STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/11/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Carroll Manor Nursing and Rehab Center from August 30, 2018 through September 11, 2018. Survey activities consisted of a review of 60 sampled residents. The following deficiencies are based on observation, record review, resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CFU Colony Forming Unit CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram	F 000	Carroll Manor Nursing & Rehabilitation Center makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, it's officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	11/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	11-11-2018

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 000	Continued From page 1	F 000		

EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
L - Liter
Lbs. - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
ng- nanograms
Neuro - Neurological
NP - Nurse Practitioner
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
Rap, R/P - Responsible party
SCSA Significant change status assessment
Sol- Solution
T4- Thyroxine
TAR - Treatment Administration Record
Trach- Tracheostomy

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F 000	Continued From page 2 TSH- Thyroid Stimulating Hormone TV- Television TX- Treatment	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550	F550 1. Resident # 114 was treated with dignity and respect as evidenced by facility staff calling him by his name. 2. All other residents have been treated with dignity and respect. 3. Staff has been educated on treating residents with dignity and respect by addressing residents by their name. 4. The Unit Manager or designee will conduct random observations on a weekly basis times 3 months to ensure that staff treats residents with dignity and respect by addressing residents by their name. The results of the observations will be reported at the monthly QAPI committee meeting for review.	11/11/18

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F 550	Continued From page 3	F 550		

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:

Based on observations and staff interview of one (1) of 60 sample residents, the facility failed to ensure Resident #114 was treated with dignity and respect as evidenced by facility staff calling resident "Poppy."

Findings included ...

Resident #114 was admitted on June 15, 2015, with diagnoses to include Osteoarthritis, Cataracts, Dementia, Sensorineural Hearing Loss, and Peripheral Vascular Disease.

During observations on August 30, 2018, at 10:30 AM, Resident #114 noted wandering on the unit with wet pants. Employee #28 in the hallway called the resident "Poppy" while trying to offer re-direction. When queried about the resident's name, the employee provided the resident's name.

On August 30, 2018, at 11:56 AM, Resident #14 walked pass the nursing station with a large wet area on the front of the pants in the groin area. Employee #21 called Resident #114 "Poppy" to gain attention to assist with changing pants.

A review of the medical record to include social services assessment, preferences, and care plans failed to demonstrate the resident's

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F 550	Continued From page 4 preference to be called "Poppy." During a face to face interview on August 30, 2018, at approximately 12:15 PM, Employee #21 stated the resident is Japanese and apologized for speaking to the resident in that manner. The employee acknowledged the findings.	F 550		
F 575 SS=F	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post in prominent locations the contact information for the State Survey Agency	F 575	F575 1. State Survey Agency information was posted in prominent locations on 9/1/2018. 2. State Survey Agency information was posted in prominent locations on 9/1/2018. 3. Staff was educated on the location of State Survey Agency information. 4. The Social Worker or designee will conduct observations on a monthly basis times 3 months to ensure that State Survey Agency information is posted in prominent locations. The results of the observations will be reported at the monthly QAPI committee meeting for review.	11/11/18

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F 575	Continued From page 5 to include the name, business address (mailing and email) and business number to ensure residents and resident representative are able to file a complaint. The facility census was 239. Findings included ... During observation on August 30, 2018, at 10:30 AM, the sign posted on the First Floor unit instructed the resident to "Please contact your assigned Social Worker or Nurse Manager if you have concerns or complaints." The sign also listed "Other Resources for Senior Citizens" to include the DC Aging and Disability Resource Center, Long-Term Care Ombudsman Program, and DC Medicaid. On September 7, 2018, between 1:00 PM and 4:00 PM, additional observations were conducted on the remaining units which revealed the identical signage was posted on those units. The facility failed to post the State Survey Agency information to include the mailing and email addresses to ensure residents and resident representatives had the contact information needed to file a complaint. During a face to face interview on September 7, 2018, 4:00 PM, Employee #1 acknowledged the findings.	F 575		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		

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F 580	Continued From page 6 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580	F580 1. Resident #44's physician was notified of the missing labs and a new lab order was received on 9/6/2018. 2. September 2018 orders of current residents were reviewed to determine if there were other instances of missing labs. 3. Licensed nurses have been educated on notifying physicians of missed labs. 4. The Unit Manager or designee will audit 10 percent of the residents will be audited on a monthly basis times 3 months to ensure that missed labs are reported to the physician. The results of the observations will be reported at the monthly QAPI committee meeting for review.	11/11/18

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F 580	Continued From page 7	F 580		

its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview of one (1) of 59 sampled residents facility staff failed to notify the physician bloodwork was not obtained for Resident# 44.

Findings included....

Review of the medical record on 9/5/18 at 2:00 PM showed Resident # 44 admitted to the facility on 12/20/02, with diagnoses which include Anemia, Hypertension, End Stage Renal Disease, Diabetes Mellitus, Thyroid Disorder.

Review of the Annual Comprehensive Minimum Data Set [MDS] dated 3/6/18 showed Section C [Cognitive Patterns] Brief Interview Score [BIMS] of "15" which indicates "Cognitively Intact".

Review of the medical record on 9/5/18 at 3:00 PM showed a Physician Order Form dated 8/14/18 "TSH (Thyroid Stimulating Hormone) with T4 (Thyroxine) please arrange with the next dialysis at dialysis center".

A review of the Dialysis Communication forms dated 8/14/18 and 8/22/18 did not show a physician order for TSH and T4 and or that the lab order was communicated to the dialysis center.

Employee# 3 was unable to provide evidence the TSH and T4 was requested in accordance with

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F 580	Continued From page 8 physicians order and/or that the physician was notified the lab (TSH/T4) was not obtained as ordered. During an interview on 9/5/18 with Employee# 3, I will call the doctor now to get a new lab order for the TSH and T4. During a face-to-face interview on 9/5/18 at 5:00 PM, Employee# 3 acknowledged the finding.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	F584 1. The exhaust vents in room #'s 455,550,553,555, and 556 provide suction. The vents in room #'s 542 and 545 were dusted. 2. The Maintenance Manager or designee conducted rounds to ensure that the exhaust vents in resident rooms suction and are free from dust. 3. The maintenance staff was educated on ensuring that the exhaust vents suction and are free from dust. 4. The Maintenance Manager or designee will randomly audit 10 percent of the resident rooms on a weekly basis times 3 months to ensure that the exhaust vents suction and are	11/11/18

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F 584	Continued From page 9 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a comfortable interior as evidenced by exhaust vents in five (5) of 66 resident rooms that did not function as intended and soiled exhaust vents in two (2) of 66 resident rooms. Findings included... Facility failed to ensure resident common areas were maintained in a safe, comfortable condition. During observations on the fourth, fifth and sixth floors on August 31, 2018, between 10:20 AM and 12:30 PM, resident rooms and common areas were observed with the following: 1. Exhaust vents did not provide suction when tested in five (5) of 66 resident rooms (#455, #550, #553, #555, #556).	F 584	F584 (Continued) free from dust. The results of the observations will be reported at the monthly QAPI committee meeting for review.	

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F 584	Continued From page 10 2. Exhaust vents were soiled with dust in two (2) of 66 resident rooms (#542, #545). During a face-to-face interview on August 31, 2018, at approximately 12:30 PM, Employee #5 confirmed the findings.	F 584		
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 by: Based on resident and staff interview for one (1) of 60 sampled residents, the facility failed to ensure that Resident #338 was free from verbal abuse. Findings included... The facility's "Abuse Prevention" policy last revised August 2018, defines mental abuse as "the use of verbal or non-verbal conduct which	F 600	F600 1. Resident #338 was assessed and provided reassurance. 2. No other residents were identified to have reported abuse. 3. Staff have been in-service to ensure that residents are free from abuse. 4. Random observations and interviews will be conducted by Nurse Manager or Designee on a weekly basis times 3 months. Results will be reviewed and addressed immediately as needed. The results of the observations will also be reported at the monthly QAPI committee meeting for review.	11/11/18

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cause or has the potential to cause a resident to experience humiliation, intimidation, fear, shame, agitation, or degradation." In addition, the policy states "IDENTIFICATION- b. Associates or person affiliated with this community who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any criminal offense shall immediately report the suspected abuse or incidents of abuse to the administrator or designee.

During the onsite recertification survey, Resident #338 reported an allegation of verbal abuse to the surveyor, during a resident interview, stating the certified nursing assistant spoke in a harsh and rude manner which was hurtful and caused the resident to cry.

Resident #338 was admitted on August 6, 2018, with diagnoses to include Anemia, Heart failure, Hypertension, Peripheral Vascular Disease, Gastroesophageal Disease, Diabetes Mellitus, and Asthma.

According to the Brief Interview for Mental Status (BIMS) Summary Score on the admission Minimum Data Set (MDS) dated August 13, 2018, the resident is cognitively intact as Section C0500 was coded "15."

During a face-to-face resident interview on August 30, 2018, at 3:15 PM, Resident #338 stated the staff providing am care spoke to in a harsh manner, which cause her to feel upset and hurt and made her cry. When asked if she

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reported the incident to anyone, the resident stated "no." A Rehab staff member (Employee #8) was waiting outside the room to transport the resident for a therapy session.

On August 30, 2018, at approximately 3:30 PM, Employee #7 was asked if the facility was aware of Resident #338's allegation of verbal abuse. The employee acknowledged being aware of the allegation and state the employee involved was sent home until further notice. Employee #7 stated she learned about the verbal allegation at around 12:00 PM. However, the employee did not report the incident to the State Agency until 4:53 PM on August 30, 2018.

During a telephone interview on September 4, 2018, at 10:45 AM, Employee #8 stated, on August 30, 2018, at approximately 9:50 AM, while waiting, outside of the resident's room, to take the resident to therapy, the employee overheard a lot of noise, yelling and rough talking. Employee #9, Certified Nurse Aide, and Resident #338 were in the bathroom. When the resident came out of the bathroom, she was crying and coughing. Employee #9 was overheard yelling at the resident to cover her mouth.

Employee #8 was asked whether she reported the incident to anyone prior to taking Resident #338 to therapy. Employee #8 stated she did not report the incident to because the resident wanted to get to therapy quickly. The employee

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F 600	Continued From page 13 decided to take the resident to therapy and report the matter to Rehab Supervisor. The employee was advised by her supervisor to report the incident to the nurses on the unit upon Resident #338's return to unit after therapy. Employee #8 stated the charge nurse was informed on August 30, 2018, at approximately 11:00 AM. During a face-to-face interview at approximately 4:00 PM on September 4, 2018, Employee #7, Unit Manager, acknowledged the witnessed incident of verbal abuse towards Resident #338.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609	F609 1. Allegation of verbal abuse was reported to the state agency within 2 hours of administration notification. 2. There were no other identified allegations of abuse. 3. Facility staff have been in-service to report all allegations of abuse to state agency immediately 4. Random observations and interviews will be conducted by Nurse Manager or Designee on a weekly basis times 3 months. Results will be reviewed and addressed immediately as	11/11/18

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F 609	Continued From page 14 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 60 sampled residents, facility failed to report Resident #338's allegation of verbal abuse by a Certified Nursing Assistant (CNA) to the State Agency within two (2) hours in accordance with Federal and State Regulations. Findings included... Resident #338 was admitted to the facility on August 06, 2018, from an acute care facility with a history of Anemia, Heart failure, Hypertension, Peripheral Vascular Disease, Gastroesophageal Disease, Diabetes Mellitus, Asthma, Chronic Obstructive Pulmonary Disease and Respiratory Failure. The resident has a below knee amputation of the right lower extremity and uses a wheel chair for mobility. According to the Admission Minimum Data Set (MDS) dated August 13, 2018, the resident's Brief Interview for Mental Status (BIMS) score was "15" indicating the resident was cognitively intact (fully alert and completely oriented). Under Section G 0110 (Activities of Daily Living) the resident is coded as requiring extensive assistance and with two person physical assist, in bed mobility, transfers, and toilet use. The resident was coded as requiring extensive	F 609	F609 (continued) needed. The results of the observations will also be reported at the monthly QAPI committee meeting for review.	

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assistance with one-person assist with locomotion on and off the unit, dressing; and personal hygiene.

During a face-to-face interview on August 30, 2018, at approximately 3:15 PM with Resident #338, I asked whether anyone has ever abused her or threatened to abuse her. The resident responded that staff spoke to her in what she described as a rude and disrespectful manner that makes her feel hurt and cause her to cry. She was not able to name anyone but said she could identify them if/when she saw them. The resident was asked whether she had reported the matter to anyone. She said "no" and added that someone was waiting to take her to therapy. "She gave me some water."

The "Someone" to whom Resident #338 made reference was identified as an employee from the Rehabilitation department (Employee #8) who was waiting to transport the resident to physical therapy when the incident occurred.

A face-to-face interview was conducted with the manager at approximately 3:30 PM on August 30, 2018, for the purpose of following up on the resident's statement. During the interview I asked the manager whether she was aware of the resident's allegation of feeling hurt and crying because of how staff speaks to her; and of the report of an employee who witnessed a certified nurse aide yelling at the resident and talking to her in a manner that caused her to cry this morning. Employee #7 responded that she was aware of the allegation.

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F 609	Continued From page 16 I asked Employee #7 had she notified the State Agency of the allegation. The employee responded that she was informed of the allegation around noon but she did not notify the State Agency of the allegation prior to this time (3:30 PM on August 30, 2018) because she thought she needed to investigate the allegation and obtain additional information before she contacted the State. Employee #8 was asked whether she reported the matter to any one on the unit prior to taking the resident to therapy. She responded that she did not and added that the resident was in a hurry to get to therapy; so she decided to take her to therapy and report the matter to her supervisor. Employee #8 stated that her supervisor advised her to report the incident to the nurses on the unit when she took the resident back to the floor. The employee stated that upon returning to the floor at around 11:00 AM on August 30, 2018, she informed the Charge Nurse of the CNA's behavior towards the resident. Facility staff failed to report Resident #338's allegation of verbal abuse by a CNA to the State Agency within 2 hours in accordance with Federal and State regulations. Employee #7 acknowledged the finding during a face-to-face interview at 3:30 PM on August 30, 2018.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		

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F 610	Continued From page 17 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on investigation documents, medical record review, and staff interview three (3) of 60 resident records, the facility failed to conduct a thorough investigation of incident involving injuries of unknown source. The failed practice affected the facility's ability to implement appropriate corrective actions to prevent reoccurrence. (Resident #15, 19, and 24) Findings include ... 1. Resident #15 was admitted on January 4, 2016 with diagnoses to include Anemia, Arthritis, Dementia, and Hypertension. Medical record review conducted on September 10, 2018, at 3:30 PM, showed Resident #15 is severely cognitively impaired as evidence by the quarterly Minimum Data Set (MDS) dated August 14, 2018, Section C1000. Cognitive Skills for Daily Decision Making was coded as "3" severely	F 610	F610 1. The Facility reviewed resident #15, #19 and #24's injury information and initiated education for staff regarding injuries of unknown origin. 2. Injuries of unknown origin and falls for current residents during the month of September 2018 were reviewed to ensure thorough investigation of injuries of unknown origin and falls. 3. Staff was educated on ensuring thorough investigation of injuries of unknown origin and falls. 4. The Unit Manager or designee will review injuries of unknown origin and falls on a weekly basis times 3 months to ensure thorough investigation of injuries of unknown origin. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	11/11/18

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impaired- never/rarely made decisions. According to Section G0110 Activities of Daily Living (ADL) Assistance, Resident #15 requires extensive assistance from two plus persons physical assistance for bed mobility and transfers, and uses a walker as a mobility device.

Review of the Nursing Notes dated June 17, 2018 at 6:00 PM showed that Resident #15 was observed moaning guarding her left foot. Upon assessment, the nurse observed swelling to the left mid-shin area extending to the ankle. The physician was notified and the resident transferred to the hospital for evaluation.

Resident #15 returned from hospital on June 18, 2018, at 6:35 AM, with diagnoses of Fracture of Distal Tibia and Fibula. On June 19, 201, Resident #15 was seen in follow-up by orthopedic and received a diagnosis of fragility fracture secondary to severe osteoporosis.

On September 7, 2018, at approximately 1:17 PM, Employee #2 was asked to provide a copy of the incident investigation. Upon receipt and review of the incident investigation, it was noted that the investigation only contain copies of handwritten statements from the staff. All of the statements indicated that staff was unaware of how the injury occurred. However, one employee indicated the use of a lift to place the resident back to bed. When asked about the facility's inquiry into the employee's statement and other questions that were asked, Employee #2 was unable to provide insight.

The facility failed to provide evidence a thorough investigation was conducted of the injury of unknown origin regarding Resident #15 on June

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F 610	Continued From page 19 17, 2018. During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conducted a thorough investigation. Employee #1 acknowledged the findings. 2. Resident #19 was admitted on February 2, 2018 with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder. Review of the Minimum Data Set dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor. Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 suddenly slid out of the wheelchair while the nurse was attempting to transfer. During a face to face interview on September 10, 2018, at approximately 3:00 PM, Employee # 21	F 610		

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stated the resident fell forward while the nurse was attempting a transfer. When asked about the resident's transfer and mobility status, Employee #21 stated that Resident #19 uses a sit-stand lift for transfers. When asked about the investigation into the incident, the employee stated that the supervisor completes the incident investigation.

Upon review of the incident investigation, the document did not provide evidence that a thorough investigation was conduct to include insight into if the mechanical life device was utilized during the transfer.

The facility failed to provide evidence a thorough investigation was conducted of the fall regarding Resident #19 on September 4, 2018.

During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #24 on July 18, 2018. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conduct a thorough investigation. Employee #1 acknowledged the findings.

3. Resident #24 was admitted on March 16, 2017 with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension.

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Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 has severe cognitively impaired as coded in Section C0600 Brief Interview for Mental Status Summary Score of "00." The staff was unable to complete the Resident Mood Interview in Section D resulting in a "Total Severity Score of 99." However, Section E0200 Behavioral Symptoms was coded for "other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging) 1 to 3 days" during the assessment reference period.

Review of nursing notes dated July 18, 2018, at 10:11 PM, showed that Resident #24 was found with an injury of unknown origin during PM care. A laceration on the middle chin measuring 1.5 centimeters by 1.5 centimeters with no active bleeding was observed. Due to Resident #24's history of Dementia, the resident was unable to give an account of the cause of the injury. The resident vital signs were documented as blood pressure 70/45, pulse-98 on the right arm; and left arm manual blood pressure measured 76/37 while lying down and pulse-99. Consequently, Resident #24 was transferred to the hospital for evaluation.

Review of the Physician Progress Notes dated July19, 2018 (no time documented), does not mention the laceration or probable cause for the injury.

During a face to face interview on September 7, 2018 at approximately 12:15 PM, Employee #2 was asked for the incident investigation related to the injury of unknown origin for Resident #24. Upon receipt and review of the incident

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investigation, it was noted that the investigation only contain copies of handwritten statements from the staff. All of the statements indicated that staff was unaware of how the injury occurred.

Further review of the investigation documents revealed the "Statement of Witness" forms completed by the staff included the following instructions "Document responses to questions below; review written responses with witness prior to signing. Attach additional page(s) if needed.) Each of the "Statement of Witness" forms attached to the incident report for Resident #24 provided by Employee #2 did not contain a set of question to which the employee was responding.

On September 7, 2018, at approximately 3:30 PM, during a face to face meeting with Employees #1, 2, and 19, the investigation process was discussed for falls and other incidents. Employee #2 stated that all incidents are report to the Department of Health and entered into the facilities incident reporting system. When asked about the completion of the investigation and the questions that are utilized to gain further insight into the incident, Employee #2 stated that the information is placed into the corporate system and the Quality Director decides the next steps. A "Level 1 Root Cause Analysis" form was attached to several of the incidents provided by Employee #2, when asked when the form is utilized for investigation, the employee stated the form is only completed when the Director of Quality instructs the team. When asked directly about the investigation and outcome related to Resident #24's injury of unknown origin, the employees were unable to provide further insight or provide evidence of a thorough investigation.

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F 610	Continued From page 23 On September 10, 2018, at 8:36 AM, during a face to face interview, Employee #20 provide the surveyor with a copy of the "Level 1 Root Cause Analysis" form and stated that the nurses complete the form with each fall. When asked if the form is completed with other incidents, the employee stated "no." The facility failed to provide evidence a thorough investigation was conducted of the injury of unknown origin regarding Resident #24 on July 18, 2018. During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #24 on July 18, 2018. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conduct a thorough investigation. Employee #1 acknowledged the findings. 3. Resident #19 was admitted on February 2, 2018 with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder. Review of the Minimum Data Set dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes	F 610		

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Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor.

Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 suddenly slid out of the wheelchair while the nurse was attempting to transfer.

During a face to face interview on September 10, 2018, at approximately 3:00 PM, Employee # 21 stated the resident fell forward while the nurse was attempting a transfer. When asked about the resident's transfer and mobility status, Employee #21 stated that Resident #19 uses a sit-stand lift for transfers. When asked about the investigation into the incident, the employee stated that the supervisor completes the incident investigation.

Upon review of the incident investigation, the document did not provide evidence that a thorough investigation was conduct to include insight into if the mechanical life device was utilized during the transfer.

The facility failed to provide evidence a thorough investigation was conducted of the fall regarding Resident #19 on September 4, 2018.

During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough

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F 610	Continued From page 25 investigation was conducted regarding Resident #24 on July 18, 2018. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conduct a thorough investigation. Employee #1 acknowledged the findings.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;	F 622		

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or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of

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this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview for two (2) of 60 sampled residents facility staff failed to ensure the completeness and accuracy of the documented information communicated with the receiving health care institution. Residents' #24 and #147.

Findings included ...

1. Resident #24 was admitted on March 16, 2017, with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension.

Review of medical record on September 6, 2018, at 10:02 AM, showed Resident #24 was hospitalized on June 15, 2018 and readmitted on June 18, 2018. Also, Resident #24 was transfer to the hospital on July 18, 2018, for Hypotension and laceration on mid-chin.

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Review of the Progress Notes showed Resident #24 was transferred to the hospital on June 15, 2018. Further review of the medical record failed to show documentation of the information communicated to the receiving healthcare facility regarding the following information: advance directive information, or comprehensive care plan goals, special risks for falls or elopement.

The nursing progress note dated June 15, 2018, at 9:43 AM, stated "Resident is alert and verbally responsive, V/S [vital signs] blood pressure on right was 105/54, pulse 124, left arm blood pressure 115/79, pulse 123, R [respirations] 21, T [temperature] 96.0, SPO2 [oxygen saturation] 95% in room air, seen by [NP], order written to transfer resident to ER XXXX Hospital for tachycardia possible sepsis unknown origin [gallstones] and left ankle/pedal edema/pain. [R/O fracture]. Resident was on nothing by mouth this morning, medication was not given. Resident left the unit at 10:28 am via 911 to XXXX Hospital. RR [resident representative] ...notified."

Further review of the medical record showed Resident #24 was transferred to the hospital on July 18, 2018, for Hypotension and mid-chin laceration.

The nursing progress note dated July 18, 2018, at 10:10 PM, stated "Nurse Reason for Transfer- Transfer resident to the nearest ER for evaluation for hypotension, Nurse other Comments- Resident was also noted with low B/P [blood pressure] of 70/45, P-98 on right and 78/44 an P-99 on left arm. When taken manually it was observed to be 76/37 when lying down. Resident asymptomatic, resident has diagnosis of Anemia and O2 [oxygen] sat [saturation] was noted to be

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F 622	Continued From page 29 99% on RA [room air]. MD [Medical Doctor] notified gave order to hold Seroquel and Lisinopril 10 mg in am tomorrow and to encourage PO [by mouth] fluids as tolerated. MD also gave order for CBC [complete blood count] with diff [differential] and CMP [comprehensive metabolic panel] tomorrow in AM. RR [resident representative] was made aware of laceration and drop in B/P. MD later call and gave order to transfer resident via 911 to the nearest ER [Emergency Room] for further evaluation. 911 called. Waiting of 911 personnel V/S R-20, T-97.6." Review of the "Resident Transfer Sheet" dated June 15, 2018, showed left the following areas blank on the transfer sheet: advance directives information, special needs related to risk for falls and elopement, notification of next of kin, comprehensive care plan goals, all information necessary to needed to address the resident's behavioral status, and the most recent vital signs. The vital signs recorded in the "Vital Signs" section were documented on June 14, 2018, at 1:41 PM; nearly 20 hours prior to transfer to the hospital. Review of the "Resident Transfer Sheet" dated June 15, 2018, showed the facility failed to document the communication ability, most recent lab results, location of the laceration, comprehensive care plan goals, all information necessary to address the resident's behavioral needs, and special risk for falls and elopement. The facility failed to communicate all pertinent information to the receiving healthcare facility such as follows: advance directive information, or comprehensive care plan goals, special risks for	F 622	F622 1. Residents # 24 and 147 were transferred to the ER and treated on the day of the incident. 2. The information for current residents in September 2018, was reviewed for completeness and accuracy of information and no issues were identified. 3. Facility staff were educated on providing complete and accurate information to receiving facilities. 4. The Unit Manager or designee will audit transfers on a weekly basis times 3 months to ensure that receiving facilities receive complete and accurate information. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	11/11/18

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falls and elopement.

During a face to interview on September 10, 2018, at 12:35 PM, Employee #21 reviewed the medical record and acknowledged the findings.

2.Review of the medical record on 9/10/18 at 9:00 AM showed Resident #147 was admitted to the facility on 5/19/09. The Comprehensive Minimum Data Set [MDS] dated 10/31/17, showed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) of "15" which indicates the resident is cognitively intact.

Review of the annual history and physical exam form dated 4/6/18, showed diagnoses which include Atherosclerosis Cardiovascular Disease, Chronic Kidney Disease without Heart Failure, Ileostomy, and Chronic Venous Insufficiency.

Review of the nurse transfer resident note dated 7/18/18, showed "resident transferred to [hospital name], reason for transfer s/p (status post) fall secondary to losing her (resident) balance while ambulating by herself via roller walker. Resident was found on the ground in front of the main entrance at the facility. Sustained laceration on the right lateral side of her right eye with small bleeding and hematoma observed. Alert and oriented x3 follows appropriately. VS (vital signs) 98 [temperature] -70 [pulse] -20 [respiration], 150/78 (blood pressure)."

Review of the "Resident Transfer Sheet" dated 7/18/18, showed a primary contact/power of attorney (POA).

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F 622	Continued From page 31 A further review of the "Resident Transfer Sheet" showed the following questions not answered by facility staff: Was the resident informed of their medical condition? Was the next of kin notified of the discharge/transfer? Both questions were left blank. Under the Nursing Information section resident was coded as "A" which indicates activity did not occur for locomotion off unit and bed mobility resident was coded as "T" which indicates total dependence. Lastly, the skin assessment section of the transfer form it reads, "skin checked, no deficit found." During a face-to-face interview on 9/10/18, at 1:00 PM with Employee #3, she stated the resident is independent, ambulates with a walker and makes her needs known to staff, the information here is not correct, and she did have a visible injury, I will make the changes now. The facility staff failed to ensure that resident information recorded on the "Resident Transfer Sheet" (to be conveyed to the receiving provider) was accurate and inclusive of all facts surrounding the resident's fall. During a face-to-face interview on 9/10/18, at 2:00 PM, Employee #3 acknowledged the finding.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 32 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview for three (3) of 60 sampled residents, the facility staff failed to accurately code the Minimum Data Set [MDS] to reflect the use of a mobility device, behaviors and diagnosis/resident's status. Residents' #19, #24 and #147. Findings included ... 1. Resident #19 was admitted on February 2, 2018, with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, and Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder. Review of the Minimum Data Set (MDS) dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3-rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands. Resident requires extensive assistance of two person with bed mobility, transfers, locomotion on unit, toilet use and personal hygiene as coded in "Section G0110-Functional Status." However, in Section G0600- Mobility Devices, the MDS was coded as "none of the above were used", referring to a cane, walker, wheelchair, or limb prosthesis. Review of the Physician's Progress notes dated	F 641	F641 1. Resident # 19's MDS was updated to reflect the use of a wheelchair. Resident #24's MDS was accurately coded to include wandering and care rejection. Quarterly assessments do not include section E1000 and E1100. Resident # 147's MDS was updated to exclude dementia. 2. The MDS coordinator reviewed MDS' to ensure that residents mobility, wandering, and care rejection were accurately reflected on the MDS. 3. The MDS coordinators were educated on ensuring that residents' mobility, wandering, and care rejection were accurately reflected on the MDS. 4. The MDS coordinator or designee will audit 5 percent of completed MDS' on a weekly basis times 3 months to ensure that residents' mobility, wandering, and care rejection are accurately reflected on the MDS. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	11/11/18

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June 21, 2018, stated resident having "trouble walking", however, resident was able to lift legs when wheelchair is pushed from the back.

Review of Nursing Note dated June 28, 2018, stated "Resident out of bed to wheelchair with two staff assistance."

On July 8, 2018, at 10:25 PM the Nursing Note stated "mobile with wheelchair on the unit."

The facility failed to accurately code the Minimum Data Set to include the use of a wheelchair as a mobility device for Resident #19.

During a face to face interview September 10, 2018, Employee #21 explained that Resident #19 has used the wheelchair for a couple of months secondary to advancing dementia and falls. When asked about the coding of the MDS, the employee was unable to provide further insight.

During a face to face interview September 10, 2018, Employee #13, MDS Coordinator reviewed the MDS and acknowledged the findings.

2. Resident #24 was admitted on March 16, 2017, with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension.

On September 4, 2018, at 3:00 PM, while making observations on the Memory Care Unit (first floor) Resident #24 was wandering into an unlocked utility room which had the door propped open with wet floor sign.

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On September 5, 2018 Resident #24 was observed wandering constantly up and down the hallways on the unit seeking a way off of the unit. In addition, the resident was observed rummaging through the linen, in another resident's room and took a towel.

Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 was coded in Section E (Behavior) as rejecting care one (1) to three (3) days, and wandering four (4) to six (6) days, but less than daily.

The MDS failed to show that Resident #24 was assessed in Sections E1000 and E1100 if the "wandering placed the resident at significant risk of getting to potentially dangerous place or intrudes on the privacy of activities of others, and how the resident's current behavior status, care rejection or wandering compare to prior assessment, respectively.

During a face to face interview on September 11, 2018 at 12:15 PM, Employee #23 reviewed the information and stated that each member of the interdisciplinary team is responsible for completing the various sections of the MDS. Employee #23 role is to verify the completion of the document. Employee #23 acknowledged the findings.

3. Review of the medical record on 9/10/18, at 9:00 AM showed Resident #147 was admitted to the facility on 5/19/09, and a Quarterly Minimum Data Set [MDS] dated 7/17/18, showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) of "15" which indicates "cognition

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F 641	Continued From page 35 intact". Section I [Active Diagnoses] Coronary Artery Disease, Dementia, Arthritis, and Hyperlipidemia, Dementia (e.g. Non-Alzheimer's Dementia such as Vascular or Multi-Infarct Dementia, Mixed Dementia, Frontotemporal Dementia) in the designated box is an "X" which indicates resident has an Active Diagnosis of Dementia. Review of the medical record showed an Admission and Annual Physical Exam Form dated 4/6/18 with diagnoses which include Atherosclerotic Cardiovascular Disease, Chronic Venous Insufficiency, Seborrheic Dermatitis, Ileostomy Status, Diabetes Mellitus, Chronic Kidney Disease without Heart Failure. A review of the Admission & Annual Physical Exam form dated 4/6/18 did not show an active diagnosis of Dementia. A further review of the medical record showed a Psychiatric Progress noted dated 6/7/18, "Active Problem List Mild Memory Disturbances not mounting to Dementia." Facility staff failed to accurately code the MDS to accurately reflect the resident's status. During a face-to-face interview on 9/10/18 at 10:00 AM, Employee #13 acknowledged the code as incorrect and acknowledged the finding.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		

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F 655	Continued From page 36 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655	F655 1. The Plan of Care for resident #188 was reviewed with the resident/ resident representative. 2. An audit of current residents admitted during September 2018 was conducted to ensure that residents' baseline careplans were presented within 48 hours. 3. Facility staff was educated on presenting admitted residents/ and or resident representatives with baseline care plans within 48 hours of admission. 4. The Unit Manager or Designee will audit 10 percent of admissions to ensure that residents/ and or resident representatives are presented with baseline care plans within 48 hours of admission. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	11/11/18

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of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview for one (1) of 60 sampled residents, the facility staff failed to provide the resident and or the resident representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility. Resident #188.

Findings included....

Review of the medical record on 9/6/18, at 9:00 AM showed Resident #188 was admitted to the facility on 1/30/18.
Review of Resident #188's Face Sheet showed that the Primary Contact listed as the Resident's Power of Attorney (POA)/Responsible Party.

A further review of the medical record showed an unsigned baseline care plan 2/1/18, the signature line for the patient and or the patient representative was blank (the signature indicates the POA or resident was made aware of the initial goals and approaches to address the residents care needs and services.)

During an interview on 9/6/18, at 10:15 AM, with Employee #14 stated the resident has a POA, the baseline care plan is in the medical record but it's not signed; and was unable to provide insight if the resident or the resident representative was informed of the initial plan for delivery of care and services.

There was no evidence that facility staff provided the resident and or his POA with a written

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F 655	Continued From page 38 summary of the baseline care plan within 48 hours after the resident's admission to the facility. During a face-to-face interview on 9/6/18 at 10:00 AM Employee# 14 acknowledged the findings.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656	F656 1. Resident # 24's careplan was updated with person-centered approaches to include falls. Resident # 85's careplan was updated with person-centered approaches to include falls, wandering elopement, toileting, and dementia. Resident # 114's careplan was updated with person-centered approaches to include communication. Resident # 218's careplan was updated with person-centered approaches to include respiratory needs. 2. An audit of current residents' care plans was conducted to ensure that residents' careplans included person-centered approaches.	11/11/18

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F 656	Continued From page 39 (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 observations, medical record review and staff interview, four (4) of 60 sampled residents, the facility failed to develop an individualized person-centered care plan to address respiratory needs for one (1) resident, to address falls for two (2) residents, and to address communication for one (1) resident. Residents' #24, #85, #114 and #218. Findings included... 1. The facility failed to develop an individualized person-centered care plan to address falls (Residents #24 and #85). A. Resident #24 was admitted on March 16, 2017, with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 was coded as extensive assistance (staff provides weight-bearing assistance) of one (1)	F 656	F656 (Continued) 3. Staff was educated on providing person-centered approaches to care plans. 4. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 months to ensure that care plans include person-centered approaches. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	

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staff member for bed mobility, transfers, walk-in room, and locomotion on unit.

On September 4, 2018, Resident #24 was observed wandering independently up and down the hallways, looking in rooms, and out the exit door glass. The resident was wearing brown slipper socks. At the time, the resident's pace was rapid and unsteady.

On September 5, 2018, Resident #24 was observed wandering constantly up and down the hallways on the unit seeking a way off the nursing unit.

The "Falls" care plan was initiated on July 3, 2018, with approaches to include PT/OT [physical therapy/occupational therapy] screen for fall, complete falls assessment quarterly, evaluate falls risks factors, and keep needed items in reach.

The falls care plan failed to include person-centered approaches address associated identified risks such as wandering, elopement, and dementia.

During a face to face interview on September 7, 2018, at 3:45 PM, Employee #20 acknowledged the findings.

B. Resident #85 was admitted on June 21, 2018, with diagnoses to include Alzheimer's Dementia, Hypertension, anemia, Degenerative Joint Disease, and Osteoarthritis.

Review of Admission Minimum Data Set dated June 28, 2018, showed Resident #85 is severely cognitively impaired with a Brief Interview for

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Mental Status Summary Score (Section C0500) coded as "3." Also, the resident rejects care and wanders one to three days, as documented in sections E0800 and E0900; respectively.

Fall risk assessments showed Resident #85 is "high" for falls as evidenced by assessments completed on June 21, 2018, with score of "14" and September 4, 2018, with score of "19".

Review of the care plans failed to reveal individualized person-centered approaches (i.e. assist with toileting, non-skid footwear, offer rest periods with wandering episodes) to minimize risk for or prevent falls.

During a face to face interview on September 10, 2018, at 1:59 PM, Employee #20 reviewed the care plans and acknowledged the finding.

The "Falls" care plan was initiated on July 3, 2018, with approaches to include PT/OT [physical therapy/occupational therapy] screen for fall, complete falls assessment quarterly, evaluate falls risks factors, and keep needed items in reach.

The falls care plan failed to include person-centered approaches address associated identified risks such as wandering, elopement, and dementia.

During a face to face interview on September 7, 2018, at 3:45 PM, Employee #20 acknowledged the findings.

2. The facility failed to develop a communication care plan with individualized person-centered

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approaches to address a non-English speaking (Resident #114).

Resident #114 was admitted on June 15, 2015, with diagnoses to include Osteoarthritis, Cataracts, Dementia, Sensorineural Hearing Loss, and Peripheral Vascular Disease.

During observations on August 30, 2018, at 10:30 AM, Resident #114 noted wandering on the nursing unit with wet pants. The housekeeping staff in the hallway called the resident "Poppy" while trying to offer re-direction. When queried about the resident's name, the employee provided the resident's name.

Review of the "Communication" care plan showed approaches to include ask simple questions; direct eye contact, provide positive feedback, give clear, directions, use interpreter services, use written communication and communication board.

Observations in Resident #114's room on September 7, 2018, at 9:00 AM failed to reveal the presence of a communication board.

The facility failed to develop and implement a communication care plan with individualized person-centered approaches to address a non-English speaking Resident to ensure communication needs are met.

During a face to face interview on September 7, 2018, at 10:27 AM, Employee #20 stated that Resident #114 understands most gestures and has used the interpreter services however, past usage of the interpretative services was unsuccessful because his speech is unintelligible.

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When asked directly about the asking simple questions and written communication, the employee was unable to provide further insight. Employee #20 acknowledged the findings.

3. The facility failed to develop an individualized person-centered care plan with goals and approaches to meet respiratory needs for Resident #218.

Resident #218 was initially admitted to the facility on December 19, 2012, with the most recent readmission on May 7, 2018. The readmission diagnoses included Urinary Tract Infection Alzheimer's Disease, Failure to Thrive and Osteoporosis.

Review of medical record on September 18, 2018, at 11:00 AM showed a Significant Change of Status Assessment Minimum Data Set dated May 15, 2015, Section O (Special Treatment Procedures and Programs) indicated Resident #218 received oxygen therapy while in the facility with the last 14 days and six (6) days of respiratory therapy services.

Review of the physician's orders showed an order dated May 7, 2018, which stipulated "2 liters per minute via nasal cannula for wheezing and check pulse oximeter every shift on room air three (3) times per day during day, evening, and night, document pulse oximetry reading, keep oxygen in place if pulse oximetry is less than 93 % on room and remove if more than 93%."

Review of the care plans failed to show the facility developed an individualized person-centered care

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F 656	Continued From page 44 plan with goals and approaches to meet respiratory needs (i.e. specific risks for complications such as increased or decreased CO2 (carbon dioxide) levels, and development of oral or ocular ulcers) for Resident #218. During a face to face interview on September 5, 2018, at approximately 4:00 PM Employee #20 stated that the daughter requested the oxygen continuously. The further stated that the oxygen was "supposed to be as needed." When queried about the order for continuous oxygen and pulse oximetry monitoring to ensure the resident's care needs are met, Employee #20 could not provide any further insight. Employee #20 confirmed and acknowledged the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657	F657 1. Resident # 19's careplan was updated with person-centered approaches to include falls. Resident # 147's careplan was updated with person-centered approaches to the use of a walker. 2. A review of current residents' care plans was conducted to ensure that residents' careplans included person-centered approaches.	11/11/18

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F 657	Continued From page 45 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 medical record review and staff interview, for two (2) of 60 sampled residents, the facility failed to revise the care plan with person-centered goals and approaches related to falls for one (1) resident and to revise the care plan to reflect one (1) resident's use of a mobility device. Residents' #19 and #147. Findings included ... 1.Resident #19 was admitted on February 2, 2018, with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder. Review of the Minimum Data Set dated August 14, 2018, showed Resident #19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor. Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 experienced a	F 657	F657 3. Staff was educated on providing person-centered approaches to care plans. 4. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 months to ensure that care plans include person-centered approaches. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	

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F 657	Continued From page 46 fall from wheelchair during transfer. Review of the falls care plan initiated on June 5, 2018, showed approaches to include physical therapy and occupational therapy screen, complete fall assessment quarterly, evaluate use of psychotropic medications. However, on September 5, 2018, the revision to the resident's care plan showed the approach as "PT/OT screen ...Transfer to ER ...Ensure that resident is properly seated in w/c [wheelchair] prior to transfer." The facility failed to revise the falls care plan after the September 4, 2018, with individualized person-centered approaches to prevent falls reoccurrence. During a face to face interview on September 10, 2018, Employee #21 reviewed the care plan and acknowledged the findings. 2. Facility staff failed to revise a care plan to address Resident #147's use of a mobility device. Review of the medical record on 9/7/18 at 11:00 AM showed Resident # 147wsa admitted to the facility on 5/19/09. The Quarterly Minimum Data Set [MDS] dated 7/17/18 showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) of "15" which indicates "Cognitively Intact". Under Section I [Active Diagnoses] the resident was coded for Hypertension, Diabetes Mellitus, Hyperlipidemia, Chronic Venous Insufficiency, and Ileostomy. Section G0300 (Balance During Transitions and	F 657		

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F 657	Continued From page 47 Walking Resident) is coded as "1" (which indicates not steady, but able to stabilize without human assistance) for moving from seated to standing position, walking (with assistive device if used) turning around and facing the opposite direction while walking, moving on and off toilet and surface to surface wheel chair). G0600. Mobility Devices (check all that were normally used) there is an X in the box for (B.) Walker, which indicates a walker is normally used. Review of the resident's care plan showed "Category Behavioral Symptoms, Problem: Ambulating without assistive devices, Approach: allow resident to express feelings, approach in calm, direct manner, continue to educate and encourage resident on safety practices." Facility staff failed to revise the care plan problems and approaches to reflect resident current status as using an assistive device (walker) for ambulation. During an interview on 9/7/18, at 1:00 PM with Employee #3, she stated the resident is independent with care and uses a walker for ambulation; this care plan needs to be changed and acknowledged the finding.	F 657		
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	F 688		

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F 688	Continued From page 48 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §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 observations, record review and staff interviews for one of (1) of 59 sampled residents, facility staff failed to apply hand splints for contracture management for a resident with a limited range of motion (bilateral hands). Resident# 193. Findings included... During an observation on 8/31/18 3:00 PM resident was observed sitting in a wheelchair with right and left hand in a fixed position (closed) and on a subsequent observation 9/3/18 at 5:00 PM showed resident sitting in a wheelchair with right and left hand in a fixed position (closed). An observation showed Employee#16 cueing resident to open her hands and the Resident# 193 was unable to open her hands fully. Resident #193 admitted to the facility on 9/13/16 with diagnoses to include Dementia, Anemia, Cerebrovascular Accident and Hypertension. Review of the Quarterly Minimum Data Set [MDS]	F 688	F688 1. Resident # 193's splint schedule was reviewed and staff is currently adhering to the schedule. 2. No other residents were identified to be non-compliant with splint application. 3. Staff was educated on applying splints per schedule and documenting instances of resident non –compliance. 4. The Restorative Coordinator or designee will conduct random audits to monitor splint application. Results of the audits will be submitted to QAPI for review.	11/11/18

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dated 5/1/18 showed a Brief Interview Mental Status score of 5 which indicate "severely impaired cognition." Section G [Functional Status] showed resident is coded as "3" for dressing which indicates extensive assistance and coded as "1" for eating which indicates supervision (by staff) for oversight or cueing.

Review of the Annual Minimum Data Set [MDS] dated 7/31/18. Section G [Functional Status] showed resident is coded as a "4" for dressing which indicates total dependence on staff and coded as "2" for eating which indicate staff providing limited assistance.

On 9/1/18 a Review of the Occupational Therapist Discharge Progress note dated 5/24/18 showed "Restorative nursing to manage hand orthotic after caregiver education completed, restorative and caregivers have been trained and instructed on orthotic application and to replace orthotics if removed."

Review of the medical record on 9/1/18 at 9:55 AM showed a physician telephone order dated 7/13/18 "add to restorative nursing program, resident to wear bilateral hand splints to both hands, apply after breakfast and remove before dinner, check skin integrity, Q [every] 2 hours while splint is on."

During an interview on 9/11/18 at 2:15 PM with Employee#16, stated "I usually put the splint on after 10:00 AM, but she takes it off, I tell the nursing supervisor about it but I don't document it anywhere."

A review of the nurses ' notes failed to show Resident #193's removal of orthotic device

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F 688	Continued From page 50 (splint) and if any other interventions/approaches were initiated to prevent further contracture of the hands. The facility failed to apply bilateral hand splints for one (1) resident with a limited range of motion (hands). During a face-to-face interview Employee# 3 present at the time of the observation and staff interview acknowledged the finding.	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 and staff interview facility failed to maintain essential equipment in safe condition as evidenced by exposed electrical wires from one (1) of one (1) meat slicer and one (1) of one (1) buffalo chopper. Findings included ... Facility failed to maintain essential equipment in safe condition as evidenced by exposed electrical wires from one (1) of one (1) meat slicer and one (1) of one (1) buffalo chopper.	F 689	F689 1. The exposed electrical wires for the meat slicer and buffalo chopper were repaired. Resident # 19's care plan was updated to reflect the use of a mechanical lift for transfer. 2. The Dining Services Manager walked through the kitchen to ensure that there were no other exposed electrical wires. A review of current residents' care plans was conducted to ensure that residents' care-plans included person-centered approaches.	11/11/18

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F 689	Continued From page 51 A.The power cord to one (1) of one (1) meat slicer was frayed and its internal electrical wires were visible and accessible and posed a safety hazard to staff. B. The power cord to one (1) of one (1) buffalo chopper was frayed and its internal electrical wires were visible and accessible and created an unsafe environment for staff. During a face-to-face interview on August 30, 2018, at approximately 12:30 PM, Employee #4 confirmed the findings. Based on investigation report, medical record, and staff interview for one (1) of 60 resident records reviewed, the facility failed to ensure a mechanical lift was utilize during transfer to prevent a fall for Resident #19, who sustained a left forehead hematoma. Findings included... Resident #19 was admitted on February 2, 2018 with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder. Review of the Minimum Data Set dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor.	F 689	F689 (Continued) 3. The Dining Services Staff was educated on reporting exposed electrical wires. Staff was educated on providing person-centered approaches to care plans. 4. The Dining Services Manager or designee will conduct weekly audits times 3 months to ensure that there are no exposed wires. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 months to ensure that care plans include person-centered approaches. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	

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F 689	Continued From page 52	F 689		

Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 suddenly slid out of the wheelchair while the nurse was attempting to transfer. Resident #19 hit her head on the floor resulting in swelling to the left side of the forehead. The resident was transfer out to the hospital for evaluation

Review of Occupational Therapy Progress and Discharge Summary dated August 15, 2018, Resident #19's sit to stand transfers "Long Term Goals" were not met and rehab discontinued "due to cognition pt [patient] has reached max rehab potential and requires max A (maximum assistance) with lift for transfer."

Review of the falls care plan initiated on June 5, 2018, showed approaches to include physical therapy and occupational therapy screen, complete fall assessment quarterly, evaluate use of psychotropic medications. However, on September 5, 2018, the revision to the resident's care plan showed the approach as "PT/OT screen ...Transfer to ER[Emergency Room] ...Ensure that resident is properly seated in w/c [wheelchair] prior to transfer."

The facility failed to ensure the care plan as revised to include the use of a mechanical lift to assist with transfers after Resident #19 was discharge from Occupational Therapy on August 15, 2018.

During a face to face interview on September 10, 2018, at approximately 10:45 AM, Employee #24 stated Resident #19 has not walked in months and requires two people to help her transfer. When asked which type of lift is use for transfer,

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the employee stated the resident "can hold on and stand with the sit to stand lift."

During a face to face interview on September 10, 2018, at approximately 3:00 PM, Employee # 21 stated the resident fell forward while the nurse was attempting a transfer. When asked about the resident's transfer and mobility status, Employee #21 stated that Resident #19 uses a sit-stand lift for transfers. When asked whether a lift was used during the transfer, Employee #21 was unable to state definitively. When asked about the investigation into the incident, the employee stated that the supervisor completes the incident investigation.

Upon review of the incident investigation, the document did not provide evidence that a thorough investigation was conduct to include insight into if the mechanical life device was utilized during the transfer and appropriate corrective actions to prevent reoccurrence.

The failure to ensure that a mechanical lift was utilized during the attempted transfer on September 4, 2018, created the potential for harm when Resident #19 fell from the wheelchair sustaining a hematoma on the forehead.

During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #19 on September 4, 2018. Employee #1 acknowledged the findings.

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and staff interview for two (2) of 60 resident records, the facility failed to ensure that nutritional supplement order include the dosage for administration, in accordance with professional standards of practice (Residents' #198 and #388). Findings included ... According to the facility's "Guidelines for Charting and Documentation" policy last revised January 2018, dietary supplement orders must specify the type, amount, frequency (i.e. Ensure 3 ounces	F 692	F692 1. Resident # 198 and 388's nutritional supplement orders were updated to include the dosage for administration. 2. The Dietician reviewed current resident nutritional supplement orders to ensure that they include the dosage for administration. 3. Licensed nurses and Dieticians were educated on ensuring that nutritional supplement orders include the dosage for administration. 4. The Dietician or designee will conduct monthly audit of nutritional supplement orders to ensure that they include dosage for administration. Results of the audits will be submitted to QAPI for review.	11/11/18

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F 692	Continued From page 55	F 692		

three times a day between meals).

1. Resident #198 was admitted on February 11, 2018, with diagnoses to include Atrial Fibrillation, Dementia, Heart Failure, edema, Hypokalemia, and Cerebral Infract.

Review of the medical record showed a physician order for "Ensure Plus one (1) time per day at 1400, Special Instructions: Daily at breakfast at 7:30 AM."

Review of the Dietary Progress Notes dated August 7, 2018, showed Resident #198 continues to receive "Ensure Plus 1x/day [one time per day]-PM."

The order for Ensure Plus failed to contain the amount to be administered to the resident at the specified time. The failure to include the dose for administration is inconsistent with standards of practice to ensure Resident 198's calorie and nutritional needs are met.

During a face to face interview on September 6, 2018, Employees' #20 and 21 were asked about the dose to be administered and the conflicting times in the order. Employee #21 stated that conflicting time was an error which should have been corrected. However, neither employee could provide further insight into the omission of the dose to be given.

During a face to face interview on September 6, 2018, at approximately 4:05 PM, Employee #22, Dietician, stated that it is not customary practice in the facility to include the amount of nutritional supplement to be administered. The findings

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F 692	Continued From page 56 were acknowledged. 2. Resident #388 was admitted on August 27, 2018, with diagnoses to include Alzheimer's Disease, Urinary Tract Infection, and Paranoid Hallucinations. On September 6, 2018, at approximately 3:00 PM, Resident #388 was observed with a cup of nutritional supplement. Review of the medical record showed a physician order for Ensure Plus three (3) times per day as supplement at 800, 1700, and 2000 dated August 31, 2018. Review of the Nutrition Consultation record dated August 31, 2018, showed the dietician recommended discontinuation of previous Ensure Plus order and recommended adding Ensure Plus three (3) times per day as supplement. The order for Ensure Plus failed to contain the amount to be administered to the resident at the specified times. The failure to include the dose for administration is inconsistent with standards of practice to ensure Resident #388's calorie and nutritional needs are met. During a face to face interview on September 6, 2018, at approximately 4:05 PM, Employee #22, Dietician, stated that it is not customary practice in the facility to include the amount of nutritional supplement to be administered. The findings were acknowledged.	F 692		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		

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F 695 SS=D	Continued From page 57 CFR(s): 483.25(i)	F 695	F695	11/11/18

§ 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.
This REQUIREMENT is not met as evidenced by:

Based on observation, policy review, medical record review, and staff interview for two (2) of 60 sampled residents, the facility failed to initiate humidification with oxygen therapy and failed to monitor oxygen saturation in accordance with the physician's order for one (1) resident; and failed to inform one (1) resident's physician that she was experiencing difficulty breathing during the night. Residents' #218 and #P1.

Findings included...

The facility failed to initiate humidification with oxygen therapy and failed to monitor oxygen saturation for Resident #218.

1. Resident #218 was initially admitted to the facility on December 19, 2012, with the most recent readmission on May 7, 2018. The readmission diagnoses included Urinary Tract Infection Alzheimer's Disease, Failure to Thrive, and Osteoporosis.

Observation on September 4, 2018, at 3:35 PM showed Resident #218 out of bed sitting in a

1. Resident # 218's oxygen saturation was obtained and humidification was provided. Resident #P1 was assessed by the registered nurse and the assessment findings were shared with the physician.
2. Residents on oxygen were reviewed to ensure that they were provided humidification. No other residents were identified to have Shortness of breath without physician notification.
3. Facility staff has been educated on obtaining oxygen saturation and providing humidification for residents with oxygen orders. Staff was also educated on notifying physicians of change of condition.
4. The Unit Manager or designee will randomly audit 10 percent or residents on oxygen to ensure humidification and oxygen saturation checks. The Unit Manager or designee will

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F 695	Continued From page 58 Geri-chair, in the common area, with oxygen via nasal cannula at 2 liters per minute. The oxygen tubing (nasal cannula) was connected directly to the oxygen concentrator without a humidification bottle. Review of the physician's order showed an order dated May 7, 2018, for 2 liters per minute via nasal cannula for wheezing and check pulse oximeter every shift on room air three (3) times per day during day, evening, and night, document pulse oximetry reading, keep oxygen in place if pulse oximetry is less than 93% (percent) on room and remove if more than 93%. The facility failed to ensure humidification with delivery of continuous oxygen therapy. The facility's "Oxygen Administration" policy last revised December 2017, states the following equipment and supplies will be necessary when performing this procedure: concentrator, nasal cannula, and humidifier bottle. The policy further states "check the mask, tank, humidifying jar, etc., to ensure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and the water level is high enough that the water bubbles as oxygen flows through, and label and date the humidifier bottle and oxygen tubing." Review of the vital signs from July 7, 2018, through September 9, 2018, showed the facility staff failed to consistently measure Resident #218's oxygen saturation level three times a day as follows: 20 out of 31 days in July 2018; 28 out of 31 days in August 2018; and 4 out of 5 days in September 2018.	F 695	F695 (Continued) also randomly audit residents with change of condition times 3 months to ensure physician notification. The results of the audit will also be reported at the monthly QAPI committee meeting for review.	

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F 695	Continued From page 59	F 695		

During a face to face interview on September 5, 2018, at approximately 3:35 PM, Employee #27, Respiratory Therapist, stated humidification was required when oxygen is administered at 2- 4 liters per minutes continuously. When asked directly about the use of humidification for Resident #218, Employee #27 stated, "Well, there isn't a policy that says we have to give it [humidification], 1-2 liters don't really need it."

During a face to face interview on September 5, 2018, at 3:45 PM, Employee #20 and #21 stated they defer to respiratory therapy since they provide care for the resident. When asked who is responsible for obtaining oxygen saturation when ordered by the physician, Employee #21, stated it is respiratory' s responsibility. Employee #21 acknowledged the findings.

2. Facility staff failed to inform a resident's physician that she was experiencing difficulty breathing during the night. Resident #P1.

Resident #P1 was admitted on September 10, 2018, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) exacerbation, COPD with hypoxia, Moderate to Severe Pulmonary Hypertension, Chest Pain and Pneumonia.

According to the Nursing Progress Notes dated September 10, 2018, at 11:55 PM, the resident was readmitted from the hospital on oxygen (O2) at 2 liters via nasal cannula with O2 saturation at 99%. "Purse lip breathing noted."

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F 695	Continued From page 60	F 695		

On September 11, 2018, at approximately 10:00 AM, the resident was observed lying in bed with labored breathing, with oxygen at three (3) liters per minute via nasal cannula. Resident #P1 stated the shortness of breath began during the night. According to the resident, during the night the nurse increased the oxygen to 4 liters per minute, which helped with her breathing efforts. Once the resident's breathing improved, the night nurse decreased the oxygen to three (3) liters. When asked if she had increased the oxygen to the current level of 3 liters, the resident stated it was changed by the nurse after being told she was having difficulty breathing.

Review of the Physician's order dated September 10, 2018, (no time specified) directed "Oxygen at 2/L (two liters) via n/c (nasal cannula) for SOB (shortness of breath); check Oxygen (O2) saturation q (every) shift;.. F/U (Follow up) with PCP (Primary Care Provider.)"

The Nursing Progress Note dated September 11, 2018, at 3:03 AM stated "Oxygen [at] 2L/min via nasal cannula in progress; no SOB, no distress observed."

The medical record lacked evidence the nursing staff assessed Resident #P1's respiratory status to include oxygen saturation level during the episode of shortness of breath described by Resident #P1 during the night shift of September 30, 2018.

During a face-to-face interview on September 11, 2018, at approximately 10:30 AM, Employee #7

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F 695	Continued From page 61 acknowledged the failure to assess Resident #P1 during the night.	F 695		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy review, resident review and staff interviews in four (4) of 60 sampled residents, the facility failed to develop an individualized care plan, and obtain necessary services for the behavioral health needs. (Residents' #24, 81, 85, and 388) Findings included ... 1. Resident #24 was admitted on March 16, 2017 with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 has severe cognitively impaired as coded in Section C0600 Brief Interview for Mental Status Summary Score of "00." The staff was unable to complete the Resident Mood Interview in Section	F 740	F740 1. Resident #'s 24, 81, 85, and 388's care plans were updated with approaches to address behavioral health issues and non-pharmacological approaches. Resident #85 was seen by her psychiatrist. 2. Other resident's with identified behavioral health issues care plans have been updated. Other residents with psychiatry needs were seen by the psychiatrist. 3. Facility staff was educated on providing person-centered approaches to care plans and psychiatry consults. 4. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 months to ensure that care plans include person-centered approaches. The Unit Manager or designee will also randomly review psychiatry needs.	11/11/18

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F 740	Continued From page 62 D resulting in a "Total Severity Score of 99." However, Section E0200 Behavioral Symptoms was coded for "other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging) 1 to 3 days" during the assessment reference period. On September 4, 2018, at 11:00 AM, Resident #24 was observed wandering independently up and down the hallways, looking in rooms, and out the exit door glass. The resident was wearing brown slipper socks. At times, the resident pace was rapid and unsteady. On September 4, 2018, at 3:00 PM, Resident #24 wandering into unlocked utility room which had the door propped open with wet floor sign. On September 5, 2018, 12:00 PM, Resident #24 was observed wandering constantly up and down the hallways on the unit seeking a way off of the unit. Review of the Nursing Notes- "Incident Behavior" from June 8, 2018 at 2:09 AM to June 13, 2018 2:23 PM showed Resident #24 no behavioral issues. However, on June 13, 2018, at 2:23 PM, the Progress Notes- "Quick Note" showed that the resident's antipsychotic medication Klonopin was increased from 0.25 milligrams to 0.50 milligrams twice daily for agitation. Resident #24 was seen by Psychiatry on May 17, 2018, and May 22, 2018, in follow-up for mood instability. The May 22, 2018, Psychiatric Consultation note showed Resident #24 experienced an increase in agitation and physical aggression; pushed another resident, pacing, and	F 740	The results of the audit will also be reported at the monthly QAPI committee meeting for review.	

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F 740	Continued From page 63	F 740		

hypersexual behavior. The recommendation included increasing Seroquel to 25 milligrams in the morning and 50 milligrams at bedtime, check urinalysis, and behavioral and supportive interventions..."

According to the Social Work notes, on June 7, 2018, 5:20 PM, Resident #24 had a "recent increase of agitation and physical aggression. He pushed a peer and was seen appearing hypersexual. Also there was an increase in pacing. The psychiatrist added Depakote 500 milligrams twice a day to address these behavioral issues. The psychiatrist will now return in 4 weeks."

Further review of the medical record failed to show the resident was seen in follow-up by the psychiatrist in 4 weeks and behavioral and supportive interventions were initiated.

Review of Resident #24 behavior, cognitive loss/dementia, psychotropic drug use care plans failed to show non-pharmacological individualized person-centered goals and approaches to address the behavioral symptoms demonstrated by Resident #24 such as physical aggression towards others, hypersexual behaviors, and agitation.

During a face to face interview on September 6, 2018, at 3:45 PM, Employee #21 stated that the unit staff is currently trained to address dementia and behaviors. They are also trying to relocate residents that are no longer appropriate for the unit. However, the employee could not provide insight into specific non-pharmacological measures being taken to address the behavioral needs of Resident #24. In addition, Employee #21

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could not provide insight into omission of the psychiatric follow-up.

During a face to face interview on September 6, 2018, at approximately 2:01 PM, Employee #29, Social Services Manager, stated the social worker assigned to the unit is a Licensed Independent Social Worker, therefore she is responsible for performing behavioral health interventions. The nursing staff identifies the behaviors and are trained to document their interventions.

The facility failed to identify the behavioral health care needs to address physical aggression toward others and hypersexual behaviors and agitation. As a result, the care plan implemented by the facility failed to include individualized person-centered non-pharmacological approaches to support Resident #24 interactions with staff and other residents.

On September 10, 2018, at 11:00 AM, Employees #20 and 21 reviewed the medical record and acknowledged the findings.

2. Resident # 81 admitted on March 19, 2018 with diagnoses to included Dementia with Behavioral Disturbance, Hypertension, Abnormalities of gait and mobility, and Muscle weakness.

Review of the Admission Minimum Data Set (MDS) dated March 26, 2018, showed Resident #81 was unable to complete the "Brief Interview for Mental Status." Section D- Mood was coded as "yes" for 'feeling or appearing down, depressed, or hopeless' for 7-11 days; and "yes" for 'being short-tempered, easily annoyed' for 2- 6 days. Psychiatric/ Mood Disorder coded in

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Section I- Active Disease included Depression.

The Quarterly MDS completed June 19, 2018 showed Resident #81 has severe cognitive impairment with a Brief Interview for Mental Status Summary Score coded as "3" in Section C0500. Also, the resident reported an increase in "feeling down, depressed, or hopeless" to "12-14 days (nearly every day) and a new report of "feeling bad about yourself- or that you are a failure or have let yourself or your family down 2- 6 days" in Section D- Mood D0200- Resident Mood Interview, since last assessment completed on Maqrch 26, 2018. Section E0200- Behavioral Symptom was coded for physical and verbal behaviors symptoms directed towards others and other behavioral symptoms not directed towards others 1 to 3 days. In addition, Resident #81 is coded for rejection of care and wandering 1 to 3 days; respectively in Sections E0800 and E0900. During the assessment reference period for this MDS, Resident #81 received antipsychotic medications for 6 days as coded in Section N- 0410 Medications; without the provision of psychology therapy Section-O0400.

During the three months between the two assessments dated March 26, 2018 and June19, 2018, Resident #81 displayed an increase in behavioral symptoms for which psychiatric consultation was received and medications initiated. The psychiatric consults occurred on March 29, 2018, May 17, 2018, June, 14, 2018 and July 17, 2018. During the June 14, 2018, psychiatric consult visit, the recommendations included "behavioral and supportive interventions."

On June 14, 2018, the physician ordered

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Risperdal 0.25 milligrams one tablet at bedtime at "2100" for behavioral and supportive intervention.

During a resident interview on August 30, 2018, at 2:04 PM Resident #81 verbalized feeling "lonely and bored." The resident also stated that she wanted to be at another place where she did not have to be "locked down". In addition, she has not been to her church in a long time. According to Resident #81, church helps with her "depression." Resident #81 has exhibited behaviors

An observation on September 5, 2018, at approximately 10:45 AM, Resident #81 was observed standing at the nurse's station with a TV remote in hand tearful, asking for her television. The Employee #21 stated that the resident has to be reminded that she doesn't have a TV.

During a face to face interview on September 5, 2018, at approximately 11:00 AM, Employee #30 stated that Resident #81 does have a TV brought in by the resident representative, however, the resident continues to unplug the TV for the power source. When asked measures taken to ensure that she is able to watch her TV, the employee replied we have tried but she continues to do things with the plug. Employee #30 further stated that she tries to spend time with the resident to allow her to express her feelings "but is attention seeking and time consuming", which makes it difficult to provide adequate services to the other residents. According to the employee,
Resident #81 has spoken with her sister in New Jersey, which appeared to help with her mood. When asked if that intervention was included into the resident's care plan, Employee #30 stated no, five (5) of the unit's staff has recently completed specialized dementia training and learning about

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individualized care plans. The newly trained team will be training the other unit staff moving forward.

Review of the Nursing Note dated June 7, 2018, show that Resident #81 is confused, "curses, yells, and cries, if things did not do her way. She is threatening to others." The staff verbally redirected and monitors the resident at all times.

Review of the Social Work Notes dated June 29, 2018, at 4:09 PM, showed 'Psychosocial Comments' which stated "She endorsed that she is feeling down/depressed as she misses her mother and son ...She endorsed being tired and complained about her hip ...She commented that she does feel bad about herself, as she feels others look down on her, especially due to her walk." In the 'Behavioral Review Comments', the note states "The resident says that she has sadness. On the GDS [Geriatric Depression Scale], she scored 6, which warrants follow-up. She said she feels bored without having her music and own TV shows. She complained that she is in not good spirits as she is not working. She feels that something bad is happening to her as she is not at home ...feels that she does not feel happy most of the time."

According to the Social Work Note on July 16, 2018, at 12:36 PM, the social worker was called to the unit to visit the resident. Upon arrival to the unit the resident was tearful.

On August 17, 2018, at 12:39 PM, the Social Work note stated the resident house was sold in foreclosure and the contents in the house are believed to have been thrown away. The resident is "very attention seeking." Also, the resident

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complained of feeling unsafe in her room. At times, she will put trash cans, pampers, and walker by the door to make it difficult for anyone to enter."

On August 17, 2018, at 12:39 PM, the Social Work note stated the resident was "very attention seeking." Also, the resident complained of feeling unsafe in her room. At times, she will put trash cans, pampers, and walker by the door to make it difficult for anyone to enter."

Review of Resident #81 care plans titled Behavioral Symptoms, Socially Inappropriate/Disruptive, and with start date of June 27, 2018 showed the following interventions allow expression of feelings in quiet area, approach in a calm, direct manner, assess causes of behavioral episodes, assist with activity programs of interest, and avoid criticism.

The facility failed to obtain necessary behavioral health services and develop an individualized person-centered care plan to include non-pharmacological approaches to address Resident #81 behavioral health needs and . In addition, upon learning of the resident traumatic history failed to obtain necessary services for behavioral health to meet the needs of Resident #81.

During an interview on September 6, 2018 at approximately 12:13 pm Employee #30, Social Worker, stated she provides lots of conversation with the resident to keep her calm. The employee further stated that Resident #81 shared that she was the victim of domestic violence and rape in her home country. As a result of these events, the resident frequently covers the windows with fall

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mats and blocks the door with chairs. When queried about behavioral and supportive services as recommended by psychiatry on June 14, 2018, Employee #30 stated that the facility does not have formal behavioral health services, they only have psychiatry services. The facility does not obtain behavioral health services from outside of the facility.

During a face to face interview on September 6, 2018 at approximately 2:01 PM, Employee #29, Social Services Manager, stated the social worker assigned to the unit is a Licensed Independent Social Worker, therefore she is responsible for performing behavioral health interventions. The nursing staff identifies the behaviors and are trained to document their interventions. When asked about measures taken to provide the behavioral and supportive services for Resident #81 upon learning about Resident #81 experience with trauma, the employee was unable to provide insight into non-pharmacological interventions and approaches to meet the behavioral health needs.

The findings were review and discussed with Employees' #20 and #21 on September 6, 2018 at 4:06 PM. The employees acknowledged the findings.

3. Resident #85 was admitted on June 21, 2018, with diagnoses to include Alzheimer's dementia, Hypertension, anemia, Degenerative Joint Disease, and Osteoarthritis.

Review of Admission Minimum Data Set dated June 28, 2018, showed Resident #85 is severely cognitively impaired with a Brief Interview for Mental Status Summary Score (Section C0500)

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coded as "3." Also, the resident rejects care and wanders one to three days, as documented in sections E0800 and E0900; respectively. Section F-Preferences for Customary Routine and Activities is coded as "very important" to have books, newspapers, and magazines, keep up with the news, and participate in religious services. Resident #85 received antipsychotic and antidepressants 7 days during the assessment reference period.

Physician order dated June 21, 2018, showed Seroquel (antipsychotic medication) 25 milligram daily at bedtime for agitation, Remeron (medication to treat depression) 15 milligram by mouth at bedtime and psych consult was ordered.

The facility failed to ensure Resident #85 was seen by the psychiatrist as order by the attending physician on June 21, 2018.

Review of the "Cognitive Loss/Dementia" and "Behavioral Symptoms" care plans showed non-specific approaches for Resident #85 such as "encourage self-help skills, ensure all ADL (Activities of Daily Living) needs are met, identify and measure behaviors resulting in anxiety, monitor sleep patterns, monitor nutrition.

The facility failed to develop a care plan with individualized, person-centered, with non-pharmacological approaches to address Resident #85's behaviors of rejection of care, wandering, agitation, use of Seroquel, or preferences for activities and failed to ensure that Resident #85 was seen by the psychiatrist in consult for history of behavioral problems.

During a face to face interview on September 10,

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2018, at 10:45 AM, Employee #20 stated that the resident has anxiety and "holds herself" when she needs to use the bathroom, receives one on one with the activities department, and the staff allows her to sit until she is ready to get up. When asked directly about the psych consult, the employee stated she was unaware of the consult order. Employee #20 reviewed the care plans and acknowledged the findings.

4. Resident #388 was admitted on August 27, 2018, with diagnoses to include Alzheimer's Disease, Urinary Tract Infection, and Paranoid Hallucinations.

On August 30, 2018, at 10:30 AM, Resident #388 was observed wandering the unit in a winter coat on and brown non-skid slipper socks. The resident startled as staff and other residents approached the resident.

Review of the medical record on September 4, 2018, at 9:00 AM showed Admission Orders dated August 27, 2018, for Haldol 2 milligrams twice a day for agitation, Remeron 7.5 milligram for depressive disorder, Depakote 250 milligrams twice a day for Manic Bipolar Disorder, and psych consult for new admission.

The Psych Consult dated August 29, 2018, showed an assessed diagnoses of Dementia of Alzheimer's type, Psychotic Disorder, and recommendations to increase Remeron to 15 milligram at bedtime and Depakote to 250 milligrams three times a day. The resident was also to continue Haldol (medication used to treat psychosis).

Review of the Baseline Care Plan showed the

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facility initiated care plans for '9 or more medication; activities of daily living, advance directives, alteration in nutrition, dehydration, Alzheimer/Dementia; elopement; and safety. However, the care plans failed to include individualized person-centered goals and non-pharmacological approaches to address Resident #388's related to behavioral health diagnoses to ensure the highest practicable well-being as she adjusted to the new environment. In addition, the care plan does not include interventions to address the use of antipsychotic medication for the management of behaviors.

Review of the Nursing Notes, on August 30, 2018, the resident experienced a fall while trying to sit on the footrest of another resident's wheelchair.

During a face to face interview on September 4, 2018, at 11:15 AM, when discussing Resident #388's behavior health needs related to wandering, refusal of care, and social isolation, Employee #21 stated the resident is new and is still adjusting." When asked how the staff addresses and monitors behaviors that lead to accidents such as the fall on August 30, 2018, the employee stated we are watching her. The resident is normally in the common area where the staff can observe movement.
When asked about the measures the staff takes to ensure the TV is adequately monitored for trip hazards due to the number of wheelchairs, Employee #21 stated that we use employees that are on light duty to help with monitoring. However, these employees are unable to provide physical assistance, if a resident trips, or needs

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F 740	Continued From page 73 physical assistance. Employee #21 acknowledged the findings.	F 740		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observations, facility assessment review, medical record review, and staff interview for two (2) of 60 sampled residents, the facility failed to provide behavioral health services and individualized care approaches to address the needs for residents diagnosed with mental disorders and psychosocial adjustment difficulty (Residents' #81 and #388). Findings included ... Review of the Facility Assessment showed that the facility has a 48-bed Dementia Care unit with the ability to meet the needs of resident with psychiatric and mood disorders. The average Behavioral Health Needs is 34 residents. 1. Resident # 81 admitted on March 19, 2018, with diagnoses to included Dementia with Behavioral Disturbance, Hypertension,	F 742	F742 1. Resident #81 and 388's Care plans were updated to include individualized person-centered goals and approaches to address behavioral health needs. 2. The Care Plans of other residents identified with behavioral needs were updated to include individualized person-centered goals and approaches. 3. Facility staff was educated on updating care-plans with individualized person-centered goals and approaches. 4. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 months to ensure that care plans include person-centered approaches. The results of the QAPI will be shared at the monthly QAPI meeting.	11/11/18

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F 742	Continued From page 74 Abnormalities of gait and mobility, and Muscle weakness. Review of the Admission Minimum Data Set (MDS) completed June 19, 2018, showed Resident #81 has severe cognitive impairment with a Brief Interview for Mental Status Summary Score coded as "3" in Section C0500. Also, the resident reported an increase in "feeling down, depressed, or hopeless" to "12-14 days (nearly every day) and a new report of "feeling bad about yourself- or that you are a failure or have let yourself or your family down 2- 6 days" in Section D- Mood D0200- Resident Mood Interview, since last assessment completed on March 26, 2018. Section E0200- Behavioral Symptom was coded for physical and verbal behaviors symptoms directed towards others and other behavioral symptoms not directed towards others 1 to 3 days. In addition, Resident #81 is coded for rejection of care and wandering 1 to 3 days; respectively in Sections E0800 and E0900. During the assessment reference period for this MDS, Resident #81 received antipsychotic medications for 6 days as coded in Section N- 0410 Medications; without the provision of psychology therapy Section-O0400. During the three months between the two assessments dated March 26, 2018 and June 19, 2018, Resident #81 displayed an increase in behavioral symptoms for which psychiatric consultation was received and medications initiated. The psychiatric consults occurred on March 29, 2018, May 17, 2018, June, 14, 2018, and July 17, 2018. During the June 14, 2018, psychiatric consult visit, the recommendations included "behavioral and supportive interventions."	F 742		

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On June 14, 2018, the physician ordered Risperdal 0.25 milligrams one tablet at bedtime at "2100" for behavioral and supportive intervention.

During a resident interview on August 30, 2018, at 2:04 PM Resident #81 verbalized feeling "lonely and bored." The resident stated that she wanted to be at another place where she did not have to be "locked down". In addition, she has not been to her church in a long time. According to Resident #81, church helps with her "depression."

An observation on September 5, 2018, at approximately 10:45 AM, Resident #81 was observed standing at the nurse's station with a television remote in hand tearful, asking for her television. The Employee #21 stated that the resident has to be reminded that she doesn't have a television.

On September 5, 2018, at 11:55 AM, an observation of Resident #81 showed a number of chairs stored in the corner and fall mats.

During an interview on September 6, 2018 at approximately 12:13 pm Employee #30, Social Worker, stated she provides lots of conversation with the resident to keep her calm. The employee further stated that Resident #81 shared that she was the victim of domestic violence and rape in her home country. As a result of these events, the resident frequently covers the windows with fall mats and blocks the door with chairs. When queried about behavioral and supportive services as recommended by psychiatry on June 14, 2018, Employee #30 stated that the facility does not have formal behavioral health services, they only have psychiatry services. The facility does not

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obtain behavioral health services from outside of the facility.

There was no evidence that facility staff developed an individualized care plan that addressed the assessed emotional and psychosocial needs, Resident #81's adjustment to the facility, and failed to develop and implement an individualized person-centered care plan with non-pharmacological approaches to care for Resident #81 upon learning of history of trauma, causing the resident increased distress and fears.

The findings were review and discussed with Employees' #20 and #21 on September 6, 2018 at 4:06 PM. The employees acknowledged the findings.

2. Resident #388 was admitted on August 27, 2018, with diagnoses to include Alzheimer's Disease, Urinary Tract Infection, and Paranoid Hallucinations.

On August 30, 2018, at 10:30 AM, Resident #388 was observed wandering the unit in a winter coat on and brown non-skid slipper socks. The resident startled as staff and other residents approached the resident.

Review of the medical record on September 4, 2018, at 9:00 AM showed Admission Orders dated August 27, 2018, for Haldol 2 milligrams twice a day for agitation, Remeron 7.5 milligram for depressive disorder, Depakote 250 milligrams twice a day for Manic Bipolar Disorder, and psych

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consult for new admission.

The Psychiatric Consult dated August 29, 2018, showed assessed diagnoses of Dementia of Alzheimer's type, Psychotic Disorder, and recommendations to increase Remeron to 15 milligram at bedtime and Depakote to 250 milligrams three times a day. The resident was also to continue Haldol (medication used to treat psychosis).

Review of the Baseline Care Plan showed the facility initiated care plans for "9 or more medications; activities of daily living, advance directives, alteration in nutrition, dehydration, Alzheimer/Dementia; elopement; and safety". However, the care plans were not inclusive of individualized person-centered goals and non-pharmacological approaches to address Resident #388's related to behavioral health diagnoses to ensure the highest practicable well-being as she adjusted to the new environment. In addition, the care plan does not include interventions to address the use of antipsychotic medication for the management of behaviors.

During a face to face interview on September 4, 2018, at 11:15 AM, when discussing Resident #388's behavior health care needs related to wandering, refusal of care, and social isolation, Employee #21 stated the resident is new and is still adjusting." When asked how the staff addresses and monitors behaviors that may lead to increased behaviors and accidents such as the fall on August 30, 2018, the employee stated we are watching her. The resident is normally in the common area where the staff can observe movement. When asked about the measures the

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F 742	Continued From page 78 staff takes to ensure the television is adequately monitored for trip hazards due to the number of wheelchairs, Employee #21 stated that we use employees that are on light duty to help with monitoring. However, these employees are unable to provide physical assistance, if a resident trips, or needs physical assistance. Employee #21 stated that the Baseline Care Plan is used to communicate with the nursing assistant. The Baseline Care Plan was reviewed with Employee #21. Employee #21 acknowledged that the care plans failed to include non-pharmacological, individualized, person-centered goals and approaches to address the behavior health care needs for Resident #388 while adjusting to the facility.	F 742		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for two (2) of 60 sampled residents, the facility staff failed to develop a care plan with individualized, person-centered, non-pharmacological approaches to address one (1) resident with severe cognitive impairment, sexually inappropriate behaviors, refusal of care, fearfulness, and wandering; and for one (1) resident with diagnoses of Dementia and associated behaviors of rejection of care, wandering and agitation. Residents' #76 and #85.	F 744		

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F 744	Continued From page 79 Findings included... 1. Resident #76 was admitted on June 30, 2017, with diagnoses to include Dementia, Hypertension, and Degenerative Joint Disease. Review of the Annual Minimum Data Set (MDS) dated June 19, 2018, showed Section C Cognitive Patterns C0500 Brief Interview for Mental Status coded as "2", which indicates severe cognitive impairment. Also, Resident #76 was coded as having wandering behaviors 1 to 3 days in Section E0900. Section V0200 Care Area Assessment and Care Planning showed 'Cognitive Loss/Dementia, Behavioral Symptoms, and Mood State' were triggered and care plan checked as "addressed in the care plan." Review of physician's order dated July 3, 2017, showed the physician ordered Risperdal (antipsychotic medication) 0.25 milligram one tablet by mouth two times a day for Dementia with psychosis and Remeron (used to treat depression) 15 milligrams one tablet by mouth one time a day for Dementia. The nursing progress note conveyed, "Mood and Behavior" incident note dated June 13, 2018, stated Resident #76 refused all ADL's even when re-approached. On August 18, 2018, the nursing progress note showed Resident #76 was "fearful and pointing to another male resident that he was going to get him. Staff redirected and provided reassurance." Review of the Mood and Behavior- Incident log from December 1, 2017 through September 10,	F 744	F744 1. Resident #76's Care plan was updated to include individualized person-centered goals and approaches to address behaviors cognitive impairment sexually inappropriate behaviors, refusal of care, fearfulness and wandering. Resident # 85's Care plan was updated to include the diagnosis of dementia and associated behaviors, rejection of care, wandering, agitation, and use of antipsychotic medication. 2. The Care Plans of other residents were updated to include individualized person-centered goals and approaches. 3. Staff was educated on providing person-centered approaches to care plans.	11/11/18

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F 744	Continued From page 80 2018, showed behaviors observed as wandering out of designated area, attempted to leave building, following visitors/staff, sexually inappropriate behaviors and refusing to change clothes, hygiene and care. Review of the care plans showed non-specific approaches to for Resident #76 such as "continue to evaluate capacity for consent, discuss with guardian, monitor whereabouts, pastoral care, ensure dignity and respect ..." The facility failed to develop a care plan with individualized, person-centered, non-pharmacological approaches to address Resident #76's severe cognitive impairment, sexually inappropriate behaviors, refusal of care, fearfulness and wandering. During a face to face interview on September 5, 2018, at 3:59 PM, Employee #21 stated the staff work works with the resident. However, the staff has just begun receiving specialized training in dementia. When asked specifically about the development of individualized care plans, Employee #21 stated, "We have to start doing that." Employee #21 acknowledged the findings. 2. Resident #85 was admitted on June 21, 2018 with diagnoses to include Alzheimer's dementia, Hypertension, anemia, Degenerative Joint Disease, and Osteoarthritis. Review of Admission Minimum Data Set dated June 28, 2018, showed Resident #85 is severely cognitively impaired with a Brief Interview for Mental Status Summary Score (Section C0500)	F 744	4. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 months to ensure that care plans include person-centered approaches. The results of the audit will be shared at the monthly QAPI meeting.	

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F 744	Continued From page 81 coded as "3." Also, the resident rejects care and wanders one to three days, as documented in sections E0800 and E0900; respectively. Physician's order dated June 21, 2018, showed Seroquel (antipsychotic medication) 25 milligram daily at bedtime for agitation was ordered. Review of the "Cognitive Loss/Dementia" and "Behavioral Symptoms" care plans showed non-specific approaches for Resident #85 such as "encourage self-help skills, ensure all ADL (Activities of Daily Living) needs are met, identify and measure behaviors resulting in anxiety, monitor sleep patterns, monitor nutrition. The facility failed to develop a care plan with individualized, person-centered, with non-pharmacological approaches to address Resident #85's diagnoses of Dementia and associated behaviors of rejection of care, wandering, agitation, and use of Seroquel. During a face to face interview on September 10, 2018, at 10:45 AM, Employee #20 stated that the resident has anxiety and "holds herself" when she needs to use the bathroom, receives one on one with the activities department, and the staff allows her to sit until she is ready to get up. Employee #20 reviewed the care plans and acknowledged the findings.	F 744		
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. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		

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F 758	Continued From page 82 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 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758	F758 1. Resident #187 was assessed for the usage of psychoactive medications and identified behaviors were monitored. 2. Target behaviors were identified for residents on psychoactive medication. 3. Facility staff was educated on identifying targeting behaviors for residents on psychoactive medications. 4. The Social Worker or designee will audit 10 percent of residents on psychoactive meds on a weekly basis times 3 months to ensure that targeted behaviors are monitored. The results of the audit will be shared at the monthly QAPI meeting.	11/11/18

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F 758	Continued From page 83	F 758		

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 and staff interview for one (1) of 60 sampled residents, facility staff failed to consistently monitor behaviors for Resident #187 who receives Seroquel, Trazadone HCL, and Remeron (psychoactive medications).

Findings included ...

On November 22, 2017, the facility admitted Resident #187 with diagnoses that included of Dementia, Muscle Weakness, and Bradycardia.

A review physician's orders signed by the physician on July 30, 2018, directed:
"Seroquel 25 mg one (1) tablet by mouth daily for agitation;
Trazadone HCL 50 mg one (1) tablet by mouth daily for insomnia and
Remeron 15 mg one (1) tablet by mouth daily for poor appetite/insomnia"

A review of the "Target Behavioral Symptoms" forms for May, June and July 2018 failed to list/indicate the types of behavioral symptoms and adverse side effects the facility staff were monitoring for Resident #187.

During a face-to-face interview conducted on May 26, 2018, at approximately 12:00 PM, Employee #10 acknowledged the findings.

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F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview of one (1) of 59 sampled residents facility staff failed to ensure the provision of care by failing to obtain bloodwork for the treatment of a thyroid disorder. Resident# 44. Findings included... Resident # 44 admitted to the facility on 12/20/02, with diagnoses which include End Stage Renal Disease, Hypertension, Seizure Disorder and Anemia. Review of the Annual Comprehensive Minimum Data Set [MDS] dated 3/6/18 showed Section C [Cognitive Patterns] Brief Interview Score [BIMS] of 15 which indicates "Cognitively Intact". Section I [Active Diagnoses] Anemia, Hypertension, End Stage Renal Disease, Diabetes Mellitus, Thyroid Disorder. Review of the care plan with a start date of 8/31/12 showed "Problem: Resident has a diagnosis of Hypothyroidism (is a condition resulting from decreased production of thyroid hormones from the thyroid gland); Approach:	F 770	F770 1. A TSH and T4 were obtained for resident #44 on 9/6/2018. 2. No other residents were identified to need blood work completed. 3. Facility staff have been educated on obtaining blood work as ordered. 4. The Unit Manager or designee will randomly audit labs on a weekly basis times 3 months to ensure that lab are received as ordered. The results of the audit will be shared at the monthly QAPI meeting.	11/11/18

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Monitor laboratory values as ordered."

Review of the September 2018 Electronic Medication Administration Record showed "Levothyroxine Sodium tablet 100 mcg (micrograms) administer 1 tablet by mouth one time a day."

A further review of the medical record showed laboratory values dated 6/20/18 Thyroid Stimulating Hormone [TSH] result of 6.83 H indicates High [Reference range 0.358-3.740 and the Free T4 [Thyroxine] result 0.95 [Reference range 0.76-146 ng/dl (nanogram/deciliter)].

Review of the medical record on 9/5/18 at 3:00 PM showed a Physician Order Form dated 8/14/18 "TSH with T4 please arrange with the next dialysis at dialysis center".

During an interview on 9/5/18 at 3:30 PM with Employee# 3, the lab was not drawn on 8/14/18, the dialysis nurse was asked to obtain the lab on 8/22/18 at the next dialysis.

Employee# 3 was unable to provide evidence the TSH and T4 was requested in accordance with physicians order.

During a phone interview on 9/5/18 at 4:30 PM the physician confirmed the order for TSH and T4.

Facility staff failed to obtain timely laboratory services to meet the needs of the resident and in accordance with the physicians services.

A review of the medical record showed no adverse outcome to the resident.

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F 770	Continued From page 86 During a face-to-face interview on 9/6 at 4:30 PM, Employee# 3 acknowledged the findings.	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to store, serve and distribute foods under sanitary conditions as evidenced by foods such as one (1) of one (1) roasted turkey breast, one (1) of one open pack of turkey cold cuts, 21 of 21 turkey sandwiches and three (3) of three (3) ham sandwiches that were not labeled or dated, sixteen (16) of sixteen (16) peanut butter and jelly sandwiches in the walk-in refrigerator that were stored beyond their 'use by' date of August 29, 2018, soiled cooking equipment and utensils such	F 812	F812 1. The unlabeled food items were discarded. Items with expired use- by dates were also discarded. The soiled cooking equipment and utensils were cleaned. The sprinkler heads in the kitchen were cleaned. The dishwashing machine was cleaned. The final rinse meets acceptable temperatures. The dented pans and dented frying pans were discarded. The Cambro carts were repaired. 2. The Dining services manager made rounds to ensure that food items were labeled, cooking equipment and utensils were clean, kitchen sprinkler heads were free from dust and grease, the dishwasher was cleaned and met acceptable rinse temperatures, dented or damaged pans were discarded, and Cambro carts were in good repair.	11/11/18

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F 812	Continued From page 87 as two (2) of two (2) convection ovens, one (1) of one (1) four-inch frying pan, one (1) of four (4) six-inch frying pan, and 13 of 13 six-inch full pans, six (6) of six (6) soiled fire sprinkler heads, three (3) of three (3) soiled air curtains from the dishwashing machine, one (1) of one (1) soiled dishwashing machine, dented cooking pans and frying pans such as five (5) of five (5) half-inch sixth pans, nine (9) of nine (9) half-inch third pans, two (2) of two (2) six-inch third pans, one (1) of one (1) four-inch pan, four (4) of four (4) six-inch pans and one (1) of one (1) twelve-inch pan and five (5) of five (5) CAMBRO food transport carts with broken latches and cracks. Findings included... During a walk-through inspection of Dietary Services on August 30, 2018, at approximately 8:55 AM, the following were observed: 1. Food items such as one (1) of one (1) roasted turkey breast, one (1) of one open pack of turkey cold cuts, 21 of 21 turkey sandwiches and three (3) of three (3) ham sandwiches were not labeled or dated. 2. Sixteen (16) of sixteen (16) peanut butter and jelly sandwiches in the walk-in refrigerator had a 'use by' date of August 29, 2018. 3. Cooking equipment and utensils were soiled with grease and/or burnt food including: two (2) of two (2) convection ovens, one (1) of one (1) four-inch frying pan, one (1) of four (4) six-inch frying pan,	F 812	F812 (Continued) 3. Dining services staff was educated on food labeling, kitchen cleanliness including the dishwasher, acceptable dishwasher temperatures, dented or damaged pans, keeping sprinkler heads free from dust and grease, and maintenance requests for equipment. 4. The dining services manager will audit food labeling, kitchen cleanliness including the dishwasher, acceptable dishwasher temperatures, dented or damaged pans, keeping sprinkler heads free from dust and grease, and maintenance requests for equipment on a weekly basis times 3 months. The results of the audit will be shared at the monthly QAPI meeting.	

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F 812	Continued From page 88	F 812		

and 13 of 13
six-inch full pans.

4. Six (6) of six (6) fire sprinkler heads located above the grease fryer, the stove, the grill and the tilt skillet were
soiled with dust and grease.

5. Three (3) of three (3) air curtains from the dishwashing machine were soiled.

6. The dishwashing machine was soiled throughout with food stains and residue.

7. Final Rinse dishwashing machine temperatures were documented at less than 180 degrees Fahrenheit on six (6)
occasions in June, three (3) occasions in July and 18 occasions in August 2018, with no documented corrective
actions initiated.

8. Cooking pans such as five (5) of five (5) half-inch sixth pans, nine (9) of nine (9) half-inch third pans and two (2)
of two (2) six-inch third pans were dented in several areas.

9. Frying pans were dented in several areas including one (1) of one (1) four-inch pan, four (4) of four (4) six-inch
pans and one (1) of one (1) twelve-inch pan.

10. Five (5) of five (5) CAMBRO food transport carts were damaged with broken latches and cracks:

The blue cart and the red cart had a broken latch at the top compartment

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F 812	Continued From page 89 The teal colored cart had a broken latch at the bottom compartment The green cart had broken latches at the top and the bottom compartments The brown cart was cracked at the top compartment. During a face-to-face interview on August 30, 2018, at approximately 12:30 PM, Employee #4 confirmed the findings.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 865	F865 1. The QAPI program was reviewed and revised to include programs consistent with person-centered approaches for residents with dementia. 2. The QAPI program was reviewed and revised to include programs consistent with person-centered approaches for residents with dementia. 3. Facility staff were educated on dementia care practices and the QAPI process. 4. Quality Director or designee will review and or revise the QAPI plan to ensure person-centered	11/11/18

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	095034	A. BUILDING _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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F 865	Continued From page 90 interview the facility failed to develop and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems as evidenced by failing to implement systems to correct identified problems within the facility and anticipate potential problems and develop interventions to prevent their occurrence. The facility census was 239. Findings included... During the interview on September 11, 2018, at approximately 10:07 AM, a review of the facility ' s quality assurance and performance improvement (QAPI) program was conducted with the facilities Employees. The review of the program showed the facility failed to identify concerns, and develop and implement actions plans to correct identified areas of deficient practice in the following areas: " The behaviors health committee has been in place since October 2017. The facility staff stated there are incidents were we do have residents that display behavior and they are not documented. " According to the CMS 671 form completed by the facility on 8/21/18 indicates the facility has a dedicated Alzheimer 's disease Unit. Based on observation, record review staff and resident interviews, the facility failed to implement a program, which provides resident residing on this unit with a person-centered environment. Also, that the facility failed to implement a systematic care process which embodies the fundamental	F 865	approaches. The QAPI plan will be shared during the monthly QAPI meeting.	

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F 865	Continued From page 91 principles of care for persons living with dementia, to include low lighting low music clutter free environment, etc.. Employees' #1 and #2 were made aware of the findings at the time of the interview.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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	F 880		

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F 880	Continued From page 92 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 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 interview and record review the facility failed to complete a risk assessment specific to its water system that identifies areas where	F 880	F880 1. The risk assessment for legionella was completed and the potable water system flow chart was updated for Carroll Manor. 2. The risk assessment for legionella was completed and the water system flow chart was updated for Carroll Manor. 3. The facilities manager was inserviced on ensuring that the risk assessment for the facility is specific to Carroll Manor. 4. Chem-Aqua will conduct quarterly water treatment sampling. Sampling findings will be forwarded to the QAPI committee, as well as the Water Management team and Environment of Care/Quality for review.	11/11/18

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F 880	Continued From page 93	F 880		

Legionella and other waterborne pathogens could grow and multiply.

Findings included ...

A review of the facility's Water Management Program Policy and Procedure item #2d (Water Systems Assessment) states "A one time risk assessment will be conducted using the Medxcel risk assessment template. (WMP 3.1B)".

However, upon further review, all 12 pages from the risk assessment template WMP 3.1B were blank.

Furthermore, the Potable Water System Flow Diagram under tab WMP 4.1 of the Water Management Program manual indicate:

1. The diagram is titled "Providence Hospital WMP 3.1A Process Flow Diagram - Potable Water System" and
does not reference 'Carroll Manor'.

2. The potable water system flow diagram is a generic diagram that flows through several systems that may or may
not be included in the facility's own potable water system. It is nonspecific.

3. The potable water system flow diagram does not identify specific areas where Legionella and other waterborne
pathogens could grow and spread.

During a face-to-face interview on September 10, 2018, at approximately 2:30 PM, Employee #1

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F 880	Continued From page 94 acknowledged the findings.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain essential equipment in safe condition as evidenced by exposed electrical wires from one (1) of one (1) meat slicer and one (1) of one (1) buffalo chopper. Findings included ... 1. The power cord to one (1) of one (1) meat slicer was frayed and its internal electrical wires were visible and accessible and posed a safety hazard to staff. 2. The power cord to one (1) of one (1) buffalo chopper was frayed and its internal electrical wires were visible and accessible and created an unsafe environment for staff. During a face-to-face interview on August 30, 2018, at approximately 12:30 PM, Employee #4 confirmed the findings.	F 908	F908 1. The meat slicer and buffalo chopper were repaired. 2. The Dining Services Manager made rounds to ensure that there were no other exposed electrical wires. 3. The Dining Services Staff were educated on reporting exposed electrical wires. 4. The Dining Services Manager or designee will conduct weekly audits times 3 months to ensure that there are no exposed wires. The results of the audit will be reported at the monthly QAPI committee meeting for review.	11/11/18
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call	F 919		

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F 919	Continued From page 95 directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 66 resident's rooms that failed to alarm when tested and two (2) of three (3) call bells in the west wing shower room with no pull cord. Findings included ... 1. During observations on the fifth floor on August 31, 2018, at approximately 10:30 AM, call bells in resident room #502 and #532 did not alarm when activated, possibly delaying residents or visitors from alerting staff in the event of an emergency in two (2) of 66 observations. 2. During observations on the fourth floor on August 31, 2018, at approximately 11:00 AM, two (2) of three (3) call bells located in the west wing shower room did not have a pull cord. During a face-to-face interview on August 31, 2018, at approximately 12:30 PM, Employee #5 confirmed the findings.	F 919	F919 1. The call bells in room #'s 502 and 532 alarm when activated. Pull cords were placed in the west wing shower room. 2. The Facilities Manager or designee will make rounds to ensure that the room call bells are in good working condition and the shower rooms have pull cords. 3. Staff was educated on reporting call bell functioning issues and missing pull cords. 4. The Facilities Manager or designee will randomly audit 10 percent of the resident rooms on a weekly basis times 3 month to ensure the functionality of call bells. Facilities Manager or designee will also audit shower rooms on a weekly basis to ensure that they have pull cords. The results of the audit will be reported at the monthly QAPI committee meeting for review.	11/11/18