IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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November 18, 2019

Shon Shuldberg, Administrator
Ashton Memorial Living Center
PO Box 838
Ashton, ID 83420-0838

Provider #: 135097

Dear Mr. Shuldberg:

On **November 1, 2019**, a survey was conducted at Ashton Memorial Living 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 one that comprises a pattern 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 **November 29, 2019**. Failure to submit an acceptable PoC by **November 29, 2019**, may result in the imposition of penalties by **December 21, 2019**.

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 6, 2019 (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 30, 2020**. A change in the seriousness of the deficiencies on **December 16, 2019**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by

February 1, 2020 includes the following:

Denial of payment for new admissions effective Febrauary 1**, 2020**. [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 May 1**, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **February 1, 2020** 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 **November 29, 2019**. If your request for informal dispute resolution is received after **November 29, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

bd/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
	135097		11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON MEMORIAL LIVING CENTER	700 NORTH SECOND STREET ASHTON, ID 83420

(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 on October 28, 2019 to November 1, 2019. The surveyors conducting the survey were: Presie Billington, RN, Team Coordinator Brad Perry, LSW Kim Saccomando, RN Abbreviations: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing IDT = Interdisciplinary Team LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set RN = Registered Nurse	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical 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).	F 578		12/6/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/26/2019

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

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' records included clear and accurate information related to Advance Directives. This was true for 2 of 8 residents (#10 and #20) reviewed for Advance Directives. This failure created the potential for harm should residents not have their decisions documented, honored, and respected when they were unable to make or communicate their health care preferences. Findings include:	F 578	F578 Specific Residents: Resident # 10 □ Living will and medical durable power of attorney were addressed with patient and family. Resident #20 - Living will and durable power of attorney for healthcare addressed with patient and family. Other Residents: All other residents have	

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F 578	Continued From page 2 The State Operations Manual, Appendix PP, defines an "Advance directive" as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POST paradigm form is not an advance directive." The facility's Advance Directives policy and procedure, revised December 2016, documented upon admission residents had the right to refuse or accept medical or surgical treatment and to formulate an Advance Directive. If the resident indicated that he or she did not have an Advance Directive, the facility staff provided assistance to establish an Advance Directive. If the resident was incapacitated and unable to receive information about his or her right to formulate an Advance Directive, the information may be provided to the resident's legal representative. Information about whether or not the resident had executed an Advance Directive should be displayed prominently in the medical record. An Advance Directives/Medical Treatment Decisions form used by the facility included a section with a check box which stated "I have	F 578	potential to be affected. Chart review was completed and no other residents were missing this information. They were all in compliance with 483.10(c)(6), 483.10(c)(8), 483.10(g)(12) Systemic Changes: Changing the advanced directives/medical treatment form in packet was adjusted to be clearer for families and surveyors. Medical Records, Nursing staff were educated on what specifics were needed in a living will, durable power of attorney for health care. They were trained about Guardianship, Power of Attorney and Living Wills. Check list was created for staff to help identify key information needed for a resident in our nursing home to be in their advanced directives. Monitoring: DNS and MDS coordinator will look at each new resident□s advanced directive to evaluate its compliance with F578 CFR(s) 483.10(c)(6)(8)(g)(12)(i)-(v). Medical Records will have a checklist to review those advanced directives for monitoring that all components are there. IDT will work together with patients and families to fill in gaps in those advanced directives.	

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F 578	Continued From page 3 chosen to formulate and issue the following Advanced Directives. I understand it is my responsibility to provide the facility copies of all pertinent documentation which verify those advance directives specified below for placement in my medical record." Options to choose from under this section included Medical Durable Power of Attorney, Guardian, Do Not Resuscitate, Do Not Hospitalize, Organ Donation, Autopsy Request, Feeding Restrictions and Type, Medication Restrictions and Type, Other Treatment Restrictions and Type, and Other Advance Directives and Type. There were two columns beside each option for facility staff to initial and document the date evidence of the selected Advance Directives were received by the facility. Another check box documented "I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to prolong my life and want life-sustaining treatment to be provided." The bottom section of the form included spaces for the signature and date of signature for the resident, resident representative, and facility representative and title. a. Resident #10 was admitted to the facility on 8/11/13, with multiple diagnoses which included Alzheimer's Disease. An annual MDS assessment, dated 7/25/19, documented Resident #10 was severely cognitively impaired. An Advance Directives/Medical Treatment Decisions form included in Resident #10's record, signed by her representative on 8/1/19, had the box checked which stated "I have chosen	F 578		

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F 578	Continued From page 4 to formulate and issue the following Advanced Directives. I understand it is my responsibility to provide the facility copies of all pertinent documentation which verify those advance directives specified below for placement in my medical record." The box was checked indicating Resident #10's had Advance Directives. Check boxes were also marked documenting Resident #10 had a living will and Medical Durable Power of Attorney and feeding restrictions of "No IV; No feeding tube". The form documented the Medical Power of Attorney was received at the facility on 3/8/17. The form did not include documentation of a date of receipt of Resident #10's living will. Resident #10's record did not include a copy of a living will or Medical Durable Power of Attorney. On 10/30/19 at 3:03 PM, LPN #1 said the upon admission Advance Directives were discussed with the resident and their representative, and each quarter the IDT reviewed the Advance Directive with the resident and the representative. LPN #1 then provided a copy of Resident #10's Durable Power of Attorney, dated 10/24/13, which documented "This power of attorney does not authorize the agent to make health care decisions for you, unless you state otherwise in the Special instructions" The Special instructions section did not include documentation authorizing the Durable Power of Attorney to make health care decisions for Resident #10. b. Resident #20 was admitted to the facility on 5/14/19, with multiple diagnoses which included traumatic subdural hemorrhage (a type of bleeding that occurs outside the brain) without	F 578		

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F 578	Continued From page 5 loss of consciousness. A quarterly MDS assessment, dated 8/19/19, documented Resident #20 was moderately cognitively impaired. An Advance Directives/Medical Treatment Decisions form included in Resident #20's record, signed by his representative on 5/30/19, had the box checked which stated "I have chosen to formulate and issue the following Advanced Directives. I understand it is my responsibility to provide the facility copies of all pertinent documentation which verify those advance directives specified below for placement in my medical record." The representative selected the option "No Not Resuscitate" and the facility documented receipt of evidence of this on 5/30/19. The form also documented "Feeding Tube ask family". The representative also documented Resident #20 was to receive IV fluids. The form did not include documentation Resident #20 had a Medical Durable Power of Attorney or a living will. Resident #20's record did not include documentation of Advance Directives, such as a living will or Durable Power of Attorney for Healthcare. On 10/30/19 at 3:03 PM, LPN #1 provided a copy of Resident #20's Idaho Statutory Form Power of Attorney, dated 6/11/19, which documented "This power of attorney does not authorize the agent to make health care decisions for you." The Idaho Statutory Form Power of Attorney documented appointment of a conservator of Resident #20's estate. It did not authorize the conservator to	F 578		

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F 578	Continued From page 6 make health care decision for Resident #20. On 10/31/19 at 9:31 AM, LPN #1, together with the DON, said when Resident #10 and Resident #20's records documented the Advance Directive were reviewed, it was the Advance Directives/Medical Treatment Decisions form that was reviewed with the residents and/or their representatives.	F 578		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 604		12/6/19

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F 604	Continued From page 7 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record and policy review, it was determined the facility failed to ensure position change alarms, floor mat alarms, and seat belt alarms were assessed as potential restraints and a consent was obtained from the resident and/or representatives prior to initiation of the alarms. This was true for 4 of 4 residents (#10, #20, #22 and #129) reviewed for potential restraints. This deficient practice had the potential for harm if the position change devices were improperly used and if resident experienced physical deterioration due to lack of movement. Findings include: The facility's Fall Investigation and Prevention Programs policy, undated, documented upon admission, residents would be evaluated for risk of falls. If the resident was at risk for falls, a Fall Risk Assessment Matrix Observation form would be completed by the DON. The policy also documented no alarms or restraints would be place on any resident without evaluation by the IDT and subsequent approval and order by the physician. IDT would review falls and make recommendations to the physician as it deemed necessary for alarms or restraint for resident safety. 1. Resident #10 was admitted to the facility on 8/11/13, with multiple diagnoses which included Alzheimer's Disease.	F 604	F604 Specific Residents- #10, #20, #22, #129 #10: A fall risk assessment was completed, along with assessment of her use of floor mat, seat belt, and tabs/chair alarm. Written consents have been signed and are in EHR. #20: Fall risk assessment done by IDT and determined resident had improved with therapies and changes in medical conditions. Alarms have been removed from room and chair per IDT and family. #22: Fall risk assessment was completed along with assessment of use of remote bed and chair alarm and found to be necessary for safety from falls. Assessments and written consents have been placed in EHR. #129: Fall risk assessment was updated in EHR and assessment for use of floor mat and w/c/tabs alarm was completed and found to be needed at this time. Written consent obtained and in record. Other Residents: All other residents have potential to be affected. Systemic changes: An audit was conducted on residents for fall risk assessments, and assessments for alarm use, and consents for alarms. These	

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F 604	Continued From page 8 A physician's order, dated 9/20/18, documented Resident #10 may continue to use the tab alarm and floor mat alarm for prevention of falls due to Alzheimer's Disease and her inability to make safe decisions. An annual MDS assessment, dated 7/25/19, documented Resident #10 was severely cognitively impaired and she required extensive assistance of one to two person for most ADLs. Resident #10's Fall care plan documented she used a seat belt alarm, floor mat alarm, and a chair/wheelchair tab alarm, for fall prevention. Resident #10's record did not include an assessment of her risk for falls. On 10/31/19 at 2:46 PM, Medical Record Personnel #1 said she did not find Resident #10's Fall Risk assessment. Resident #10's record did not include an assessment of her use of the floor mat, seat belt, and chair alarms as potential restraints. On 10/28/19 at 2:25 PM, 10/28/19 at 4:44 PM and 10/29/19 at 12:11 PM, Resident #10 was observed in her wheelchair with a tab alarm attached to the back of her wheelchair. Resident #10's record did not include an assessment of her use of the floor mat, seat belt, and tab/chair alarms as potential restraints. On 10/30/19 at 10:36 AM, the DON, together with LPN #1, said Resident #10's representative requested the position alarms. The DON said the IDT obtained a verbal consent from Resident	F 604	conclusions were discussed in Nurse staff meeting on 11/19/19. Discussed frequency and risk assessment accuracy. A new resident fall risk assessment will continue on admission and after a subsequent fall. Quarterly fall risk assessments will be done as well as those needed with any changes in condition. In the case that a resident would necessitate the use of an alarm, ALC will conduct an assessment of possible negative potential or actual outcomes which may result from the use of position change alarms as a physical restraint. Consents for alarms will be obtained and placed in EHR. Monitoring: DNS or designee will audit EHR for ongoing fall and alarm assessments, weekly x 4, and then monthly with regular EHR auditing. Reports will be provided to QAPI committee.	

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F 604	Continued From page 9 #10's representative and Resident #10 was assessed for the use of position alarms. The DON said the IDT determined it was safe for Resident #10 to use the position alarms, but they did not document the assessment. The DON and LPN #1 said they did not consider the position alarms as potential restraints. 2. Resident #20 was admitted to the facility on 5/14/19, with multiple diagnoses which included traumatic subdural hemorrhage (bleeding that often occurs outside the brain as a result of a severe head injury). A quarterly MDS assessment, dated 8/19/19, documented Resident #20 was moderately cognitively impaired and dependent on one staff member for all cares except for eating and drinking. Resident #20's Fall Risk assessment, dated 5/14/19, documented he was a high risk for falls. Intervention included Falls Prevention Program and a referral to Occupational Therapy and Physical Therapy. On 10/29/19 at 10:14 AM, Resident #20 was in bed and a floor mat alarm was observed on the floor. On 10/29/19 at 11:25 AM, Resident #20 was in his wheelchair with a chair/tab alarm attached on the back of his wheelchair. Resident #20's record did not include an assessment of his use of floor mat and chair alarms as potential restraints.	F 604		

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F 604	Continued From page 10 On 10/30/19 at 10:36 AM, the DON, together with LPN #1, said Resident #20's representative requested the position alarms. The DON said the IDT obtained a verbal consent from Resident #20's representative and Resident #20 was assessed for the use of position alarms. The DON said the IDT determined it was safe for Resident #20 to use the position alarms, but there was no documentation of the assessments. 3. Resident #22 was admitted to the facility on 3/13/15 and was readmitted on 8/7/17, with multiple diagnoses which included major depressive disorder. A physician's order, dated 3/22/18, documented Resident #22 may continue to use her pressure alarm in her bed alarm and tab alarm while in chair for fall prevention. A quarterly MDS assessment, dated 9/9/19, documented Resident #22 was severely cognitively impaired and she used bed and chair alarms. Resident #22's Fall care plan, documented she was a high risk for falls and staff was directed to make sure Resident #22's bed and chair alarms were properly placed. Resident #22's record did not include an assessment of her risk for falls. On 10/31/19 at 2:46 PM, Medical Record Personnel #1 said she did not find Resident #22's Fall Risk assessment. Resident #22's record also did not include an assessment of her use of bed and chair alarm as potential restraints.	F 604		

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F 604	Continued From page 11 On 10/29/19 at 10:30 AM, Resident #22 was observed in her wheelchair with an alarm attached on the back of her wheelchair. On 10/30/19 at 10:36 AM, the DON said the IDT obtained a verbal consent from Resident #20's representative and Resident #20 was assessed for the use of position alarms. The DON said the IDT determined it was safe for Resident #22 to use the position alarms, but they did not document the assessment. 4. Resident #129 was admitted to the facility on 9/20/19, with multiple diagnoses which included Parkinson's disease (a progressive nervous system disorder that affects movement). A physician's order, dated 9/20/19, documented Resident #129 may use a floor mat alarm and tab alarm while in the recliner and wheelchair. An admission MDS assessment, dated 9/27/19, documented Resident #129 was severely cognitively impaired and he used chair and floor mat alarms. Resident #129's record did not include an assessment of his risk for falls. On 10/28/19 at 2:46 PM, Resident #129 was observed sitting in the recliner with a tab alarm attached to the recliner. On 10/29/19 at 2:01 PM, Resident #129 was sitting in his wheelchair with a tab alarm attached on the back of his wheelchair.	F 604		

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F 604	Continued From page 12 Resident #129's record also did not include an assessment of his use of the floor mat and wheelchair/tab alarms as potential restraints. On 10/31/19 at 8:46 AM, the DON said the IDT obtained a verbal consent from Resident #129's representative and Resident #129 was assessed for the use of position alarms. The DON said Resident #129 was assessed for the use of the position alarms. The DON said IDT determined it was safe for Resident #129 to use the position alarms, but they did not document the assessments.	F 604		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		12/6/19

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F 623	Continued From page 13 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623		

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F 623	Continued From page 14 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, the facility failed to ensure written notice was provided to the resident and resident's representative prior to transfer to the hospital. This was true for 1 of 1	F 623	F623 Specific Residents: #9 will be given written notice of transfer to her and to her representative, if transferred for any	

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F 623	Continued From page 15 resident (Resident #9) reviewed for transfer/discharge to the hospital. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include: The facility's policy and procedure for Transfer or Discharge Notice, updated December 2016, documented when transfer is emergent the facility transfer or discharge notice would be given as soon as practicable but before the transfer or discharge. The resident and/or representative would be notified in writing the reason for the transfer and the location of transfer. This policy was not followed. Resident #9 was admitted to the facility on 3/2/14, with multiple diagnoses including hereditary and idiopathic neuropathy (damage to the nerves that carry information from the brain and spinal cord, to the rest of the body, and interferes with the functioning), osteoarthritis, and chronic pain. A Progress Note, dated 7/17/19 at 1:30 AM, documented Resident #9 was found in her room by staff and Resident #9 stated she had tripped and broken her ankle. Resident #9's record documented on 7/17/19 at 2:13 AM she left by ambulance to go to a local hospital. Resident #9's record did not include documentation of a written notice of transfer given to her and her representative. On 10/28/19 at 3:50 PM, Resident #9 stated she was unable to recall if she had received	F 623	reason. Other residents: All other residents have potential to be impacted. Systemic changes: During a root cause analysis of our process it was discovered that appropriate written notice of transfer was being signed upon admission, but not signed and dated when actual transfer was initiated. ALC will have appropriate notices available for resident to sign and date for transfer. All other documents needed for transfer will be given to them and documented in nurses progress notes. Monitoring: Training was conducted on 11/19/19 in nurse staff meeting about sending appropriate notice of transfer with resident and representative. Progress notes will also reflect what accompanied the resident for transfer. DNS or designee will monitor all transfers daily x 2 wks. and then monthly for written notice of transfer documentation. Medical records will continue to audit during monthly audits and report results to QAPI committee.	

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F 623	Continued From page 16 paperwork regarding her transfer to the hospital on 7/17/19. On 10/31/19 at 11:27 AM, the DON said she was unable to find documentation in Resident#9's record of transfer paperwork given to Resident #9 and her representative.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		12/6/19

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F 656	Continued From page 17 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included the use of tab/chair alarm. This was true for 2 of 12 residents (#20 and #129) whose care plan were reviewed. This failure created the potential for harm should residents receive inappropriate or inadequate care. Findings include: The facility's Comprehensive Care Plan Policy statement, revised December 2016, documented "The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." 1. Resident #20 was admitted to the facility on 5/14/19, with multiple diagnoses which included traumatic subdural hemorrhage. A quarterly MDS assessment, dated 8/19/19, documented Resident #20 was moderately	F 656	F656 Specific residents: #20, #129 care plans have been updated in the EHR to reflect the changes. Other residents: All other residents have potential to be impacted. Systemic changes: After reviewing care plans and process of adding approaches to the care plan, it was determined that communication of changes needed to be refined to reflect these changes. It was discussed in Nurse staff meeting on 11/19/19 that any changes or new approaches, needed to be care planned immediately for quality and safe care of residents. IDT will discuss any changes and review care plans for accuracy. Monitoring: DNS or designee will conduct audits of care plans for any inconsistencies daily x 2weeks and then	

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F 656	Continued From page 18 cognitively impaired and dependent on one staff member for all cares except for eating and drinking. On 10/29/19 at 10:14 AM, Resident #20 was in bed and a floor mat alarm was observed on the floor. On 10/29/19 at 11:25 AM, Resident #20 was in his wheelchair with chair/tab alarm attached on the back of his wheelchair. Resident #20's care plan did not document the use of the chair and floor mat alarms. On 10/31/19 at 9:05 AM, the DON said Resident #20's the chair and floor mat alarms should be on the care plan and he did not see them documented on the care plan. 2. Resident #129 was admitted to the facility on 9/20/19, with multiple diagnoses which included Parkinson's disease (a progressive nervous system disorder that affects movement). A physician's order, dated 9/20/19, documented Resident #129 may use a tab alarm while in his recliner and wheelchair. An admission MDS assessment, dated 9/27/19. documented Resident #129 was severely cognitively impaired and he used a chair alarm. On 10/28/19 at 2:46 PM, Resident #129 was observed sitting in the recliner with chair/tab alarm attached to the recliner. On 10/29/19 at 2:01 PM, Resident #129 was	F 656	weekly with IDT and care plan conferences quarterly.	

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F 656	Continued From page 19 sitting in his wheelchair with a tab alarm attached on the back of his wheelchair. Resident #129's care plan did not document the use of the chair/tab alarm. On 10/31/19 at 8:46 AM, the DON said Resident #129's chair/tab alarm should be on the care plan and he did not see it documented on the care plan.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were assisted with hand hygiene. This was true for 1 of 12 residents (Resident #10) reviewed for ADL care. This failure created the potential for harm by potentially exposing residents to the risk of infection. Findings include: Resident #10 was admitted to the facility on 8/11/13, with multiple diagnoses which included Alzheimer's disease. An annual MDS assessment, dated 7/25/19, documented Resident #10 was severely cognitively impaired and she required extensive assistance of one to two persons for most ADLs. On 10/28/19 at 4:44 PM, CNA #1 and CNA #2	F 677	F677 Specific resident: #10 is having her hands washed after cares being provided. Other residents: All other residents have potential to be affected. Systemic changes: Following observation of cares, it was determined to be an isolated case. CNA #1 and CNA #2, as well as all staff were instructed on 11/19/19 at an all staff meeting about not only offering hand hygiene to residents, but also to assess those that are cognitively impaired, and assisting them with hand hygiene. Training will continue and conducted with all staff specifically.	12/6/19

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F 677	Continued From page 20 were observed as they assisted Resident #10 to stand up using the Sara lift (a sit to stand lift). CNA #1 and CNA #2 then wheeled Resident #10 to the restroom. Inside the restroom Resident #10 was observed to touch her genitalia using her right hand as soon as CNA #2 removed the resident's incontinence brief. CNA #1 took Resident #10's hand and asked Resident #10 to hold on the Sara lift's grab bar. CNA #2 proceeded to clean Resident #10's periarea and then applied new incontinence brief to the resident. CNA #1 and CNA #2 then removed their gloves and performed hand hygiene and assisted Resident #10 to stand using the sit to stand lift. CNA #1 and CNA #2 did not assist Resident #10 with hand hygiene after she used the restroom. On 10/29/19 at 3:44 PM, CNA #1 and CNA #2 were observed as they assisted Resident #10 to stand up using the Sara lift. CNA #1 and CNA #2 then wheeled Resident #10 to the restroom. Inside the restroom, CNA #2 removed Resident #10's incontinence brief soiled with fecal matter. While Resident #10 was being cleaned by CNA #2, Resident #10 was holding on the Sara lift grab bar, she then dangled her hand then touched the arm of CNA #1 who was standing in front of her with the Sara lift, and then Resident #10 touched her lower abdomen. Resident #10 repeatedly held on to the grab bar and touched CNA #1's arm while CNA #2 was completing pericare. At one-point Resident #10 was observed to hold on to CNA #2's left gloved hand. When CNA #1 and CNA #2 finished performing pericare to Resident #10, both CNAs removed their gloves and performed hand hygiene. CNA #1 and CNA #2 assisted Resident #10 to transfer to her wheelchair using the Sara lift. CNA #1 and	F 677	Monitoring: DNS or designee will monitor, observe, and document cares and observe that residents are given the opportunity to have hand hygiene. Auditing 3 x a week for 2 weeks and then weekly x 6 weeks. Results will be reported in QAPI committee.	

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F 677	Continued From page 21 CNA #2 did not assist Resident #10 with hand hygiene after she used the restroom. On 10/29/19 at 4:10 PM, CNA #2 said she did not wash Resident #10's hands after using the restroom. CNA #2 said she should have washed Resident #10's hands when she finished with her pericare. On 10/29/19 at 4:13 PM, CNA #1 said she did not wash Resident #10's hands after they assisted her to the restroom. CNA #1 said she should have washed Resident #10's hands after they were finished with her pericare.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident and staff interview, it was determined the facility failed to ensure the residents' environment was free from accident hazards when thresholds were too high in 2 of 2 dining rooms. This was true for 5 of 12 residents (#1, #13, #19, #20, and #26) reviewed for accident hazards and 1 of 11 residents (Resident #5) in the group interview. This deficient practice created the potential for harm if residents fell due to trip hazards. Findings include:	F 689	F689 Specific Resident(s): #1, #13, #19, #20, #26 and #5 had potential for harm due to a fall. Rubber threshold on floor and doorway was replaced with a lower to the floor threshold. Other Resident (s: All other residents have potential to be impacted.	12/6/19

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F 689	Continued From page 22 The facility's safety policy, dated July 2017, documented staff were trained to identify and report safety risks and environmental hazards to prevent avoidable accidents. This policy was not followed. On 10/29/19 at 9:13 AM, Resident #19 said he had difficulty maneuvering over the "hump" in the main dining room with his wheelchair. He said CNAs also had trouble helping residents over the hump. On 10/29/19 at 9:32 AM, the main dining room had a 1 and 1/2-inch wide hard rubber threshold that separated the carpet and laminate floor that ran parallel just right of the entrance door. The threshold was 11 feet long and then turned at a right angle that ran perpendicular for 15 feet to the right wall. The inside area of the threshold was laminate flooring and the rest of the dining room was carpet flooring. On 10/29/19 at 9:34 AM, the assisted dining room had a 1 and 1/2-inch wide hard rubber threshold that was 3 foot-long and separated the hallway carpet floor with the dining room laminate floor. On 10/29/19 from 11:25 AM to 11:46 AM, the following were observed in the assisted and main dining rooms: * At 11:25 AM, Resident #20 unsuccessfully attempted to self-propel his wheelchair over the hallway threshold two times into the assisted dining room. The Activity Director told him that	F 689	Systemic Changes: Maintenance supervisor and Housekeeping supervisor evaluated all rubber threshold in building for no "Humps". No additional "Humps" were found in the building. Monitoring: Maintenance supervisor will monitor all new thresholds for safety. QAPI committee will review if there have been any concerns about a particular building safety issue from staff or residents with a special focus on thresholds.	

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F 689	Continued From page 23 she would assist him and pushed his wheelchair over the threshold. * At 11:32 AM, CNA #4 assisted Resident #13 in her wheelchair into the main dining room and over the parallel section of the threshold and onto the laminate floor. The front right wheel then caught on the perpendicular section of the threshold which abruptly stopped the wheelchair's momentum. CNA #4 then pressed her right foot on Resident #13's wheelchair rear extender bar and pressed down with her hands onto the wheelchair handles which elevated the front wheels over the threshold. CNA #4 then assisted her to her table on the carpeted section of the main dining room. * At 11:39 AM, Resident #26 used her walker to maneuver over the parallel section of the threshold and onto the laminate floor. Her walker's front right wheel then caught on the perpendicular section of the threshold which abruptly stopped her momentum. CNA #5 who had walked beside Resident #26, picked up the walker so the wheel could clear the threshold. Three legs of Resident #26's dining room chair were on the laminate section and the back-right leg was on the carpet when CNA #5 assisted her into the chair. CNA #5 then lifted the back-right corner of the chair over the threshold and onto the laminate floor. * At 11:46 AM, Resident #1 self-propelled his wheelchair into the main dining room and proceeded to pass over the parallel section of the threshold and onto the laminate floor. He unsuccessfully attempted to cross over the perpendicular section of the threshold and his	F 689		

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F 689	Continued From page 24 wheelchair rolled back. Resident #1 then leaned forward in his wheelchair and self-propelled over the perpendicular section of the threshold. He then proceeded to his table on the carpeted section of the dining room. On 10/30/19 at 10:03 AM, during a group interview, Resident #5 said sometimes it was difficult to move her walker over the hump in the main dining room. On 10/30/19 at 10:46 AM, CNA #4 said the "bump" in the dining room was "a pain" to maneuver over. She said she had to put her foot on Resident #13's wheelchair bar, the previous day, in order to get her wheelchair over the threshold. CNA #4 said the threshold had been a problem for at least a year. On 10/30/19 at 11:10 AM, CNA #5 said she assisted Resident #26 over the threshold, the previous day, when her walker wheel was stuck. She said she was careful in helping residents over the threshold, so they did not fall. CNA #5 said several staff members knew about the threshold difficulty and was unaware of any plans to correct the concern. On 10/30/19 at 1:56 PM, the Maintenance Representative measured the thresholds in the assisted and main dining rooms. He said the threshold was 1 and 1/2-inches wide and 1/2-inch high. He said the threshold could be a safety issue for residents.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		12/6/19

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F 758	Continued From page 25 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 26 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received gradual dose reductions (GDR) of psychotropic medications unless clinically contraindicated. This was true for 1 of 5 residents (Resident #12) reviewed for unnecessary medications. This failure created the potential for harm if residents receive psychotropic medications that were unwarranted, ineffective, and used for excessive duration. Findings include: The facility's Tapering Medications and Gradual Drug Dose Reduction policy and procedure, dated April 2007, directed staff to attempt a GDR of psychotropic medications at least annually unless clinically contraindicated. This policy was not followed. Resident #12 was admitted to the facility on 3/22/11, with multiple diagnoses including depression, hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body). Resident #12's physician orders, dated 6/2/16 documented he received duloxetine 60 mg (milligrams) delayed release capsule daily. On	F 758	F758 Specific resident: #12 has been offered a GDR on his antidepressant and reviewed by Physician. Other residents: All other residents have potential to be impacted. Systemic changes: DNS conducted an audit of other residents for GDR in psychotropic medications and found this to be an isolated case. Facility pharmacist does monthly reviews of all residents and their medications. Pharmacist will track all GDR□s and recommend for Physician□s review at least annually for all residents that are on psychotropic medications. The effectiveness of GDR□s will continue to be discussed in QAPI committee. Monitoring: DNS or designee will track and document residents for possible GDR□s weekly x 6 weeks and then monthly with pharmacist. All results will be reported to QAPI committee.	

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F 758	Continued From page 27 3/8/18 the order changed to document duloxetine 30 mg delayed release capsule once a day with a 60 mg tablet of duloxetine to equal 90 mg per day. The physician orders did not include an indication for use of the duloxetine. Resident #12's care plan documented Resident #12 received duloxetine for treatment of depression. A pharmacist's progress note, undated, with a print date of 5/10/18, documented no medication changes had occurred since the last pharmacist visit and Resident #12's behaviors continued at status quo, with no positive changes. The note further documented "No concerns." A pharmacist's progress note, undated, with a print date of 9/12/18, documented a note would be sent to Resident #12's physician regarding review of the duloxetine dosage. The pharmacist's note to the physician, undated, with a print date of 9/12/19, documented Resident #12's depression scores were low and the pharmacist did not see other overt signs and symptoms of depression. The note further stated Resident #12 did continue with unabated negative behaviors. On 9/18/18, the physician responded to the note by ordering a GDR of the duloxetine from 90 mg daily to 60 mg daily. On 10/11/18 Resident #12's physician orders documented an increase of the duloxetine back to the previous dosage of 30 mg delayed release capsule to be given with 60 mg delayed release capsule to equal 90 mg of delayed release duloxetine per day. The order did not include an	F 758		

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F 758	Continued From page 28 indication for the use of the duloxetine. A pharmacist's progress note, undated, with a print date of 10/15/18, documented a GDR was completed for the duloxetine on 9/18/18, and after that Resident #12's negative behaviors escalated rapidly and the dose was increased back to 90 mg daily. The note documented Resident #12 continued to receive a 30 mg extended release capsule and a 60 mg extended release capsule for depression which were given together daily for a total of 90 mg. Resident #12's record did not include documentation of a GDR for duloxetine after 9/18/18. Resident #12's MAR for August, September, and October 2019 documented he received duloxetine 30 mg delayed release capsule taken once a day with a 60 mg delayed release capsule of duloxetine to equal 90 mg per day. On 10/31/19 at 1:28 PM, the DON said Resident #12's record did not document a GDR was attempted since 9/18/18.	F 758		
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	F 880		12/6/19

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F 880	Continued From page 29 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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	F 880		

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F 880	Continued From page 30 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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 observation, staff interview and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 3 of 3 residents (#1, #10 and #25) when staff failed to perform hand hygiene between resident contact. Additionally, it was determined the facility failed to ensure a Sara lift used to safely transfer residents to a standing position was cleaned after each use. These deficient practices created the potential for the spread of infectious organisms from cross-contamination. Findings include: 1. The facility's Handwashing/Hand Hygiene policy, revised August 2019, directed staff to use an alcohol based hand rub containing at 62% alcohol or alternatively soap and water before and after direct contact with residents.	F 880	F880 Specific resident: #1, #10, #25 will have the opportunity to have hand hygiene offered or assisted with, and all staff will perform handwashing/hand hygiene before and after direct contact with residents. Other residents: All other residents have potential to be affected. Systemic changes: In an all staff meeting conducted on 11/19/19 policies and procedures were discussed about handwashing/ hand hygiene and the cleaning and disinfecting noncritical care items (sit to stand lift). The policy was	

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F 880	Continued From page 31 This policy was not followed: On 10/29/19 at 3:26 PM, CNA #3 asked Resident #1 if the surveyor could see his legs. Resident #1 said "yes." CNA #3, with his bared hands, removed Resident #1's shoes and socks. The surveyor then asked CNA #3 to put Resident #1's shoes and socks back on, which he did. CNA #1 then left the room without performing hand hygiene. CNA #3 walked to the fireplace area and talked to Resident #25 then shook Resident #25's hand before leaving the area. CNA #3 was then observed to walk to the TV (Television) area and talk to Resident #10. CNA #3 shook Resident #10's hand before leaving the TV area. On 10/29/19 at 3:35 PM, CNA #3 said hand hygiene was performed before and after resident contact. CNA #3 said he did not perform hand hygiene after removing and putting back Resident #1's shoes and socks. CNA #3 said he also did not perform hand hygiene between his interactions with Resident #25 and Resident #10. 2. The facility's Cleaning and Disinfecting Non-Critical Resident-Care Items policy, revised June 2011, directed staff to clean and disinfect reusable items in between residents uses. This was not followed: On 10/29/19 at 3:44 PM, CNA #1 and CNA #2 were observed as they assisted Resident #10 to stand up using the Sara lift (sit to stand lift). CNA #1 and CNA #2 then wheeled Resident #10 to the restroom. Inside the restroom, CNA #2 removed Resident #10's incontinence brief soiled	F 880	reviewed and staff was able to participate in scenarios involving the cleaning of equipment after each use. Education will continue to be part of all staff meetings. Reinforcement of these policies will be tracked and monitored for effectiveness. Monitoring: DNS or designee will conduct an audit of staff performing cares and ensuring that this includes noncritical equipment (sit to stand lift). 3 x a week for 2 weeks and then weekly x 6 weeks. Results will be reported to QAPI.	

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F 880	Continued From page 32 with fecal matter. While Resident #10 was being cleaned by CNA #2, Resident #10 was holding on to the Sara lift grab bar. She then dangled her hand then touched the arm of CNA #1 who was standing in front of her with the Sara lift, and then Resident #10 touched her lower abdomen. Resident #10 repeatedly held on to the grab bar and touched CNA #1's arm while CNA #2 was performing pericare. At one point Resident #10 was observed to hold on to CNA #2's left gloved hand. When CNA #1 and CNA #2 finished performing pericare to Resident #10, both CNAs removed their gloves and performed hand hygiene. CNA #1 and CNA #2 assisted Resident #10 to transfer to her wheelchair using the Sara lift. CNA #2 then wheeled Resident #10 to the TV area. CNA #1 took the Sara lift and said she would bring it back to the storage area. CNA #1 did not clean or sanitize the Sara lift after it was use by Resident #10. On 10/29/19 at 3:58 PM, CNA #1 was about to enter the storage area with the Sara lift when CNA #6 said she needed the Sara lift for another resident. CNA #6 took the Sara lift and went to the TV area and assisted a resident to transfer from the recliner to her wheelchair. CNA #6 did not clean or sanitize the Sara lift before using it to help transfer the resident. On 10/29/19 at 4:45 PM, CNA #6 said she did not clean the Sara lift when she used it to help transfer a resident from the recliner to the resident's wheelchair. CNA #6 said she assumed the Sara lift was cleaned after it was used for Resident #10. On 10/30/19 at 9:27 AM, the DON said the Sara	F 880		

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F 880	Continued From page 33 lift should be cleaned or wiped down after each resident use. 3. Refer to F677 as it relates to the failure of the facility to ensure residents were assisted with hand hygiene after toileting.	F 880		