Resident #8's Weekly Skin Reports, dated 7/30/18, 8/6/18, 8/13/18, 8/20/18, 8/27/18, 9/4/18, 9/17/18, 9/24/18, 10/1/18, 10/8/18 and 10/15/18, each referenced the wounds as shearing to her bilateral buttocks. On 9/25/18, the wounds were documented as red and blanchable and not open. The wounds were not assessed during the weeks of 9/9/18 - 9/15/18. d. Resident #8's treatments were not consistently	F 686		

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F 686	Continued From page 24 provided as follows. A Physician Order, dated 6/19/18, documented staff were to clean Resident #8's right and left buttock with normal saline every three days and as needed. Resident #8's 6/19/18 through 10/23/18 TAR documented she was not provided treatments on 9/20/18, 10/2/18, and 10/17/18. e. Observations of Resident #8's positioning: On 10/22/18 from 12:02 PM to 12:50 PM, Resident #8 was observed sitting in her wheelchair in the dining room eating her lunch. On 10/22/18 at 2:24 PM, Resident #8 was observed sitting in her wheelchair in the dining room decorating a pumpkin. On 10/22/18 at 4:10 PM, Resident #8 was observed wheeling herself down the hallways in her wheelchair. On 10/23/18 at 9:35 AM, Resident #8 was observed in her wheelchair wheeling down the hallways towards her room. Resident #8 stated she had skin impairments on her bottom and she was unsure how she got them. Resident #8 stated staff did not assist with repositioning when she was in her chair or her bed due to her tremors "bounced her all over." On 10/23/18 from 10:21 AM through 11:36 AM, Resident # 8 was observed wheeling down the hallway. Resident #8 was also observed in her wheelchair at various activities and moving about	F 686		

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F 686	Continued From page 25 the facility on 10/23/18 from 2:15 PM - 2:32 PM, 10/24/18 at 9:54 AM, 10:21 AM, 12:22 PM, 2:39 PM, and on 10/25/18 at 8:16 AM. On 10/24/18 at 10:15 AM, Resident #8's skin was observed while CNA #1 assisted Resident #8 to the bathroom. Resident #8's pants were soaked through and her wheelchair pad was wet. CNA #1 stated Resident #8's catheter was leaking. Resident #8's bottom was observed with two linear areas located on her buttocks bilaterally. The wounds were approximately 2.5-3 inches in length and 0.5 to 1 inch in width. CNA #1 notified nursing of the two open areas to Resident #8's bilateral buttocks. On 10/24/18 at 10:21 AM, LPN #1 stated Resident #8 has two skin impairments located on her buttocks bilaterally, and the facility was monitoring these two areas. LPN #1 stated she had just viewed Resident #8's skin and the two areas were excoriated. On 10/25/18 at 2:02 PM, the DON, MDS Nurse, and the Administrator stated skin assessments should be completed weekly. The DON stated the facility had identified skin assessments not being completed as an area they were working on. The DON stated the skin assessments were to be completed on Saturdays. The DON stated the treatments were to be completed per physician orders. The DON stated the nursing staff should assess the wound for the progression of the wounds and measure the wounds. The Administrator stated Resident #8's urine was very acidic and could cause skin impairments.	F 686		

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F 686	Continued From page 26 2. Resident #26 was readmitted to the facility on 8/22/18, with diagnoses which included spastic hemiplegia affecting the left side, unsteadiness on feet, dementia, and muscle weakness. A significant change MDS assessment, dated 9/5/18, documented Resident #26 had severe cognitive impairment and required extensive assistance of two staff members with bed mobility and transfers. The care plan area addressing Resident #26's Risk for Skin Breakdown, revised 9/12/18, documented staff were to reposition Resident #26 every 2 hours while he was in bed. The care plan area addressing Resident #26's ADLs, revised 9/10/18, documented he required extensive assistance of two staff members for bed mobility, toileting, and transfers. a. Resident #26 was not repositioned consistently as follows: On 10/22/18 at 2:28 PM, Resident #26 was observed in bed on his back. On 10/23/18 from 9:06 AM through 11:54 AM, Resident #26 was observed in bed on his back watching TV. During the observation time frame the surveyor stood in the hallway and no staff member entered the room. At 10:22 AM, Resident #26's feet slipped closer to the left side of his bed and his head was positioned closer to the top right corner of the bed. At 11:40 AM, Resident #26 was observed slipping further down in bed and was	F 686		

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F 686	Continued From page 27 positioned more at an angle in bed. Resident #26's feet were touching the left corner of his bedframe and his head was angled towards the right top corner of the bed. On 10/23/18 at 11:54 AM, a surveyor asked CNA #6 and CNA #7 to assist Resident #26 with his positioning. CNA #6 stated Resident #26 must have slipped down in bed for his feet to be touching the end of the bed. CNA #6 stated Resident #26 was supposed to be repositioned every 2 hours. On 10/24/18 from 9:52 AM through 11:00 AM, Resident #26 was observed positioned in bed on his back watching television without staff entering the room to assist him with repositioning. On 10/24/18 at 11:00 AM, CNA #8 and CNA #7 were observed assisting Resident #26 into his wheelchair and at 11:04 AM, Resident #26 was observed being wheeled out to the dining room by CNA #8. On 10/24/18 from 11:04 AM to 12:53 PM, Resident #26 was observed in his wheelchair and was observed assisted to bed at 12:54 PM. Resident #26 was observed in bed from 12:54 PM to 3:38 PM on 10/24/18 without staff repositioning him. b. The facility had a Turning and Repositioning Schedule, dated 10/1/18 through 10/23/18, which documented every two hours Resident #26's position. The schedule was inconsistent with the observations seen above. Resident #26's 10/23/18 Turning and	F 686		

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F 686	Continued From page 28 Repositioning Schedule documented at 8:00 AM, 10:00 AM, and 12:00 PM he was repositioned in his chair. On 10/23/18 from 9:06 AM through 11:54 AM Resident #26 was observed in his bed without staff repositioning him. On 10/24/18 at 2:56 PM, CNA #2 was observed as she carried the Turning and Repositioning book with all residents' names listed in it. CNA #2 stood outside Resident #26's doorway and looked in the room and wrote in the book and she did not reposition Resident #26. CNA #2 continued down the hallway and looked in other residents' rooms and wrote residents' positions in the book and did not reposition them. On 10/25/18 at 8:40 AM, the DON stated Resident #26 should be repositioned every 2 hours like documented on his care plan. The DON was unable to explain why Resident #26 was documented as repositioned in his chair on 10/23/18 when he was seen in his bed from 9:06 am -11:54 AM. The DON stated the documentation was incorrect and the facility was working on correcting the positioning documentation. The DON stated the staff should be actively repositioning residents and not documenting their positions as seen by staff.	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	F 688		11/30/18

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F 688	Continued From page 29 §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. §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. 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 received treatment and services to prevent further decrease in range of motion (ROM). This was true for 2 of 2 residents (#4 and #26) reviewed for treatment and services related to ROM. The failed practice created the potential for more than minimal harm when Resident #4 and Resident #26 did not receive Passive ROM (PROM) as care planned to prevent deterioration of existing ROM limitations. Findings include: 1. Resident #4 was readmitted to the facility on 4/9/18, with diagnoses including Parkinson's disease, unspecified lack of coordination, abnormal posture, dementia, and muscle weakness. A significant change MDS assessment, dated 7/27/18, documented Resident #4 had total dependence for bed mobility and transfers, requiring the assistance of two or more staff. The MDS also documented Resident #4 had a bilateral upper and lower ROM impairment.	F 688	Increase or prevent decrease in ROM/ mobility. the facility must ensure that a resident who enters the facility without limited ROM does not experience reduction in ROM. 1. This affected 2 of 32. Resident #4 RNA program was reassessed by therapy department. RNA program changed and updated to only count the minutes of ROM of fingers and hand, not the hand washing. Care plan was updated to reflect these changes. Resident #26 RNA program was reassessed by therapy department. Program updated with changes, as well the care plan. 2. This has the potential to affect all residents being referred to RNA from therapy department, all current residents with RNA programs. All programs reviewed for compliance to residents current needs. 3. All RNA recommendation from therapy	

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F 688	Continued From page 30 Resident #4's care plan, dated 9/20/18, documented his left hand was contracted and he was to have his palmar guard (hand splint) applied to his left hand in the morning and take it off in the evening, or as tolerated. Resident #4's care plan also documented he was at risk for skin break down due to his left hand contracture and the Restorative Nurse Assistant (RNA) was to wash his hand with soap and water daily and have him open and close his fingers for at least 15 minutes per day. On 10/23/18 at 9:41 AM, CNA #4 was observed providing PROM to Resident #4's fingers on his left hand 3 to 5 times, taking less than 3 minutes. Resident #4 did not complain of pain, grimace, or pull away. CNA #4 told Resident #4 it looked like it was as far as she was going to be able to get his fingers to move for the day. CNA #4 then replaced Resident #4's brace and exited his room. When CNA #4 exited the room and was asked about Resident #4's restorative therapy, she said the PROM was done as long as the resident could tolerate it. On 10/24/18 at 10:37 AM, CNA #5 said she washed Resident #4's left hand, removed his brace, and performed PROM with his fingers approximately 10 minutes a day. She stated the whole process was about 15 minutes. On 10/25/18 at 9:14 AM, the Restorative RN stated her interpretation of the physician order for range of motion to Resident #4's left hand was to wash his hand and do ROM to his fingers. She said the whole process was 15 minutes. When shown the order which stated the Restorative	F 688	department to be in writing. Communication form to be used for referrals to RNA programs. Therapy/Restorative nursing in-serviced on the communication form, and the need to follow the program as defined by therapy department. 4.Restorative Nurse to observe RNA doing program Q week. Director of Nursing/Designee to perform audits one time weekly for four weeks, then monthly for three months. All audits to be reviewed in QA/QI	

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F 688	Continued From page 31 Nurse Aid was to wash Resident #4's hand with soap and water daily and then have him open and close his fingers for at least 15 minutes per day, the Restorative RN agreed her interpretation differed from the order. On 10/25/18 at 9:37 AM, the Physical Therapist said if he made a recommendation for ROM for 15 minutes, his expectation was ROM was performed for that amount of time. The Physical Therapist also said if the ROM was performed to the resident's tolerance, he would have been specific on how much time to spend on each joint, how much pressure to apply to the area, and include "as tolerated." The facility failed to implement the ROM program for Resident #4. 2. Resident #26 was readmitted to the facility on 8/22/18, with diagnoses which included spastic hemiplegia affecting the left side, unsteadiness on feet, dementia, and muscle weakness. A significant change MDS assessment, dated 9/5/18, documented Resident #26 had severe cognitive impairment and required extensive assistance of two staff members with bed mobility and transfers. The MDS documented Resident #26 had bilateral upper and lower ROM impairment. Resident #26's care plan, dated 10/12/18, documented he was to wear a hand splint brace to his left hand for 2-3 hours or as tolerated. The care plan also addressed Resident #26's PROM, dated 10/12/18, and documented he was receive PROM to his left wrist for at least 15 minutes 7	F 688		

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F 688	Continued From page 32 days a week, and open his hand and make a fist for 10 repetitions. The care plan documented Resident #26 was to flex his wrist up and down and then more in circular motions for 10 repetitions each. The facility's list of residents who were on a restorative program, did not include Resident #26. Resident #26's ADL PROM documentation, dated 10/13/18 through 10/24/18, documented the staff completed PROM for 15 minutes each day. Resident #26's ADL Splinting documentation, dated 10/13/18 through 10/24/18, documented the staff applied his brace to his left hand on some days 15 minutes and other days up to 120 minutes per day. Resident #26's record documented he averaged approximately 15 minutes of wearing the splint. The documentation did not include if Resident #26 took off the brace or if staff removed the brace early and did not include the 2-3 hours he was supposed to be wearing the brace. On 10/23/18 from 9:06 AM through 11:54 AM, Resident #26 was observed in bed on his back watching TV and his blue brace was located on the top of the dresser. On 10/24/18 at 10:18 AM, CNA #5 was observed as she entered Resident #26's room and she worked with his left hand and wrist for approximately 3 minutes. CNA #5 was observed as she located and placed a blue hand and wrist brace onto Resident #26's left arm and left his room at 10:24 AM.	F 688		

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F 688	Continued From page 33 On 10/24/18 at 10:25 AM, CNA #5 stated she provided range of motion exercises to residents such as Resident #26 and applied braces. CNA #5 stated when a resident was assisted with "getting dressed" this could be counted as range of motion. CNA #5 stated Resident #26 sometimes participated group activities for his range of motion and if he did not participate she provided the ROM individually in his room like today. CNA #5 stated she could get Resident #26 to agree to utilize his hand brace easily. CNA #5 said the restorative program was provided 7 days a week for residents and she thought Resident #26's care plan said he was to wear the brace to his left hand for 1 hour a day or as tolerated. CNA #5 stated Resident #26 was able to remove the brace from his hand and he would remove the brace. CNA #5 stated ROM activities were provided as tolerated with most residents, including Resident #26. On 10/24/18 at 10:36 AM, Resident #26 was observed in bed with the blue brace set on top of his covers and not on his left hand. On 10/24/18 at 2:04 PM, the Restorative RN stated when residents were added to the restorative program, she received a referral from a therapist with a program the resident needed to follow. The Restorative RN stated Resident #26 was to utilize a brace and a PROM program for his left hand and wrist for 15 minutes. The Restorative RN stated she in-serviced her aides when a new resident was added to the caseload and reviewed the residents' goals. The Restorative RN stated Resident #26 was followed by Occupational Therapy for his	F 688		

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F 688	Continued From page 34 left-hand ROM issues and he was new on the case load. The Restorative RN stated the aide knew what the programs entailed and how long the braces were to be worn because of the meetings she held with the aides. The Restorative RN stated she talked with cognitive residents to verify the ROM was provided to residents. On 10/25/18 at 9:14 AM, the Restorative RN stated the orders should have been more clear for the residents' ROM and the braces should be worn as tolerated. The CNA was to follow the program if the resident tolerated the activity. The Restorative RN stated CNA's were expected apply the braces and document how long they were worn, however, the system does not let them document different times. On 10/25/18 at 9:35 AM, the Physical Therapist (PT) stated when residents completed therapy and needed further assistance, he referred them to the restorative program. The PT stated he wrote instructions for the restorative program and safety instructions. The PT stated he made recommendations for how long residents needed to be provided the ROM, how much pressure needed to be applied to the areas, the types of stretches to use, and how long to spend on each area. The PT stated the timeframes for most ROM programs was 15 minute sessions of just the motions. The PT stated the cleansing of the hand and preparing of the hand should not count towards the time. The PT stated if residents tolerated more than 15 minutes of ROM the resident's may maintain or improve their current range of motion. The PT stated the current orders for Resident #26's ROM were completed	F 688		

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F 688	Continued From page 35 in less time than 15 minutes. On 10/25/18 at 9:49 AM, the Restorative RN stated Resident #26's name was not added to the aides list of names for ROM or splinting, however her aides knew which programs to use for Resident #26. The facility failed to implement the ROM program as developed by therapy.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, observation, facility policy review, and review of I&A reports, it was determined the facility failed to ensure each resident received adequate supervision. This was true for 1 of 5 residents (#6) who were reviewed for supervision. Failure to provide adequate supervision created the potential for harm if the resident had falls or accidents that resulted in injury or death. Findings include: The facility's Falls Policy and Procedure, dated 2/2015, documented staff attempted to identify the root cause of falls and develop a treatment plan for residents.	F 689	The facility must ensure that resident environment remain free of potential hazards for accidents as much as possible. 1. This affected 1 of 32. Resident #6 was informed of risk and benefits in writing of doing self cares and having husband assist with cares verses staff. Staff in-serviced to intervene and offer assistance when allowed. Care plan updated. 2. This has the potential to affect all residents. All care plans were reviewed and updated	11/30/18

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F 689	Continued From page 36 1. Resident #6 was admitted to the facility on 5/5/16, with diagnoses which included syncope, lack of coordination, and muscle weakness. A quarterly MDS assessment, dated 10/12/18, documented Resident #6 was cognitively intact and had experienced one fall without injury. Resident #1 was admitted to the facility on 7/10/18, with diagnoses which included dementia and macular degeneration. Resident #1 was Resident #6's husband and they resided in the same room. Resident #6 was assisted with ADLs such as transferring to and from her recliner chair, transferring from her wheelchair and or walker, applying oxygen, and using the restroom with the assistance of Resident #1, her spouse. a. The care plan area addressing Resident # 6's falls, initiated 7/24/18, documented she was at risk for falls with major injury related to weakness and her history of syncope. The care plan documented Resident #6 attempted to ambulate without assistance and without assisted devices. The care plan documented staff were to ensure her belongings were put away so Resident #6 did not try and do this herself. The care plan documented Resident #6 used a wheelchair for locomotion and staff or Resident #1 assisted her with locomotion. Resident #6's care plan did not document Resident #6's preference for Resident #1 to assist her with cares nor that the facility had discussed the risk verses benefits regarding the couple's choices which placed Resident #6 at increased risk for falling. A 10/8/18, I&A report documented Resident #6	F 689	with changes when necessary. 3. All staff in-serviced to monitor for resident need of assistance and to offer assist when possible. 4. Interdisciplinary team to audit ADL's for increase or decrease in independence one per week for four weeks and then monthly for three months. All audits to be reviewed in QA/QI	

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F 689	Continued From page 37 experienced a witnessed fall in her room when she was attempting to put clothing items away in her closet. The I&A documented Resident #6's walker was in front of her when she fell. A 10/12/18, Fall Assessment documented Resident #6 required hands-on assistance to move from place to place, and she exhibited balance issues when standing. When Resident #6 was assisted by Resident #1 she was not always provided the interventions needed as documented on the fall assessment. b. The care plan area addressing Resident # 6's toileting, initiated 7/24/18, documented there were times Residents #1 would "push" Resident #6 into the bathroom and wait for her to finish using the restroom. Resident #6's care plan did not document the facility had discussed the risk verses benefits and educated Resident #6 on potential injuries when she did not allow staff to assist her with cares. On 10/22/18 at 3:09 PM, Resident #6 was observed sitting in a recliner chair with her legs elevated on a pillow and the foot rest extended. Resident #6 stated Resident #1 assisted her with cares at the facility such as transfers, going to the bathroom, getting out of bed, and whatever she needed. Resident #6 stated staff would assist her when Resident #1 was busy or not in the room. On 10/22/18 at 3:40 PM, Resident #1 assisted Resident #6 out of her recliner chair. Resident #6 removed her nasal cannula, which was attached to her oxygen concentrator, and Resident #1 pulled Resident #6 up by her hands to a standing	F 689		

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F 689	Continued From page 38 position and walked her to her wheelchair. Resident #6 sat down hard into her wheelchair and the brakes were not locked. Resident #6's portable oxygen was not turned on and the nasal cannula was placed on her nose. Resident #1 wheeled Resident #6 outside the building on a walk. On 10/22/18 at 4:01 PM, Resident #1 and Resident #6 arrived back into their room. Resident #1 stopped Resident #6's wheelchair in front of her recliner chair and did not apply the brakes. Resident #6 was stooped over and was reaching for her recliner chair with one hand and holding onto the wheelchair with the other hand. The wheelchair was rocking back and forth while she was standing and transferring into her recliner chair. On 10/23/18 at 2:22 PM, Resident #6 and Resident #1 were observed leaving the bathroom together. Resident #6 stated she just finished using the restroom with her husband's assistance. Resident #6 was using a front wheeled walker to walk to and from her room. Resident #1 held on to Resident #6's elbow as he assisted Resident #6 back into her recliner chair. On 10/24/18 at 4:15 PM, The RSM and DON stated Resident #1 assisted Resident #6 with small things such as making the bed, assisting her with locomotion in her wheelchair, and notifying staff if she was not feeling well. The DON stated Resident #1 was not supposed to assist Resident #6 with going to the bathroom or transfers. The DON and the RSM stated they did not have documentation a risk verses benefits discussion was completed with the couple,	F 689		

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F 689	Continued From page 39 however, they would correct this on 10/24/18. The RSM and the DON stated the facility did not have a discussion with the couple regarding their choices which placed Resident #6 at increased risk for falling. Resident #6's 10/24/18, Risk Verses Benefit documented, Resident #6 understood she was at increased risk of falling when Resident #1 assisted her with transfers, and if Resident #6's oxygen was turned on by Resident #1 or not turned on Resident #6 was at increased risk. On 10/25/18 at 11:39 AM, the DON stated when Resident #6 did not allow staff to assist her with pericare it increased her risk of infection. The DON stated Resident #6 was recently hospitalized with a UTI and the infection was E-coli, which did indicate poor pericare. The DON stated Resident #6 and Resident #1 could benefit from education on proper pericare. The facility failed to provide adequate assitance and supervision with Resident #6's ADL's to prevent falls and ensure . The facility did not provide education about risk verse benefits.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		11/30/18

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F 695	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 4 of 4 residents (#6, #14, #26, and #29) reviewed for respiratory care. The deficient practice had the potential for harm if residents did not receive oxygen therapy and nebulizer treatments as ordered to maintain adequate oxygen levels. Findings include: The facility's Oxygen Administration Policy and Procedure, dated 6/12/17, documented before staff administered oxygen they needed to assess the humidifier (a device for keeping the atmosphere moist) to ensure it was securely placed and in good working order. The policy documented the water level needed to be high enough for the water to bubble as oxygen flows through. The policy documented staff were to periodically assess the water level in the humidifier. The facility's Administering Medications through a Small Volume (Handheld) Nebulizer Policy and procedure, dated 1/8/18, documented the facility utilized KeyMed's policy and procedure for nebulizer treatments. The KeyMed procedure stated staff were to stay with residents for the duration of the treatment unless the resident was assessed and authorized to self-administer the medications. The American Association for Respiratory Care (AARC) website dated April 2012, accessed on 10/29/18, stated clinical practice guidelines for	F 695	The facility must ensure that a resident, who needs respiratory care, is provided such care consistent with professional and standard of practice. 1. This affect 4 of 32 residents. 2. Resident # 29 was reassessed for self administration of medication. License staff in-serviced to stay with resident for nebulizer treatment. Care plan was updated with changes. Resident # 6 was reassessed and changes were made to plan of care. License staff in-serviced to stay with resident for nebulizer treatment. Resident # 14 was reassessed and changes were made to plan of care. License staff in-serviced to stay with resident for nebulizer treatment. Resident #26 oxygen concentrator has been monitored for need of humidifier to be changed Staff is to assess placement of when turning concentrator on and off. 2. This has the potential to affect all residents with orders for oxygen and Nebulizer treatments. All concentrators were audited to be sure that humidifier was placed properly and functioning. The only resident with nebulizer orders is #6, #14, and #29. 3. All License staff in-serviced on Nebulizer policy, and procedure. All staff in-serviced on changing humidifier out when oxygen tubing is being changed. 4.Director of Nursing/ Designee will ensure audits are performed one time	

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F 695	Continued From page 41 aerosol delivery device to monitor the patient for adverse response, assess whether or not the patient is using the device correctly, and assess response to therapy and document findings. 1. Residents nebulizer treatments were not administered appropriately by the staff as follows: a. Resident #29 was admitted to the facility on 5/5/16 with diagnoses which included COPD. A quarterly MDS assessment, dated 9/26/18, documented Resident #29 had a moderate cognitive impairment and was inattentive with disorganized thinking. The care plan area addressing Resident #29's COPD, initiated 5/5/16, documented she was a mouth breather and was reminded to breathe through her nose. The care plan documented she was to receive her nebulizer per orders. Resident #29's Physicians Orders included the following: - DuoNeb Solution 0.5-2.5 mg/3ml (inhaler used to treat wheezing and shortness of breath) vial inhaled twice daily for asthma, ordered 3/29/18. - DuoNeb Solution 0.5-2.5 mg/3ml vial inhaled every 4 hours PRN for COPD and held per a hand-held device, ordered 6/13/17. On 10/23/18 from 10:39 AM to 10:48 AM, Resident #29 was not feeling well and was experiencing episodes of emesis. On 10/23/18 at 10:52 AM, LPN #1 was observed as she set up Resident #29's PRN DuoNeb	F 695	per week for four weeks, then one time per month for three months.	

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F 695	Continued From page 42 treatment up and left the room. On 10/23/18 from 11:01 AM to 11:05 AM, Resident #29's DuoNeb hand-held device was observed to be misting and the device was positioned next to her leg. Resident #29's head was bent over, and she appeared to be sleeping. On 10/23/18 at 11:05 AM, Resident #29 woke up and placed the hand-held device to her mouth and activated her call light. On 10/23/18 at 11:08 AM, LPN #1 entered the room and turned off the treatment and asked Resident #29 what she needed. Resident #29 could not remember what she needed. LPN #1 turned the treatment back on and left the room. On 10/23/18 from 11:14 AM to 11:17 AM, Resident #29's DuoNeb hand-held device was observed to be misting and the device was positioned next to her leg. Resident #29's head was bent over, and she appeared to be sleeping. On 10/23/18 at 11:18 AM, LPN #1 entered Resident #29's room and removed the tubing from her hand. b. Resident #6 was admitted to the facility on 5/5/16, with diagnoses which included syncope. A quarterly MDS assessment, dated 10/12/18, documented Resident #6 was cognitively intact and received oxygen therapy. The care plan area addressing Resident # 6's cough and shortness of breath, initiated 7/24/18, documented she had a cough and shortness of	F 695		

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F 695	Continued From page 43 breath mostly likely due to breast cancer and she wished to stay comfortable. The care plan documented staff were to provide DuoNeb treatments per orders. A 7/17/18 Physicians Order documented Resident #6 received 0.5-2.5 mg/3ml DuoNeb Solution vial inhaled orally every 6 hours for her cough. Resident #6's 10/1/18 -10/23/18 MAR documented her scheduled DuoNeb treatment was provided per physician's orders. On 10/23/18 at 11:19 AM, LPN #1 was observed as she placed a mask onto Resident #6's face for her scheduled DuoNeb breathing treatment and left the room. LPN # 1 returned to the room when the treatment was completed at 11:39 AM. c. The American Association for Respiratory Care (AARC) website, dated April 2012, accessed on October 29, 2018, documented clinical practice guidelines for aerosol delivery device to monitor the patient for adverse response, assess whether or not the patient is using the device correctly, and assess response to therapy and document findings. 2. Resident #14 was admitted to the facility on 12/08/13, with multiple diagnoses including allergic rhinitis, disturbances of salivary secretion, wheezing, and history of recurrent pneumonia. Resident #14's care plan, dated 5/25/16, directed staff to provide Resident #14 a DuoNeb treatment via mask related to a history of	F 695		

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F 695	Continued From page 44 recurrent pneumonia, wheezing, excessive salivation, and cough. Resident #14's physician orders, dated 8/10/17, documented DuoNeb Solution 0.5-2.5 (3) mg/3ml (Ipratropium-Albuterol) 1 vial inhale orally every 6 hours related to disturbances of salivary secretion via mask. Resident #14's October 2018 MAR, documented DuoNeb Solution 0.5-2.5 (3) mg/3ml (Ipratropium-Albuterol) 1 vial inhale orally every 6 hours related to disturbances of salivary secretion via mask. Resident #14's annual MDS assessment, dated 11/30/17, documented he received respiratory therapy on a routine basis. On 10/22/18 at 3:14 PM, Resident #14 was observed receiving a breathing treatment in his room, with oxygen and humidity, and wearing an oxygen mask, and staff was not monitoring the treatment. On 10/23/18 at 1:13 PM, LPN #1 stated when a resident needed a breathing treatment the process was to open a vial of the medicine and the process would take approximately 15 minutes to complete. LPN #1 stated it depended on what was going on in the facility during that time frame when she would check on residents. LPN #1 stated if a resident was using a hand-held device and it was not to her mouth she was not receiving the medicine. LPN #1 stated she thought Resident #29 was assessed to self-administer medications and she thought it was care planned. LPN #1 stated Resident #6's	F 695		

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F 695	Continued From page 45 breathing treatment was a scheduled one and she had placed it on her and left the room because she was busy with other tasks. 3. Resident #26 was readmitted to the facility on 8/22/18, with diagnoses which included pneumonia. An 8/22/18 Physician Order documented Resident #26 received 3 liters of oxygen continuously via nasal cannula for pneumonia. A significant change MDS assessment, dated 9/5/18, documented Resident #26 had severe cognitive impairment and utilized oxygen therapy. The care plan area addressing Resident #26's pneumonia, revised 9/12/18, documented he was on 3 liters of oxygen to ensure his oxygen saturation remained above 90%. The oxygen was recieved via nasal cannula. On 10/22/18 at 2:28 PM, Resident #26 was observed in bed on his back with a nasal cannula in place in his nose. The humidifer was attached and bubbling. On 10/23/18 from 9:06 AM through 11:54 AM, Resident #26 was observed in bed on his back watching TV. Resident #26 had his nasal cannula in place. Resident #26's oxygen humidifier was unplugged and not bubbling. On 10/23/18 at 11:56 AM, CNA #6 stated the humidifier should be plugged in and there should be bubbles going in the machine. CNA #6 stated the water level was not appropriate and the nurse needed to be notified about Resident #26's	F 695		

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	135056		**10/26/2018**

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F 695	Continued From page 46 humidifier. CNA #6 asked CNA #7 to get the the nurse to change the humidifier. On 10/23/18 at 11:57 AM, LPN #1 stated the humidifier should be plugged in and there should be bubbles present to verify it was working. LPN #1 stated she needed to replace the humidifier. LPN #1 stated she was unsure how long Resident #26's humidifier was like this. On 10/24/18 at 9:07 AM, the DON stated the staff should be in the area for all breathing treatments and she was made aware of what occurred on 10/23/18 and in-serviced the staff. The DON stated the DuoNebs were medications and should be treated as such. The DON stated the nurses changed the humidifier on the oxygen concentrator and should be watching for water levels and correct placements every time they enter a residents' room. The DON stated the CNAs could let the nurses know there was an issue and the nurse would correct the issue.	F 695		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		11/30/18

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F 880	Continued From page 47 §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 48 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and staff interview, it was determined the facility failed to ensure staff performed hand hygiene and implemented infection prevention measures. This was true for 5 of 11 residents (#8, #12, #18, #21, and #26) observed for infection control. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include: 1. Staff members did not appropriately wear Personal Protective Equipment (PPE). Examples include: The facility's Personal Protective Equipment - Using Face Masks Policy, dated September 2014, documented personnel will use a face mask to prevent transmission of infectious agents. The face mask must cover the nose and mouth while performing treatment or services for the patient.	F 880	The facility must establish and maintain an infection prevention and control program. designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable disease and infections. 1. this affected 5 of 32 residents. CNA #3 and NA #1 were in-serviced and counseled on proper use of facial protective gear. Resident #21 and # 26 were assessed for change in health condition, related to improper placement of facial gear. Resident #12 was educated on hand hygiene when handing soiled items, in writing, due to the fact he will ask to hold his catheter, which can put him at risk for infection.. Resident #8 catheter bag, has been placed in privacy bag, which has been attached higher on bed and wheel chair,	

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F 880	Continued From page 49 a. On 10/22/18 at 2:28 PM, CNA #3 was observed with a face mask that did not cover her nose. CNA #3 entered Resident #26's room and obtained vitals signs. On 10/22/18 at 2:34 PM, Resident #21 was observed in the hallway when CNA #3 approached her with a face mask that did not cover her nose. Resident #21 asked CNA #3 what was wrong with her and CNA #3 stated she was feeling a little under the weather. Resident #21 asked CNA #3 to "please not bother" her because she did not "want to get it." b. On 10/23/18 at 3:57 PM, NA #1 was observed providing cares to residents with a face mask that did not cover her nose. NA #1 stated she was sick and had a cold and runny nose. NA #1 stated at that time she was supposed to wear the mask that covered her nose and her mouth. 2. Catheter bags were observed on the floor. Examples include: The Centers for Disease Control and Prevention (CDC) website, updated October 24, 2016, accessed on 10/29/18, included recommendations for proper techniques for urinary catheter maintenance. One recommendation stated to not rest the catheter bag on the floor. The facility's Urinary Catheter Care Procedure, dated June 2015, documented personnel will wash and dry hands thoroughly, put on gloves, perform catheter care, remove gloves and discard, and wash and dry hands thoroughly. The procedure documented personnel will make sure	F 880	so as not to touch the floor. Staff in-serviced not to place a soiled item on a clean surface. 2. This has the potential to affect all residents with orders for catheters, and all residents during ADL cares. Staff in-serviced to place a clean barrier between floor and catheter bag. All catheter bags to be placed in a privacy bag, when resident is in bed or wheel chair for dignity. Privacy bag to be placed in such a manner so as not to touch floor. 3. All staff in-serviced on hand hygiene, staff to be randomly tested for compliance. All staff in-serviced on placement of catheter bag, and placement of privacy bag for catheter. All staff in-serviced on proper procedure in wearing facial gear. All staff in-serviced on redirecting resident from holding the catheter bag, due to the potential of infection. 4.Director of Nursing or/Designee will perform audits one time weekly for four weeks, then monthly for three months. Audits to include one resident a week that has a catheter, and than 5 staff members will be audited for hand hygiene. All audits to be reviewed by QA/QI.	

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F 880	Continued From page 50 the catheter tubing and drainage bag are kept off the floor. a. On 10/22/18 at 2:43 PM, Resident #18's catheter bag was observed touching the floor, and was kicked by RN #1 during cares. On 10/23/18 at 9:14 AM, Resident #18 was resting in bed, and the catheter bag was observed touching the floor. Resident #18's catheter bag was observed on the floor again on 10/23/18 at 2:30 PM, 10/24/18 at 1:29 PM, and 10/24/18 at 3:30 PM. On 10/24/18 at 3:35 PM, RN #2 stated Resident #18's catheter bag should not be touching the floor. b. On 10/23/18 at 11:44 AM, CNA #8 and CNA #1 were observed assisting Resident #12 with transferring into his wheelchair. CNA #1 emptied Resident #12's catheter bag into a container and placed the opened empty catheter bag on the floor while she left the room. CNA #1 returned to the room, changed her gloves without performing hand hygiene, and picked up the catheter bag from the floor, closed it and placed it in a privacy bag on his wheelchair. c. On 10/24/18 at 10:41 AM, LPN #1 was observed transferring Resident #8 from her wheelchair to her bed to check her urinary catheter for leakage. During the transfer, the catheter bag fell to the floor and Resident #8 stepped on the catheter bag before being positioned on the bed. LPN #1 picked up the catheter bag from the floor and put it on the bed. LPN #1 then removed her gloves and put on new	F 880		

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F 880	Continued From page 51 gloves without performing hand hygiene between the glove change. LPN #1 then checked Resident #8's catheter placement. 3. Staff did not perform hand hygiene after personal cares. Examples include: The facility's Handwashing/Hand Hygiene Policy, dated September 2014, documented personnel will wash their hands before and after direct resident contact, before and after assisting a resident with personal care, and before and after changing a dressing. The facility's Perineal Care Procedure, dated September 2014, documented personnel will wash and dry hands thoroughly, put on gloves, perform perineal care, remove gloves and discard, and wash and dry hands thoroughly. The facility's Incontinent Briefs/Underpads Procedure, dated September 2014, documented personnel will wash and dry hands thoroughly, put on gloves, remove soiled brief, clean skin of resident and replace fresh brief, remove gloves and discard, and wash and dry hands thoroughly. On 10/23/18 at 11:59 AM, CNA # 6 and CNA #7 assisted Resident #26 with pericare and changing of his soiled adult briefs. CNA #6 cleansed Resident #26's front side and he was rolled over to his back and CNA #7 assisted him with pericare on his back side. CNA #6 and #7 applied clean adult briefs on Resident #26 and they removed their gloves and placed new gloves on without performing hand hygiene between changing their gloves and after assisting with pericare.	F 880		

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F 880	Continued From page 52 On 10/23/18 at 12:49 PM, the RSM and CNA #8 were observed checking Resident #26's Incontinence brief. After checking Resident #26's brief by sliding her hand slightly into the front and back of the brief and looking to see if it was soiled, the RSM removed her gloves and put new ones on, but did not perform hand hygiene between the glove change. She then adjusted Resident #26's oxygen tubing. On 10/24/18 at 10:46 AM, CNA #8 stated Resident #26's adult briefs needed to be changed. CNA #7 and CNA #8 assisted Resident #26 with changing his adult briefs and performed pericare. CNA #7 provided pericare to Resident #26's backside and CNA #8 provided pericare to his front. Resident #26 was assisted into a clean pair of adult briefs and pants and both CNA's had not changed their gloves or performed hand hygiene until they completed assisting him with his pants. On 10/24/18 at 11:03 AM, CNA #7 and CNA #8 stated they should have cleaned their hand and changed their gloves when they moved from dirty to clean. 4. Residents were not offered hand hygiene: On 10/22/18 at 12:40 PM, Resident #12 was assisted to bed by LPN #1 and the DON using a Hoyer lift. LPN #1 handed Resident #12 his urinary catheter bag for the duration of the transfer. The DON obtained the urinary catheter bag from Resident #12 when the transfer was completed, and placed the catheter bag into a privacy bag at the side of his bed. Resident #12	F 880		

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F 880	Continued From page 53 was not offered or provided hand hygiene after the transfer was completed. On 10/23/18 at 12:42 PM, the Resident Services Manager and CNA #8 were observed transferring Resident #12 with a hoyer lift from his wheelchair to his bed. Resident #12 was holding his urinary catheter during the transfer. The Resident Services Manager nor CNA #8, provided hand hygiene to Resident #12 after holding his urinary catheter. On 10/24/18 at 9:45 AM, the Infection Control Nurse, with the DON present, stated hand hygiene should be performed before and after cares of residents, residents should not be holding catheter bags for infection control, and catheter bags should be in a privacy bag and should not be on the floor. The facility failed to ensure appropriate hand hygiene when moving from soiled to clean areas.	F 880		