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	095019	A. BUILDING ______ B. WING ______	03/26/2019

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

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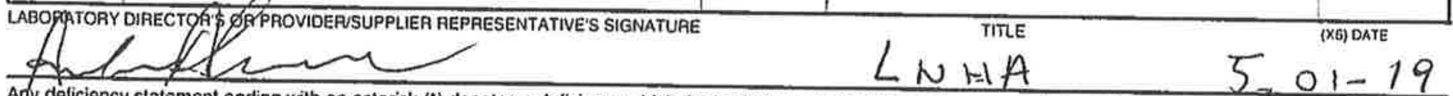
F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Deanwood Rehabilitation and Wellness Center from March 18, 2019 through March 26, 2019. Survey activities consisted of a review of 68 sampled residents. The following deficiencies are based on observation, record review and 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 resident census during the survey was 283. 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 AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia	F 000	**DEANWOOD REHABILITATION AND WELLNESS CENTER DISCLAIMER.** Facility submits this plan of correction under procedures established by the Department of Health In order to comply With the Department's directive to change Conditions which the Department alleges are deficient under state Regulations Relating to long term care. This should not be construed as either a waiver of the Facility's right to appeal and to Challenge the accuracy or severity Of the alleged Deficiencies or any Admission of any wrong doing.	5/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE



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 DCMR- District of Columbia Municipal Regulations D/C- Discontinue DI- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse 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 Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney	F 000		

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F 000	Continued From page 2 POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on an observation, record review, resident and staff interview for one (1) of 68 sampled residents, facility staff failed to ensure that one resident who was observed with medications at her bedside was cleared by the Interdisciplinary Team (IDT) to self-administer her medications. Resident #248 Findings included. . . Resident #248 was admitted to the facility on November 5, 2018 with diagnoses which include Generalized Muscle Weakness, Type 2 Diabetes without complications, Essential (Primary)	F 554	**F554** **Corrective action for the residents affected:** 1.This facility cannot be retroactively correct the deficiency. Resident #248 was reassessed on 3/19/19 Resident suffered no negative outcome. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents to identify Potential resident who has medication on his/her bedside and was not cleared by the Interdisciplinary Team (IDT) to self-administer his/her medications. 2. Any issues found during the audit/ assessment will be addressed. No residents were identified as affected.	5/17/19

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F 554	Continued From page 3 Hypertension, Cerebral Infarction Unspecified, Alcohol Abuse Uncomplicated, Drug Abuse Counseling and Surveillance of Drug Abuser and Acquired Absence of Right leg below knee. Review of Section C (Cognitive Patterns) of the admission Minimum Data Set (MDS) dated November 12, 2018 and the last quarterly MDS dated February 23, 2019 both show the resident with a BIMS (Brief Interview for Mental Status) score of 15; which indicates that the resident's cognitive ability is intact and she is able to make her own decisions. The resident is coded as a one (1) indicating that she functions independently except for cueing and support under Section G (Functional Status). Activities of Daily Living. On March 19, 2019 at approximately 10:55 AM this surveyor entered Resident #248's room and observed two (2) white tablets on the resident's over-the-bed table. The resident was asked what the tablets were and why they were on her table. She responded that they were Tylenol's and that the nurse had left them for her to take before she went to therapy. The resident then placed the two tablets in her mouth and swallowed them with some water. The resident then added, "He [the nurse caring for the resident] knows that I like to take the Tylenol's just before I go to therapy." Employee #16 was not available for questioning. However, during a face-to-face interview on March 25, 2019 at 2:40 PM Employee #10 (the Unit Manager) acknowledged that Resident #248 was not identified by the Interdisciplinary Team as	F 554	**Measures to prevent recurrence** Facility licensed nurses will be in-serviced on not to leave medication on residents' bedside unless resident was cleared by the Interdisciplinary Team (IDT) to self-administer his/her medications. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents to identify potential resident who has medication on his/her bedside and was not cleared by the Interdisciplinary Team (IDT) to self- administer medications weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 554	Continued From page 4 being able to administer her own medications and acknowledged the finding.	F 554		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and facility document review for one (1) of 68 sampled residents, the facility staff failed to provide Resident #7 with quarterly statements within 30 days after the end of the quarter and/or upon request. Findings included ..... Resident #7 was admitted to the facility on 6/19/14 with diagnoses which include: Hypertension, Diabetes Mellitus, Hyperlipidemia and Chronic Obstructive Pulmonary Disease. Review of the Quarterly Minimum Data Set	F 568	**F568** **Corrective action for the residents affected:** 1. This facility cannot be retroactively correct the deficiency. Resident #7 did not suffer any negative outcome. 2. Education will be provided to the Business Office Manager and Accounts Payable representatives to ensure resident quarterly statements are provided within 30 days after the end of the quarter and/or upon request. **Identification of others with potential to be affected.** All resident residing in the facility have the potential to be affected. 1. Immediate house wide audit of residents with quarterly statements will be completed to ensure that residents are provided with quarterly statements within 30 days after the end of the quarter and/or upon request. 2. Any issue found will be addressed.	**5/17/19**

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F 568	Continued From page 5 12/4/18 showed Section C-Cognitive Patterns: Brief Interview for Mental Status scored as "15" which indicates cognitively intact. During an interview with Resident #7 on 3/18/19 at approximately 11:30 AM, he was asked, do you get a quarterly statements from the facility? Resident #7 responded, "I don't get my monthly statements." During an interview on 3/18/19 at 2:00 PM with Employee #3, he stated, yes, the residents are supposed to get their statements but some residents throw them away. I don't have anything to show you that I have given the statements to the residents. I have not given the residents their statements. Facility staff failed to ensure that residents or their representative received their quarterly statements in writing within 30 days after the end of the quarter, and upon request. During a face-to-face interview on 3/18/19 at 2:00 PM Employee #3 acknowledged the findings.	F 568	**Measures to prevent recurrence:** Education will be provided to Business Office Manager and Accounts Payable Representative to ensure residents Quarterly statements are provided within 30 days after the end of the quarter and/or upon request. **Monitoring corrective action:** Monthly audit will be completed by Manager and Accounts Payable Representative to ensure that resident are provided with quarterly statements within 30 days after the end of the quarter and/or upon request. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months. **F583** **Corrective Action for the Residents Affected:** 1. This facility cannot be retroactively correct the deficiency. The # 96 resident was reassessed on 3/19/19.	5/17/19
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F 583	The # 96 resident did not suffer any negative outcome. 2. Education will be provided to the facility staff to respect resident's privacy by knocking on the resident's door and wait for permission before entering resident's room; and to pause before entering for residents who are	

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F 583	Continued From page 6 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on an observation, record review and staff and resident interview for one (1) of 68 sampled resident's, the facility staff failed to respect Resident #96's privacy by failing to knock on the resident's door and entering the resident's room without receiving permission to enter. Findings included . . .	F 583	nonverbal. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to respect their privacy by not knocking on the resident's door and entering the resident room without receiving permission to enter. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to respect resident's privacy by knocking on the resident's door and entering the resident's room after receiving permission to enter. **Monitoring corrective action:** Assistant Director of Nursing/ Designee will complete house wide Assessment / audit of residents to identify potential resident that the facility staff failed to respect resident privacy by knocking on the resident's door and entering the resident room without receiving permission to enter weekly times 4 then monthly times 3 months. Findings will be reported to the Quality Assurance Performance. Improvement Committee monthly for the next 3 months.	5/17/19

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F 583	Continued From page 7 Resident #96 was admitted to the facility on September 27, 2017, with diagnoses which included Arthritis, Depression, Hypertension, Atrial Fibrillation, Heart Failure and Renal Insufficiency as recorded in Section I of the annual Minimum Data Set dated October 10, 2018. Review of Section G (Functional Status) shows that the resident requires extensive assistance and support from one person for all activities of daily living except transfer and eating. The resident requires assistance from two persons for transfer and only requires cueing and/or oversight for eating. Review of the Brief Interview for Mental Status BIMS in Section C (Cognitive Patterns) showed a score of 15 which indicated that the resident was cognitively intact and able to make his own decisions. During an interview with Resident #96 at approximately 11:00AM on March 19, 2019, someone pushed the door and entered the room without knocking on the door and/or waiting to receive permission to enter the room. The employee who entered the room tried to leave the room but I asked him to come into the room. I also asked the employee why he did not knock on the door before entering the room. The employee paused and said, "I am sorry. I should have knocked." During a face-to-face interview at 3:00 PM on March 25, 2019 Employee #10 acknowledged that the employee should have knocked on the door and waited for permission to enter the room and acknowledged the finding.	F 583		
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		

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F 584 SS=B	Continued From page 8 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; §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	F 584	**F584** **Corrective action for the residents affected:** 1. Privacy curtains to Bed (A) and Bed (B) in resident room #502 identified were replaced on 3/19/17 2. Four (4) of four (4) soiled exhaust vents located on the clean area of the laundry room were cleaned on 3/19/19. 3. A stained ceiling tile identified in resident room #530 was replaced on 3/19/19. **Identification of others with the potential to be affected.** All residents residing in the facility have the potential to be affected. An inspection was done **throughout** the facility by the Director of Housekeeping/Designee, and Director Maintenance/Designee to ensure that: 1. All privacy curtain in the residents rooms are intact and not torn. 2. All exhaust vents in the facility are clean 3. All ceiling tiles are without stains. **Measure to Prevent Recurrence:** Housekeeping and maintenance Services staff will be in-serviced by Staff Development on the Importance of ensuring that all privacy curtains in the residents' rooms are intact and not torn, all exhaust vents in the facility are clean, and all ceiling tiles are without stains.	5/17/19

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F 584	Continued From page 9 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by torn privacy curtains in one (1) of 56 resident's rooms, four (4) of four (4) soiled exhaust vents in the Laundry area, and a stained ceiling tile in one (1) of 56 resident's rooms. Findings included ... During an environmental tour of the facility on March 19, 2019, between 9:07 AM and 2:30 PM, and on March 20, 2019, at approximately 11:00 AM, the following were observed: 1. Privacy curtains to Bed (A) and Bed (B) in resident room #502 were torn, attached to each other with pieces of cloth and tied to the power cord to Bed (B), one (1) of 56 resident's rooms surveyed. 2. Four (4) of four (4) exhaust vents located on the clean area of the laundry room were soiled with dust. 3. A stained ceiling tile was observed in resident room #530, one (1) of 56 resident's rooms surveyed. During a face-to-face interview on March 20, 2019, at approximately 11:30 AM, Employee #14 and /or Employee #15 acknowledged these findings.	F 584	**F584** **Monitoring Corrective Action:** Random audits will be conducted by the Director of Housekeeping/Designee, and Director Maintenance/Designee, weekly times 3, then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee Monthly for the next 3 months.	5/17/19

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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 observation, medical record review and staff interview for one (1) of 68 sampled resident facility staff failed to ensure Resident #186 was free from neglect by failing to assess the resident's care needs after the resident repeatedly called a Certified Nursing Assistants (CNA) for assistance. Resident #186. Findings included... Record review of the facility's policy titled "Prohibition of Abuse Administration" with a revision date of 1/19, showed "Neglect- is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."	F 600	**F600** **Corrective action for the residents affected:** Resident #186 was reassessed on 3/19/19 The resident #186 did not suffer any negative outcome. 2. Education will be provided to the facility staff to proactively assess the care needs of residents; and to make sure residents are free of neglect. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to assess residents' care needs, and to make sure residents are free of neglect. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to proactively assess the care needs of residents; and to make sure residents are free of neglect. **Monitoring corrective action:** Assistant Director of Nursing/ Designee will complete house wide Assessment / audit of residents to identify potential resident that the facility staff failed to assess residents' care needs and free of neglect weekly times 4, then monthly times 3months. Findings will be reported to the Quality Assurance	5/17/19

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

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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 600	Continued From page 11 Resident #186 was admitted to the facility on 5/21/18 with diagnoses which include; Anemia, Heart Failure, Hypertension, Alzheimer Disease, Cerebrovascular Accident and Peripheral Vascular Disease. Review of the Quarterly Minimum Data Set [MDS] dated 2/8/19 showed Section C-Cognitive Patterns. Brief Interview for Mental Status [BIMS] is scored as "12" which indicates cognition is moderately impaired. Section G-Functional Status [Activities of Daily Living] resident is scored as "3" extensive assistance (resident involved in activity, staff providing weight-bearing support) for dressing, eating, toileting, and personal hygiene. G0600-Mobility devices the space is marked for wheelchair to indicate the mobility device normally used by the resident. Observation on 3/19/19 at 2:50 PM showed Resident #186 sitting in a wheelchair at the dining table in the day area (resident's chair was positioned at a 45 degree angle from the dining table). Writer was sitting at the nurse's station and heard Resident #186 repeatedly call for the assistance of Employee #29,Certified Nursing Assistant, the resident was heard saying "are you coming, when are you coming, how long will it take, are you coming now.?" Employee #29, CNA was approximately 25 feet away from Resident #186 and the resident was in her direct sight, Employee #29 was observed entering	F 600	F600 Performance Improvement Committee monthly for the next 3 months.	5/17/19

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	095019	A. BUILDING ______ B. WING ______	03/26/2019

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F 600	Continued From page 12	F 600		

information into a wall computer. There was other staff observed in the dining area along with other residents seated throughout the dining area/day room. Writer was seated at the nurses station and the unit manager was also seated at the nurses station at the time the resident was calling for the assistance of Employee #29. After repeated calls for assistance the writer approached Resident #186, seated in a wheelchair and the resident stated, "my diaper is too tight and it is paining me that is why I am calling."

Writer approached Employee #29, who was standing at the wall computer and asked, "did you hear the Resident #186 calling you?" Employee #29 responded "yes, I was going to go to her, but we have a certain time to get our charting done and I had to chart." Employee #29 was told the resident is complaining of pain because her diaper is too tight.

Writer then told the unit manager of the incident and the unit manager along with Employee #30 took the resident to her room. The writer followed, and resident restated "the diaper was too tight". Writer left the room for care to be rendered by staff (Employee #7 and Employee #30). After Employees #7 and #30 left the room, writer returned to the room and asked Resident #186 if she was in any pain the resident stated, "no not now, the diaper is okay.'

During an interview on 3/19/19 at 3:15 PM, Employee #29 stated "I was working with the Resident #186 all morning, I should have gone over to her, I heard her calling me but we have a time limit to get our charting done so I was trying

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F 600	Continued From page 13 to enter my data. I wheeled her back to the day room and pushed the wheel chair toward the dining table, but I could see her from where I was standing at the wall computer, other staff where there too." During an interview on 3/19/19 at 3:20 PM Employee #7 stated "I did not hear the resident but there were other staff in the dining area/day room. We have staff there to monitor the residents in the dining/day area." Employee #7 provided the names of two staff that were present in the dining area/day room at the time Resident #186 was calling for assistance. Facility staff failed to assess and provide timely care (repeated calls for assistance) for a Resident complaining of "pain from a tight-fitting adult brief." At the time of the observation on 3/19/19 at 3:40 PM during a face-to-face interview Employees #7 and # 29 acknowledged the finding.	F 600		
F 610 SS=D	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 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.	F 610	**F610** **Corrective action for the residents affected:** 1. Resident #186 was reassessed on 3/19/19. The resident #186 did not suffer any negative outcome. 2. Education will be provided to the facility staff to thoroughly conduct an investigation involving an incident of neglect.	5/17/19

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F 610	Continued From page 14 §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 observation, investigative documents, medical record review and staff interview of one (1) of 68 sampled residents facility staff failed to conduct a thorough investigation involving an incident of neglect. Resident# 186. Findings included .... Record review of the facility's policy titled "Prohibition of Abuse Administration" with a revision date of 1/19, showed "Neglect- is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." Resident# 186 was admitted to the facility on 5/21/18 with diagnoses which include; Anemia, Heart Failure, Hypertension, Alzheimer Disease, Cerebrovascular Accident and Peripheral Vascular Disease. Review of the Quarterly Minimum Data Set [MDS] dated 2/8/19 showed Section C-Cognitive Patterns. Brief Interview for Mental Status [BIMS] is scored as "12" which indicates cognition is moderately impaired. Section G-Functional	F 610	**Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to thoroughly conduct an investigation involving an incident of neglect. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to thoroughly conduct an investigation involving incident of neglect. **Monitoring corrective action:** Assistant Director of Nursing/ Designee will complete house wide Assessment / audit of residents to identify potential resident that facility staff failed to thoroughly conduct investigation involving incident of neglect, weekly times 4, then monthly times 3months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 610	Continued From page 15 Status [Activities of Daily Living] resident is scored as "3" extensive assistance (resident involved in activity, staff providing weight-bearing support) for dressing, eating, toileting, and personal hygiene. G0600-Mobility devices the space is marked for wheelchair to indicate the mobility device normally used by the resident. Observation on 3/19 at 2:50 PM showed Resident #186 sitting in a wheelchair at the dining table in the day area (resident's chair was positioned at a 45 degree angle from the dining table). Writer was sitting at the nurse's station and heard Resident #186 repeatedly call for the assistance of Employee #29,Certified Nursing Assistant, the resident was heard saying "Are you coming, when are you coming, how long will it take, are you coming now?" Employee #29, CNA was approximately 25 feet away from Resident #186 and the resident was in her direct sight. Employee #29 was observed entering information into a wall computer. There was other staff observed in the dining area along with other residents seated throughout the dining area/day room. Writer was seated at the nurses' station and the unit manager was also seated at the nurses' station at the time the resident was calling for the assistance of Employee #29. After repeated calls for assistance the writer approached Resident #186, seated in a wheelchair and the resident stated,"my diaper is too tight and it is paining me that is why I am calling Employee #29." Writer approached Employee #29, who was standing at the wall computer and asked, "did you	F 610		

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F 610	Continued From page 16	F 610		

hear the resident calling you?" Employee #29 responded, "yes, I was going to go to her, but we have a certain time to get our charting done and I had to chart." Employee #29 was told the resident is complaining of pain because her diaper is too tight.

Writer then told the unit manager of the incident and the unit manager along with Employee# 30 took the resident to her room, the writer followed, and resident restated "the diaper was too tight". Writer left the room for care to be rendered by Employee #7 and Employee #30. After the staff left the room, writer returned to the room and asked resident if she was in any pain the resident stated, "no not now, the diaper is okay."

During an interview on 3/19/19 at 3:15 PM, Employee #29 stated, "I was working with the resident all morning, I should have gone over to her, I heard her calling me but we have a time limit to get our charting done so I was trying to enter my data in the computer, I wheeled her back to the day room and pushed the wheel chair toward the dining table, but I could see her from where I was standing at the wall computer, other staff were there too."

During an interview on 3/19/19 at 3:20 PM Employee #7 stated "I did not hear the resident but there were other staff in dining area/day room, we have to have staff there to monitor the residents in the dining/day area." Employee # 7 provided the names of two staff (Employees) that were present in the dining area/day room at the time Resident #186 was calling for the assistance.

During a face-to-face interview on 3/19/19 at 4:00

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F 610	Continued From page 17 PM Employee #2, stated "here is the completed investigation, here it is". The investigating documents failed to show interviews of the Employees (staff) present in the dining room/day area at the time Resident #186 was calling for assistance. There was no evidence Employee #2 interviewed all of the Employees in the dining/day area at the time Resident #186 was calling for assistance. During a face-to-face interview on 3/19/19 at 4:00 PM Employee #2 acknowledged the finding.	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	F 622	**F622** **Corrective action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. Resident #126 did not suffer any negative outcome. Resident #215 did not suffer any negative outcome. Resident #247 did not suffer any negative outcome. 2.. Education will be provided to the facility staff to document the information communicated to the receiving health care institution during Transfer and Discharge.	5/17/19

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F 622	Continued From page 18 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; 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).	F 622	**Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to document the information communicated to the receiving health care institution during Transfer and Discharge. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to document the information communicated to the receiving health care institution during Transfer and Discharge. **Monitoring corrective action:** Assistant Director of Nursing/ Designee will complete house wide Assessment / audit of residents to identify potential resident that facility staff failed to document the information communicated to the receiving health care institution during Transfer and Discharge; weekly times 4, then monthly times 3months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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(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 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 record review and staff interview for three (3) of 68 sampled residents, the facility staff failed to document the information communicated to the receiving health care institution for Residents' #126, # 215 and #247.

Findings included...

1. The facility staff failed to document the information communicated to the receiving health care institution for Resident #126.

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F 622	Continued From page 20 Resident #126 was admitted to the facility on April 23, 2013, with diagnoses to include Anemia, Hypertension, Hyperlipidemia, Osteoporosis, End Stage Renal Disease, Alzheimer's and Major Depressive Disorder. A review of the Significant Change in Status Minimum Data Set [MDS] dated January 21, 2018. Section C [Cognition Patterns] C1000 Cognitive Skills for Daily Decision Making coded "3" Severely impaired which indicates, "Resident never/rarely made decisions". A review of the physicians' order dated December 28, 2018, showed, "Transfer to the hospital for poor PO intake (unable to swallow) GI consult for G-Tube placement (family agreed to G-tube placement)." A review of the Patient Transfer notes dated December 28, 2018 showed a lack of the following documented information: contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident's diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status. The facility staff failed to ensure all information mentioned above was communicated to the receiving healthcare facility as evidenced by the medical record's lack of documented evidence to show that the information was sent with Resident	F 622		

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F 622	Continued From page 21 #126 to the emergency room on December 28, 2018. During a face-to-face interview conducted on March 25, 2019, at approximately 10:00 AM with Employee#10. He acknowledged the finding. 2. The facility staff failed to document the information communicated to the receiving health care institution for Resident #215. Resident #215 was admitted to the facility on 12/04/18, with diagnoses which include Anemia, End Stage Renal Disease, Hypertension, Pneumonia, Diabetes Mellitus, Depression and Muscle Weakness. On March 25, 2019 at 10:00 AM, a review of the medical record showed the Resident was hospitalized on 1/3/19 for wound debridement. According to the nurses note dated January 3, 2019 "Resident left unit via [ambulance company name] along with escort at 3:30 PM in a stable condition all due paperwork was sent to the hospital with the Resident, medical diagnosis and care plan goal face sheet included report was given to [name of hospital] admitting nurse...". The medical record lacked documentation to support the facility communicated the name of the practitioner who is responsible for the care of the resident, resident's representative contact information, advance directive information, special instructions and precautions, and comprehensive care plan goals to the receiving health care institution for the transfer that occurred 1/3/19.	F 622		

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F 622	Continued From page 22 On March 25, 2019 at 10:30 AM, during a face-to-face interview Employee #12 acknowledged the finding. 3. The facility staff failed to document the information communicated to the receiving health care institution for Resident #247. Resident #247 was admitted to the facility on August 11, 2016, with diagnoses to include Hypertension, End Stage Renal Disease, Anemia, Schizophrenia, Hepatitis B, Pneumonia, Heart Failure, Liver Carcinoma and Major Depressive Disorder, A review of the Quarterly Minimum Data Set [MDS] dated October 3, 2019. Section C [Cognition Patterns] Brief Interview for Mental Status [BIMS] was recorded as "14" which indicates resident is cognitively intact. A review of a nurse's progress note dated January 25, 2019, showed "Hospital for coffee ground emesis, to [named hospital] for treatment due to abdominal pain, Nausea, and vomiting, he was admitted to hospital ... ". A review of the Patient Transfer notes dated January 25, 2019, lacked the following documented information: "Contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of	F 622		

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F 622	Continued From page 23 transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status" The facility staff failed to ensure all information mentioned above was communicated to the receiving healthcare facility as evidenced by the medical record's lack of documented evidence to show that the information was sent with Resident #247 to the emergency room on January 25, 2019. During a face-to-face interview conducted on March 25, 2019, at approximately 10:00 AM with Employee#10, he acknowledged the finding.	F 622	**F623** **Corrective Action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. Resident #215 did not suffer any negative outcome. 2. Education will be provided to the facility staff to always communicate with residents and representative of the reason for transfer from the facility to the hospital. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to notify residents and representative of the reason for transfer from the facility to the hospital.	5/17/19
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 24 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623	**F623** 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to always notify residents and representatives of the reason for transfer from the facility to the hospital. **Monitoring corrective action:** Assistant Director of Nursing/ Designee will complete house wide Assessment / audit of residents to identify potential residents and representatives that the facility staff failed to notify of the reason for transfer from the facility to the hospital; weekly times 4, then monthly times 3months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 623	Continued From page 25	F 623		

and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to notify one (1) of 68 residents of the reason for transfer from the facility to the hospital. Resident #215.

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F 623	Continued From page 26 Findings included... Resident #215 was admitted to the facility on 12/04/18, with diagnoses which include Anemia, End Stage Renal Disease, Hypertension, Pneumonia, Diabetes Mellitus, Depression and Muscle Weakness. A review of the resident's record on March 19, 2018 at 11:00 AM showed he was transferred to hospital from the facility on January 3, 2019. Review of Resident #215's nurse's notes and social work progress note on March 24, 2019 at 9:00 AM showed there was no documentation indicating that the resident and the resident's representative were notified in writing or verbally of the transfer and the reasons for the move in writing. The medical record lacked documentation to support the facility communicated the name of the practitioner who is responsible for the care of the resident, resident's representative contact information, advance directive information, special instructions and precautions, and comprehensive care plan goals to the receiving health care institution for the transfer that occurred 1/3/19. During a face-to-face interview on March 25, 2018, at approximately 12:00 PM, Employee #12 acknowledged findings.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 27 §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 record review and staff interviews of three (3) of 68 sampled residents, the facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) Resident's Discharge to home, for one (1) Resident's use of psychotropic medications and for one (1) resident with a behavioral indicator for psychosis. Residents' #70, #198 and #258. Findings included... 1. Resident #70 admitted to the facility on 12/14/18, with diagnoses which include: Opioid Use unspecified, Encephalopathy, unspecified, Pressure Ulcer of Sacral Region (Unstageable), Right Heel (Unstageable) and Left Heel (Unstageable). Review of the Physician Order dated 1/29/19 showed "discharge patient to home on 1/31/19 scripts done." Review of the physicians discharge summary dated 1/31/19 "discharge date: 2/1/19, disposition: home." Review on the Nursing Home Discharge Minimum Data Set [MDS] dated 2/1/19 showed Cognitive Patterns: Brief Interview for Mental Status scored as "13" which indicate cognitively intact. Review of Identification Information [Discharge Status] is coded as "3" which	F 641	**F641** **Corrective Action for the Residents Affected:** The affected Resident #70 was reassessed and the deficiency was corrected on 4/29/19 Resident #70 did not suffer any negative outcome. The affected Resident # 198 was reassessed and the deficiency was corrected on 3/25/19. Resident #198 did not suffer any negative outcome. The affected Resident # 258 was reassessed and the deficiency was corrected on 4/30/19 Resident #258 did not suffer any negative outcome. 2.. Education will be provided to the facility MDS staff to accurately code Minimum Data Set (MDS) for residents. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Facility MDS Director/Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to accurately code Minimum Data Set (MDS).	5/17/19

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F 641	Continued From page 28 indicated the resident was discharged to an acute hospital. Facility staff failed to accurately code the MDS to reflect the resident's discharge status as discharged to home (not to an acute hospital). During a face-to-face interview on 3/26/19 at 2:00 PM, Employee #4 stated "I see the error he was discharged to home not to an acute hospital". At the time of the interview the employee acknowledged the finding. 2. Resident #198 was admitted to the facility on April 2, 2018 with diagnoses that included Schizophrenia, Major Depressive Disorder, and Dementia. A review of the physician's orders on 3/25/19 at 9:00 AM showed the resident was to receive, "Haldol (anti-psychotic) 0.5 ml po (by mouth) BID (twice a day) for the month of February 2019. A Review of the February 2019 Medication Administration Record 3/25/19 at 9:15 AM showed the facility staff administered Haldol 0.5 ml po to the resident twice a day and were monitoring the resident for aggressive behaviors and the side effects of medication. A Review of the Annual MDS on 3/25/19 at 9:15 AM showed that under Section C0500 (Brief Interview for Mental Status (BIMS) Summary Score)- resident had a BIMS score of 5 (indicating the resident has severe cognitive	F 641	**F641** 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility MDS staff to accurately code Minimum Data Set (MDS) for residents. **Monitoring Corrective Action:** Facility MDS Director/Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to accurately code Minimum Data Set (MDS); weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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impairment. Under Section E0100 Potential Indication for Psychosis- the resident was coded as "yes" for delusions. Under Section E0200 Behavioral Symptoms- the resident was coded as having physical symptoms directed towards others. Under Section E0800 Rejection of Care- the resident was coded as "yes" as occurring. Under Section E0900 Wandering Presence & Frequency - the resident was coded as having a behavior of this type "wandering" occurring within 4 to 6 days. Under Section N0410 Medications- the resident was not coded as receiving an anti-psychotic medication.

There was no evidence that facility staff coded the Annual MDS for the Resident receiving anti-psychotic medication.

During a face-to-face interview on 03/25/19 at 10:29 AM , Employee # 4, acknowledged the findings.

3. Resident# 258 was admitted to the facility on 2/11/19, a review of the admission record showed the following diagnoses: Anemia Unspecified, Dementia in Other Diseases Classified without Behavioral Disturbance, Delusional Disorders, Unspecified Psychosis not due to a Substance, and Heart Failure.

Review of the Comprehensive Nursing Home Minimum Data Set [MDS] dated 2/18/19, showed Section C-Cognitive Patterns: Brief Interview for Mental Status resident was scored as "99" which indicate the resident was not able to complete the interview. Section D [0100]- Mood was coded a 0 to indicate resident's mood interview was not conducted (resident is rarely/never understood).

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F 641	Continued From page 30 Section E [0100] Potential indicators of psychosis allocated box is marked X none of the above to indicate no behaviors of psychosis exist (hallucinations or delusions). Review of the Nurse Practitioner's Admission Assessment and Medication Review note dated 2/12/19 showed admitted from [hospital name], seen today for assessment and medication review. Assessment; Risk for Fall, Altered Mental Status (AMS), Uncontrolled Hypertension ...Dementia/Delirium. Review of the Physician's Progress Note dated 2/12/19 showed "Patient has no history of mental illness but is on Risperidone and Lorazepam for agitations and behavioral problems with periods of Delirium". Review of the Nurse Practitioner's Assessment Status Post Hospital Discharge Note dated 2/16/19 showed Assessment: Risk for Fall, AMS, Uncontrolled Hypertension...Dementia/Delirium. Review of the Medication Administration Record for February 2019 showed, monitor resident for aggressive behavior and restlessness every day and evening shift; monitor resident for agitation every day and evening shift. Further review of the Comprehensive Nursing Home Minimum Data Set dated 2/18/19 showed Section E: Behavior [E0100. Potential for Psychosis], check all that apply A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli), B. Delusions (misconceptions or beliefs that are firmly held,	F 641		

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F 641	Continued From page 31 contrary to reality). None of the above box was marked with an "X" to indicate the resident did not exhibit those behaviors. During an interview with Employee #4 on 3/26/19 at 3:30 PM, the employee was asked what sources were used to complete the MDS, the employee replied "I use the doctor's and nurse practitioner progress note, hospital discharge summary, nurses notes, charted notes by the certified nurse assistants and observations to complete the MDS." Employee# 4 continued by saying the day the MDS was completed the resident was not exhibiting the behavior. Facility staff failed to accurately code Resident# 258 for a potential indicator for psychosis. During a face-to-face interview on 3/26/19 at 3: 30 PM, Employee# 4 acknowledged the finding.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645	**F645** **Corrective Action for the residents affected:** 1.The facility cannot retroactively correct the deficiency. Resident #262 was reassessed on 4/30/19 Resident #262 did not suffer any negative outcome. Education will be provided to facility staff to ensure that the Level II Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation screening was completed prior to admission.	5/17/19

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F 645	Continued From page 32 and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.	F 645	**F645** **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected 1.Facility MDS Director/Designee, and Social Services Director/ Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to ensure that the Level II Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation screening was completed prior to admission 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to ensure that the Level II Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation screening was completed prior to admission. **Monitoring corrective action:** Facility MDS Director/Designee and Social Services Director/ Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to ensure that the Level II Pre-Admission Screen/ Resident Review for Mental Illness and or Mental Retardation screening was completed prior to admission weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months	5/17/19

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F 645	Continued From page 33	F 645		

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for one (1) of 68 sampled residents, it was determined that facility staff failed to ensure that the Level II Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation screening was completed for Resident #262.

Findings included ...

A review of the Pre-Admission Screening/Resident Review for Mental Illness and or Mental Retardation Level I [PASRR] screen, signed as completed by the facility staff on January 9, 2019, revealed that Resident #262 was identified as positive for major mental disorder Schizophrenia, and a Level II screen is required.

There is no evidence that the facility staff completed the Level II Pre-Admission Screening/Resident Review as indicated from the level I screening.

Facility staff failed to ensure that the Level 2

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F 645	Continued From page 34 Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation was completed for Resident #262 who had a diagnosis of Schizophrenia. A face-to-face interview was conducted with Employee #22 on 3/25/2019 at 9:00 AM after a review of the findings she acknowledged that the level II screening was not done.	F 645		
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 §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.	F 655	**F655** **Corrective Action for the Residents Affected:** 1. The facility cannot retroactively correct the deficiency. Resident #591 was reassessed on 3/21/19 Resident #591 did not suffer any negative outcome. 2. Education will be provided to facility staff to provide the resident and or the resident's representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. Assistant Director of Nursing/Designee will complete house wide assessment/ audit of residents to identify potential residents that facility staff failed to provide the resident and or the resident's representative with a written summary of the baseline care plan within 48 hours after the resident's	5/17/19

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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 655	Continued From page 35 (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 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 68 sampled residents, the facility staff failed to provide the resident and or the resident's representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility. Resident #591. Findings included.... Review of the medical record on 3/21/19 at 12:00 PM showed Resident # 591 admitted to the facility on 3/15/19 with diagnoses to include: Diabetes Mellitus, End Stage Renal Disease, Urinary Tract Infection, and Malignant Neoplasm of Prostate.	F 655	**F655** admission to the facility. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to provide the resident and or the resident's representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility. **Monitoring corrective action:** Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to provide the resident and or the resident's representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility weekly times 4, then monthly times 3months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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	095019	A. BUILDING ____ B. WING ____	03/26/2019

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F 655	Continued From page 36 Review of Resident #591 Face Sheet showed two Primary Contacts listed. A further review of the medical record showed an unsigned baseline care plan dated 3/18/19 the signature line for the resident, the resident's representative, and the facility's designee was blank (the signature indicates that the resident and/or the resident's representative was made aware of the initial goals and approaches to address the resident's care needs and services.) During an interview on 3/21/19 at 1:00 PM, Employee #27 stated, " The resident has a son, the baseline care plan is in the medical record but it's not signed." Also, Employee #27 stated that she was unable to provide insight if the resident or the resident's 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 resident representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility. During a face-to-face interview on 3/21/19 at 1:00 PM Employee# 27 acknowledged the findings.	F 655	**F657** **Corrective Action for the residents affected:** The facility cannot retroactively correct the deficiency. Resident #215 was reassessed on 3/25/19 Resident#215 suffered no negative outcome. 2. Education will be provided to facility staff to revise/update the care plan after Resident hospitalization.	5/17/17
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	F 657	**Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to revise/ update the care plan after resident hospitalization. 2.Any Issue found will be addressed.	

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F 657	Continued From page 38 [illegible] review of Resident [illegible] Data Set [MDS] dated [illegible] a [illegible] Interview for Mental Status [BIMS] with a score [illegible] staff. [illegible] An explanation must be included in a resident's medical [illegible] Care Plan was [illegible] on [illegible]. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or [illegible] staff revised/updated [illegible] including both the comprehensive and quarterly review assessments. [illegible] face interview with Employee #12 on 3/25/19, at 3:15 PM.	F 657	**F657** **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to revise/update the care plan after resident hospitalization **Monitoring corrective action:** Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to revise/ update the care plan after resident hospitalization weekly times 4, then monthly times3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19
	Based on record review and staff interview for one [illegible] facility staff failed to [illegible] care plan after Resident #215's hospitalization. Findings included:			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews for one (1) of 68 sampled residents, facility staff failed to provide necessary services to maintain good grooming (Removal of facial hair from chin) and Activities of Daily Living	F 677	**F677** **Corrective Action for the Residents Affected:** 1. The affected resident #223 was reassessed on 3/19/19. Activities of Daily Living was provided, and facial hair was removed from the resident's chin. Resident #223 suffered no negative outcome. 2. Education will be provided to facility staff to provide necessary services to maintain good grooming (Removal of facial hair from chin) and Activities of Daily Living for the residents.	5/17/19
	Resident #215 was admitted to the facility on 12/04/18, with diagnoses which include Anemia, End Stage Renal Disease, Hypertension, Pneumonia, Diabetes Mellitus, Depression, and Muscle Weakness.			

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F 677	Continued From page 39 for Resident #223. Findings included . . . Resident #223 was admitted to the facility on October 12, 2014. Review of Section I (Active Diagnoses) of the annual assessment dated August 30, 2018 shows diagnoses which include Anemia, Heart Failure, Hypertension, Gastroesophageal Reflux Disease (GERD), Renal Insufficiency, Viral Hepatitis and Diabetes Mellitus. Review of Section C (Cognitive Patterns) of the quarterly Minimum Data Set (MDS) dated January 18, 2019, show the resident with a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact and able to make her own decisions. And, under Section G (Functional Status) - Activities of Daily Living (ADL) the resident was coded as a three (3), which indicated the resident required extensive assistance from staff with ADLs. On March 19, 2019 at approximately 1:21 PM the resident was observed with thick facial hair on her chin. The resident was asked whether she wanted the hair on her chin and she responded, "No". The resident was asked whether she had asked anyone to remove the hair. The resident responded that she did not ask anyone to remove the hair. During a face-to-face interview with Employees' #10 and 25 on March 25, 2019 at approximately	F 677	**F677** **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to provide necessary services to maintain good grooming (Removal of facial hair from chin) and Activities of Daily Living for the resident. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to provide necessary services to maintain good grooming (Removal of facial hair from chin) and Activities of Daily Living for the residents. **Monitoring corrective action:** Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to provide necessary services to maintain good grooming (Removal of facial hair from chin) and Activities of Daily Living for the residents' weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 677	Continued From page 40 2:30 PM both employees stated that the resident was non-compliant with care and said she wanted to keep the facial hair. However, there was no documented evidence that Resident #223's facial hair was addressed in the care plans or the progress notes. Employee #10 acknowledged the finding.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, family and staff interviews for one (1) of 68 sampled residents facility staff failed to honor the resident's preferences and choice of activities to support her psychosocial well-being. Resident # 201. Findings included ... Resident #201was admitted to the facility on 3/7/18 with diagnoses which included: Acute Pancreatitis, Contracture of Muscle, Unspecified Atrial Fibrillation, Chronic Kidney Disease, and Dependent on Renal Disease.	F 679	**F679** **Corrective Action for the Residents Affected:** 1. The affected resident #201 was reassessed on 3/21/19. Resident #201 suffered no negative outcome. 2. Education will be provided to the facility staff to honor the resident's preferences and choice of activities to support her psychosocial well-being. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee, and Director of Therapeutic Activities and Recreation/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to honor the resident's preferences and choice of activities to support his/her psychosocial well-being	5/17/19

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F 679	Continued From page 41 Review of the Admission Record showed the husband listed as the Resident Representative and Emergency Contact # 1 and the resident's daughter is listed as the Emergency Contact #2. Review of the Comprehensive Minimum Data Set [MDS] dated 2/6/19, showed Section A1100 [Language] preferred language "Spanish", which indicates Spanish is resident's preferred language. A1200. Marital Status in the allocated space the code entered is "2" which indicates the resident is married. Section C [Cognitive Patterns]; Brief Interview for Mental Status resident is coded as "99" which indicates resident was unable to complete the interview. Section F [Preferences for Customary Routine and Activities, resident prefers (check all that apply) "family or significant other involvement in care discussions and listening to music" are selected. Observation on 3/21/19 at 1:00 PM showed the posted calendar in the resident's room was in English, additionally the television in the resident's room was on and showing an English speaking channel. Review of Resident # 201's care plan showed Focus: "Frailty indicates the need for soothing bedside programs limited to subtle (visual/auditory/tactile stimulation), provide a daily chronicle in Spanish with list of scheduled activities, location and current events ...all participation will be care tracked and reviewed quarterly." During a family interview on 3/21/19 at 1:30 PM, the writer used interpreter phone services to	F 679	**F679** **.Measures to prevent recurrence:** Staff Development will provide education to the facility staff to honor the residents' preferences and choice of activities to support his/her psychosocial well-being. 2. Any Issue found will be addressed. **Monitoring corrective action:** Assistant Director of Nursing/Designee and Director of Therapeutic Activities and Recreation/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to honor the residents' preferences and choice of activities to support his/her psychosocial well-being, weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3months.	5/17/19

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F 679	Continued From page 42 communicate with the resident's daughter. The daughter was asked if the resident received the daily chronicle in Spanish and if the television had access to Spanish channels or music. The daughter responded, "No, I never see a Spanish paper or anything, and the TV is English ask my father, is always here, and he will be here later today." During a family interview on 03/21/19 at 4:00 PM, the writer used interpreter phone services to communicate with the resident's husband. The husband stated, "Everything is in English. I told them the television stopped showing Spanish TV. They don't give us anything in Spanish." Additionally, the resident's husband was shown the Spanish Chronicle and he stated, "Never saw that before." During an interview on 3/21/19 at 4:20 PM, Employee# 6 was shown the posted calendar that was in English and he was asked about the daily Spanish Chronicle. Employee #6 stated, "My assistant gives the Spanish Chronicle to the resident every day here is a copy, and they should have the Spanish television package." Although Employee #6 was present during the interview with Resident #210's husband, he could not offer any additional insight into the matter. On 3/21/19 at 4:30 PM Employee #28, Engineer, came to the room and he was observed to go through all the television channels multiple times and stated, "There must be a problem. No, I don't see a Spanish channel. I will go and correct the problem." Facility staff failed to honor resident's preferences	F 679		

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F 679	Continued From page 43 and choice of activities to support the resident's psychosocial well-being. During a face-to-face interview on 3/21/19 at 4:20 PM Employee# 6 acknowledged the findings.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility staff failed to administer oxygen in accordance with the physician's order for one (1) of 68 sampled residents. Resident #53. Findings included ... Resident #53 was admitted to the facility on June 12, 2018, with diagnoses that included Chronic Obstructive Pulmonary Disease, Heart Failure, Hypertension, and Atrial Fibrillation. During an observation on 03/20/19 at approximately 10:40 AM, the dial on Resident # 53's oxygen concentrator was observed to be set at 3 liters.	F 684	**F684** **Corrective Action for the Residents Affected:** 1. The affected resident #53 was reassessed on 3/20/19. Resident #53 suffered no negative outcome. 2. Education will be provided to the facility staff to administer oxygen per the physician's order. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to administer oxygen following physician's order. 2. Any issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to administer oxygen following physician's order.	5/17/19

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F 684	Continued From page 44 Review of the March 2019 physician's order on 03/20/19 at 10:45 AM showed Resident #53 was to receive "Oxygen at 2 liters via nasal cannula". During a face-to-face interview on 03/20/19 at 10:50 AM, Employee #23 acknowledged the finding.	F 684	**Monitoring corrective action:** Assistant Director of Nursing/Designee will complete house wide assessment / audit of residents to identify potential residents that facility staff failed to administer oxygen following physician's order weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
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 observations and interview, facility staff failed to provide an environment free from accident hazards as evidenced by privacy curtains that were attached to an electrical power cord in one (1) of 56 resident's rooms. Findings included ... During an environmental tour of the facility on March 19, 2019, between 9:07 AM and 2:30 PM, Privacy curtains to Bed (A) and Bed (B) in resident room #502 were tied to the power cord to Bed (B) with strands of cloth, one (1) of 56 resident's rooms surveyed. This practice presented an electrical safety hazard to residents, staff and visitors.	F 689	**F689** **Corrective Action for the Residents Affected:** 1. The affected resident room #502 was reassessed on 3/19/19. Privacy curtains to Bed (A) and (B) were detached from the electrical power cord in resident's room #502. 2. Education will be provided to the facility staff to provide an environment free from accident hazards. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Director of Housekeeping/Designee will complete house wide assessment /audit of residents' rooms to Identify potential residents' room privacy curtains that were attached to an electrical power cord. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to provide an environment free from accident hazards, by ensuring that privacy curtain are not attached to the electrical power cord in residents' rooms. **Monitoring corrective action:** 1. Director of Housekeeping/Designee will complete house wide assessment /audit of residents' rooms to identify potential	5/17/19

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F 689	Continued From page 45 During a face-to-face interview on March 20, 2019, at approximately 11:30 AM, Employee #14 and Employee #15 acknowledged these findings.	F 689	residents' room privacy curtains that were attached to an electrical power cord weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced Based on observation, record review and staff interview,the facility staff failed to ensure the filter of an oxygen concentrator was free of dust for one (1) of 68 sampled residents. Resident #53. Findings included ... Resident #53 was admitted to the facility on 6/12/18, with diagnoses that included Chronic Obstructive Pulmonary Disease, Heart Failure, Hypertension and Atrial Fibrillation. On 03/20/19 at 10:40 AM, during an observation of Resident #53, it was noted that the resident's oxygen concentrator filter was covered with dust. A review of the physician's order on 03/20/19 at 10:45 AM showed Resident #53 was to receive "oxygen at 2 liters per minute via nasal cannula	F695	**F695** **Corrective Action for the Residents Affected:** 1.The affected resident #53 was reassessed on 3/20/19. 2. Oxygen Concentrator filter was cleaned on 3/20/19. Resident #53 suffered no negative outcome. 2. Education will be provided to the facility staff to ensure oxygen concentrator filters are clean and free of dust. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment / audit of residents to identify potential residents that facility staff failed to ensure the oxygen concentrator filter is free of dust. 2. Any Issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to ensure oxygen concentrator filters are clean and free of dust. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide assessment / audit of residents to identify potential residents that facility staff failed to ensure the oxygen concentrator filter is free of dust weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months	5/17/19

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F 695	Continued From page 46 continuously for short[sic] of breath ...rinse O2 (oxygen) filter with H20 (water), pat dry and replace." During a face-to-face interview on 03/20/19 at 10:50 AM, Employee #23 acknowledged the finding.	F 695		
F 740 SS=D	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 medical record review and staff interview for one (1) of 68 sampled residents, facility staff failed to monitor and consistently document Resident# 258's aggressive/delusional behavior and to obtain necessary services to address the resident's behavioral health care needs. Findings included ....: Resident# 258 was admitted to the facility on 2/11/19, a review of the admission record showed the following diagnoses Anemia Unspecified,	F 740	**F740.** **Corrective Action for the Residents Affected:** The affected resident #258 was reassessed on 3/20/19 Resident #258 suffered no negative outcome. 2. Education will be provided to the facility staff to ensure monitoring and consistently documenting on resident's aggressive/delusional behavior as it occurs and to obtain necessary services to address the resident's behavioral health care needs. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment/audit of residents to identify potential residents that facility staff failed to monitor and consistently documenting on residents' aggressive/ delusional behavior and to obtain necessary services to address the resident's behavioral health care needs. 2. Any issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to ensure that staff are monitoring and consistently documenting on residents' aggressive/delusional behavior and to obtain necessary services to address the resident's	5/17/19

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F 740	Continued From page 47 Dementia in Other Diseases Classified without Behavioral Disturbance, Delusional Disorders, Unspecified Psychosis and, Heart Failure. Review of the Comprehensive Nursing Home Minimum Data Set [MDS] dated 2/18/19, showed Section C-Cognitive Patterns: Brief Interview for Mental Status [BIMS] resident was scored as "99" which indicate the resident was not able to complete the interview. Section D [0100]- Mood was coded a 0 to indicate resident's mood interview was not conducted (resident is rarely/never understood). Section E [0100] Potential indicators of psychosis allocated box is marked X none of the above to indicate no behaviors of psychosis exist (hallucinations or delusions). Review of the physician's progress note dated 2/19/19, showed, "Patient has no history of mental illness but is on Risperidone and Lorazepam for agitations and behavioral problems with periods of delirium." Review of the nurse's note dated 2/25/19 showed "Interdisciplinary team met, resident has a history of Dementia with behavioral disturbance, history of agitation and resident made a statement that "he will punch them if they touch him" resident will be on behavior monitor list for aggressive behavior to know the number of daily occurrences ...as care plan was revised and reviewed and it is appropriate at this time." Review of the nurse practitioner progress note dated 2/25/19 "nurse reported that patient was in the dining room yesterday very agitated ....delusions, agitation and dementia, recently seen by psychiatrist and started on Risperdal	F 740	**F740** behavioral health care needs. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to monitor and consistently documenting on residents' aggressive/ delusional behavior and to obtain necessary services to address the resident's behavioral health care needs weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 740	Continued From page 48 (antipsychotic medication), on Ativan 0.5 mg that was increased to 1mg." Review of the physician's progress note dated 2/26/19 "resident has been seen for another evaluation since he is still out of control toward staff delusional as well as not being able ale to sleep at night, recently resident has been quite combative ...Altered Mental Status and delusions still present with aggressive behavior. Review of physician's note date 3/14/19, showed "resident was seen for another evaluation he is still out of control aggressive toward staff and delusional ...according to staff he is very delusional, resident states yesterday he was on his way home he was mugged by two men they wanted money and he had to fight, stated he had to knock one out of the cloud, Altered Mental Status and delusions still present with aggressive behavior." Review of the March 2019 Treatment Administration Record (TAR) showed staff documented "no" to indicate resident did not display aggressive or agitated behaviors. On 3/25/19 at 2:00 PM a review of the resident's care plan with an initiation date of 3/25/19 showed "problematic manner in which resident acts characterized by ineffective coping agitation ...Intervention: behavior monitor and daily documentation, behavior monitoring every shift, initiate Behavior Management Consult." During an interview on 3/25/19 at 3:00 PM, Employee #7 was asked for the daily behavior monitoring sheets and for the behavioral consult. Employee responded " I don't have any sheets to	F 740		

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F 740	Continued From page 49 show you, and I will put in the referral now for the behavioral management consult." Facility staff failed to monitor and document resident's behavior daily and to initiate a behavioral management consult for a resident with aggressive and delusional behaviors. During a face-to-face interview on 3/25/19 at 3:00 PM Employee #7 acknowledged the findings.	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755	**F755** **Corrective Action for the Residents Affected:** 1. The affected Resident #166 was reassessed on 3/25/19 Resident #166 suffered no negative outcome. 2. Education will be provided to the facility staff to ensure resident's routine medication is ordered in a timely manner and available for resident use or when requested by the resident **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment / audit of residents to identify potential residents that facility staff failed to have residents' routine medication available for their use and when requested. 2. Any issue found will be addressed **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to ensure that residents' routine medication is available for residents use and	5/17/19

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F 755	Continued From page 50 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview for one (1) of 68 sampled residents, facility staff failed to have Resident #166's routine medication available for her use when she requested it. Findings included . . . Resident #166 was admitted to the facility on October 25, 2017, with diagnoses which include Coronary Artery Disease (CAD), Deep Vein Thrombosis (DVT), Hypertension, Schizophrenia, Post Traumatic Stress Disorder (PTSD) and Asthma. Review of the annual Minimum Data Set (MDS) dated November 01, 2018 shows the resident with a score of 15/15 on the Brief Interview for Mental Status in Section C (Cognitive Pattern). According to the "MDS 3.0 User's Manual", page C-14, a score of '13-15" suggests that the resident is cognitively intact. According to Section G of the MDS (Functional Status) Activities of Daily Living, the resident is assessed as requiring supervision for bed mobility, transfers, ambulation, eating, toilet use and personal hygiene and totally independent for bathing.	F 755	when requested by the residents **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to have residents' routine medication available for use and when requested by the residents; weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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On March 25, 2019 at approximately 3:30 PM Resident #166 informed this writer that she did not receive her Hydroxyzine when she requested it at around 10:00 PM last night (March 24, 2019).

A review of the current physician 's orders show Hydroxyzine HCL tablet 50mg one tablet to be administered by mouth in the evening for Insomnia. Initial order date of medication May 9, 2018. Review of the Medication Administration Record (MAR) for March 2019 showed that the resident received the medication March 01, through March 23, 2019. The resident did not receive the medication on March 24, 2019.

According to the resident's account she usually requests and receives 50mg of Hydroxyzine around 10:00 PM every night. On last night March 24 she requested the medication but did not receive it. Employee #17 told her there was no Hydroxyzine in her medication drawer, but she would get her a dose of the medication from upstairs (the Omnicell-an automatic medication dispenser. It is used to store medications that can be used in an emergency). According to the resident the nurse told her she would get her a dose of the Hydroxyzine and went upstairs to get 50mg of Hydroxyzine from the Omnicell. Upon her return the nurse gave her a pill that she did not recognize and she did not take it.

A review of the Resident's electronic medical record showed the following list of the medications administered to the resident between

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9:00 and 10:00 PM on March 24, 2019. The medications were provided by Employee #16 and reconciled with the medications that the resident received (according to the Medication Administration Record (MAR). The medications that were administered to the resident were:

Prosource 600 ml
Albuterol Sulfate Nebulization
Benzotropine 1mg
Oxycodone HCL 10mg
Metoprolol 25mg
Senna - Docusate
Aricept 10mg
Seroquel 100 mg
Gabapentin
Lyrica 200 mg

Hydroxyzine was charted as two (2) in the designated box (which according to the Follow up Codes is an indication that the medication was refused).

At approximately 11:30 AM on March 25, 2019 a review of Resident #166's medication drawer on the medication cart did not show any 50mg doses of Hydroxyzine. However, a single 25mg Hydroxyzine tablet was noted in an unidentified upper drawer on the cart that was not assigned to a resident.

A face-to-face interview was conducted with Employee #10 at the time of the observation 11:30 AM on March 25, 2019. Employee #10 stated that they kept the 25mg of Hydroxyzine on the unit in case the resident decided to take it.

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The employee also added that the medication has been reordered and will be in the facility by this evening.

A face-to-face interview was conducted with Employee #17 at approximately 10:00 AM on March 26, 2019. The employee stated that she was not aware that the resident did not have any Hydroxyzine until the resident requested it and she went to administer it. The employee added that she reordered the medication before she left the facility at 8:00 AM on 3/25/19.

Facility's policy titled "Medication Ordering and Prescribing Reorders" Policy 4.2 Page 1 of 2 (no date documented) was reviewed on March 25, 2019. Under the heading of Procedure: Reorder of Routine Medication, item number 1 states "Nurse will examine supply of remaining medication to ascertain when a reorder/ refill is needed for the resident. As a guideline, reorder medications when a four-day supply remains."

A review of the drawer that contains Hydroxyzine on the Omnicell was empty (contained no Hydroxyzine). During an interview on March 25, 2019 at approximately 12:00 PM (following the observation) with Employee #18 he acknowledged that there was no Hydroxyzine on the Omnicell and that the Pharmacy only refills the Omnicell on Fridays. Employee #18 added that the last 50mg dose was removed during the evening on March 24, 2019 for Resident #166.

Facility staff failed to have Resident #166' routine

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F 755	Continued From page 54 medication available to be administered when the resident requested it. Employee #10 acknowledged the finding during a face-to-face interview at 10:30 AM on March 26, 2019.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756	**F756** **Corrective Action for the Residents Affected:** 1.The affected Resident #105 was reassessed on 3/26/19. Resident #105 suffered no negative outcome. 2. The affected Resident #173 was reassessed on 3/26/19. Resident #173 suffered no negative outcome. 3. A meeting will be held with the facility's physicians to ensure that the physicians document rationale if they disagreed with the pharmacy consultant's recommendations to evaluate residents' medication for a gradual dose reduction (GDR). **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that the physicians failed to document rationale when they disagreed with the pharmacy consultant's recommendation to evaluate residents' medication for a gradual dose reduction (GDR). 2. Any issue found will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to make sure that physicians document rationale when they disagreed with	5/17/19

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F 756	Continued From page 55 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 68 sampled residents, facility staff failed to respond to a request from the pharmacist to evaluate one (1) resident's Trazadone and Seroquel and one (1) resident's Zoloft medication for a gradual dose reduction (GDR). Residents' #105 and #173. Findings included... 1. Facility staff failed to respond to a request from the pharmacist to evaluate Resident #105's Trazadone (used to treat bedtime insomnia) and Seroquel medication for a gradual dose reduction (GDR). Resident #105 was admitted to the facility on June 21, 2018, with diagnoses, which included Chronic Pancreatitis, Diabetes Mellitus, Hypertension, Hyperlipidemia, and Depression Disorder. A review of the Quarterly Minimum Data Set [MDS] dated 1/4/19 showed Section C: Cognition; Brief Interview for Mental Status [BIMS] scored as "15" which indicates the resident is cognitively	F 756	the pharmacy consultant's recommendation to evaluate residents' medication for a gradual dose reduction (GDR). **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide assessment / audit of residents to identify potential residents that the physicians failed to document rationale when they disagreed with the pharmacy consultant's recommendation to evaluate residents' medication for a gradual dose reduction (GDR); weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 756	Continued From page 56 intact . A review of the physician's orders and the Medication Administration Records from January 2019 to present showed that Resident #105 was ordered and received Trazadone (used to treat bedtime insomnia) 150mg one time a day (since 9/7/18), Trazodone increased to 300mg for bedtime insomnia on 2/12/19. Seroquel 25mg at bedtime for insomnia (since 1/4/19 to present). A review of the Pharmacy Consultant drug regimen review documentation from October 11, 2018, to present, showed the following, "please evaluate hs (bedtime) trazodone for GDR (dated 10/11/18), Please clarify Seroquel insomnia decrease (dated 2/1/19), and Trazadone increased to 300mg please evaluate increased dose and Seroquel use (dated 3/6/19)." A review of the Medication record from October 2018 to present, lacked evidence that the drug regimen review related to the use of antipsychotic, antidepressant and antidepressant/sedative medications for Resident #105 requested by the pharmacy for consideration of gradual dose reduction was not responded to by the facility. Facility staff failed to respond to and act on the Pharmacy consultant's drug regimen review irregularities for October 11, 2018, November 2, 2018, and February 1, 2019, mentioned above with the documented rationale for not reducing the dosage of the medications or stipulated why doing so would be detrimental to the resident's well-being.	F 756		

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A face-to-face interview was conducted on March 26, 2019, with Employee #20 at approximately 9:30 AM. He acknowledged the findings and stated, "we do not always receive the pharmacy reviews."

2. Facility staff failed to respond to a request from the pharmacist to evaluate resident #173's Zoloft medication for a gradual dose reduction (GDR).

Resident #173 was admitted to the facility on 11/14/15 with diagnoses which include: Heart Failure, Hypertension, Depression, Viral Hepatitis, Diabetes Mellitus and Seizure Disorder. Quarterly Minimum Data Set [MDS] dated 1/31/19 showed Section C: Cognition; Brief Interview for Mental Status [BIMS] scored as "11" which indicates moderate cognitive impairment.

The resident was receiving medications to include Sertraline (Zoloft) HCl tablet 100mg one time a day for depression.

Review of the March Medication Record showed "Sertraline HCl tablet 100mg give one tablet by mouth one time a day for Depression."

The pharmacist reviewed the resident medications on 1/7/19 and wrote the following "Please evaluate Zoloft for a GDR (gradual dose reduction) ..."

Review of the medical record failed to show evidence of the physician's review of the pharmacist recommendation.
During an interview on 3/26/19 at 3:30 PM Employee# 2 stated "here is the form (presented a blank form without the pharmacist

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F 756	Continued From page 58 recommendation) I have it, no I did not send it to the doctor, yet." Facility staff failed to provide evidence of the physician's review of the pharmacist recommendation to evaluate Zoloft for a GDR. During a face-to-face interview on 3/26/19 at 3:30 PM Employee# 2 acknowledged the finding.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761	**F761** **Corrective Action for the Residents Affected:** 1. The affected resident #53 was reassessed on 3/20/19. Resident #53 suffered no negative outcome. 2. Education will be provided to facility staff to ensure resident's metered dose inhaler is safely stored in it appropriate manufacturer box. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete a house wide assessment /audit of residents to identify potential residents that facility staff failed to ensure residents' metered dose inhalers are safely stored in their appropriate manufacturers boxes. 2. Any issue found will be addressed **Measures to prevent recurrence:** Staff Development will provide education to the facility staff to ensure that resident's metered dose inhalers are safely stored in their appropriate manufacturers boxes. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of	5/17/19

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F 761	Continued From page 59 by: Based on observation, and interview the facility's staff failed to ensure metered dose inhalers Pulmicort (treatment of lung disease) and Spiriva Respimat (treatment of lung disease) were safely stored for one (1) of 68 sampled residents Resident #53. Findings included ... Resident #53 was admitted to the facility on June 12, 2018 with diagnoses that included Chronic Obstructive Pulmonary Disease, Heart Failure, Hypertension and Atrial Fibrillation. On 03/20/19 at 10:45AM, Employee # 23 was observed administering the medication to Resident #53. During the observation, it was noted that Pulmicort 180 mcg inhaler was stored in a manufacturers box labeled as Spiriva Respimat 2.5 mcg inhaler and Spiriva Respimat 2.5 mcg inhaler was stored in the manufacturers box labeled as Pulmicort 180 mcg inhaler. The facility's staff failed to ensure Resident #53's metered dose inhalers were safely stored in their appropriate manufacturers boxes. During a face-to-face interview on 03/20/19 at 11:30 AM, Employee # 23 acknowledged the findings.	F 761	residents to identify potential residents that facility staff failed to ensure residents' metered dose inhalers are safely stored in their appropriate manufacturers boxes; weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months **F812** **Corrective Action for the Residents Affected:** 1. This deficiency was reassessed and corrected on 3/18/19. All sheet pans were washed, rinsed and sanitized then stored individually to dry before placing on the ready to use shelf. Education will be provided to facility staff to ensure that all sheet pans are washed, rinsed and sanitized, then stored individually to dry before placing on the ready to use shelf. No resident suffered any negative outcome. 2. This deficiency was reassessed on 3/18/19 and corrected. One case of the evaporated milk with a "Best By " date of February 28,2017 was discarded and replaced with a new case of evaporated milk on 3/18/2019. No resident suffered any negative outcome. Education will be provided to facility staff to ensure that food items stored for emergency use are not expired and should constantly be checked for expiration. 3. The facility cannot retroactively correct. The test tray of Puree food dishes conducted on 3/20/19. No resident suffered any negative outcome. Education will be provided to ensure that food is preserved at the recommended temperature.	5/17/19
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	**Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected.	

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F 812	Continued From page 60 §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 staff interview, facility staff failed to store, prepare, distribute and serve foods under sanitary conditions as evidenced by fifteen of nineteen nine-inch sheet pans that were stored wet and ready for use, one (1) of one (1) case of evaporated milk with a "Best By" date of February 2017, stored for use as emergency food, and three (3) of four (4) puree food dishes that tested at less than 135 degrees Fahrenheit (F) from the test tray. Findings included ... 1. Fifteen of nineteen nine-inch sheet pans were stored wet, on a ready-for-use shelf.	F 812	Any issue found will be addressed. 2. The Food Service Director, Assistant Director and Lead Dietitian/ Designee will complete house wide assessment /audit of all food supplies/items stored for emergency used to identify potential food supplies/items with expired dates. Any issue found will be addressed. 3. The Food Service Director, Assistant Director will conduct a random assessment/audit of completed test trays to identify potential food trays that are served below required temperatures. Any issue found will be addressed **Measures to prevent recurrence:** Staff Development will provide education to facility Food and Nutrition Services to ensure that: 1. All sheet pans are washed, rinsed and sanitized and stored individually to dry before placing on the ready to use shelf. 2. All food items stored for emergency use are rotated and inspected for expired dates. 3. Food is served at the recommended temperature. **Monitoring corrective action:** 1. The Food Service Director/Assistant Director/ Dietitians will complete house wide assessment /audit of sheet pans to identify potential sheet pans that are stored wet, on a ready-to-use shelf; weekly times 3, and then monthly times 3. Findings will be reported to the Quality Assurance and Performance Improvement Committee monthly for the next 3 months. 2. The Food Service Director, Assistant Director and Dietitians will complete house wide assessment /audit of all food supplies/items stored for emergency used to identify potential food supplies/items with expired dates weekly	5/17/19

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F 812	Continued From page 61 2. One (1) of one (1) case of evaporated milk with a "Best By" date of February 28, 2017, was stored for use as an emergency food item. 3. Puree food dishes such as beef (129 degrees F), vegetables (119 degrees F), and bread (117 degrees F) were below 135 degrees F during a test tray assessment on March 19, 2019, at approximately 2:00 PM. During a face-to-face interview on March 18, 2019, at approximately 11:00 AM, Employee #13 acknowledged these findings.	F 812	**F812** times 3, and then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months. 3. The Food Service Director, Assistant Director will conduct a random assessment/audit of completed test trays to identify potential food trays that are served below required temperatures weekly times 3, and then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F 880	**F880** **Corrective Action for the Residents Affected:** 1.The affected Resident # 591 was reassessed on 3/25/19. Resident suffered no negative outcome. Education will be provided to facility staff to maintain infection control practices by wearing appropriate PPE when providing Foley catheter care to a resident with VRE in the urine. 2. The identified two (2) of two (2) blade guards of electrical fans in use in the clean laundry area, were cleaned on 3/20/19. Education will be provided to facility Maintenance and Housekeeping staff to ensure that electrical fans in use in the clean laundry area are always cleaned and free of dust. 3. The identified Four (4) of four (4) exhaust vents located in the clean area of the laundry room were cleaned on 3/20/19. Education will be provided to facility Maintenance and Housekeeping staff to ensure that exhaust vents located in the clean area of the laundry room are clean and free of dust.	5/17/19

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F 880	Continued From page 62 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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	F 880	4. The affected sheet pans were reassessed and corrected on 3/18/19. All sheet pans were washed, rinsed and sanitized and then stored individually to dry before placing on the ready for use shelf on 3/18/2019. Education will be provided to facility staff to ensure that all sheet pans are washed, rinsed, sanitized and stored individually to dry before placing on the ready for use shelf. No resident suffered any negative outcome. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to maintain infection control standard of practices by failing to use appropriate personnel protective equipment (PPE) when providing Foley catheter care for resident with VRE in the urine. Any issue found will be addressed. 2.The Director of Maintenance and Director of Housekeeping services will complete house wide assessment /audit of electrical fans in use in the facility to identify potential blade guards for electrical fans in use that are soiled with dust. Any issue found will be addressed. 3. The Director of Maintenance and Director of Housekeeping services will complete house wide assessment /audit of exhaust vents in use in the facility to identify potential exhaust vents that are soiled with dust. Any issue found will be addressed. 4. The Food Service Director, Assistant Director and Lead Dietitian/ Designee will complete house wide assessment /audit of sheet pans to identify potential sheet pans that	5/17/19

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F 880 Continued From page 63

infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

Based on observation, medical record review and staff interview for one (1) of 68 sampled residents facility staff failed to maintain infection control standard of practicice by failing to use approriate personnel protective equipment (PPE) when providing Foley catheter care for Resident # 591 with Vancomycin-Resistant Enterococcus (VRE) in the urine and to ensure that laundry items are handled, stored, and processed in a sanitary manner as evidenced by two (2) of two (2) soiled electrical fans, in use in the clean laundry area, four (4) of four (4) soiled exhaust vents, and fifteen of nineteen nine-inch sheet pans that were stored wet and ready for use.

Findings included...

According to the Center for Disease Control [CDC] Guidelines for preventing spread of VRE

"Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.
Donning gown and gloves upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination."

F 880

F880 — 5/17/19

are stored wet on the ready for use shelf.
Any issue found will be addressed.

Measures to prevent recurrence:

1.Staff Development will provide education to facility staff to maintain infection control practices by wearing appropriate PPE when providing Foley catheter care to a resident with VRE in the urine.
2. Staff Development will be provided to facility Maintenance and Housekeeping staff to ensure that the blade guards of the electrical fans in use in the clean laundry area are clean and free of dust.
3. Staff Development will provide education to facility Maintenance and Housekeeping staff to ensure that exhaust vents located in the clean area of the laundry room are clean.

4. Staff Development will provide education to facility Food and Nutrition Services to ensure that all sheet pans are washed, rinsed, sanitized and stored individually to dry before placing on the ready to use shelf.

Monitoring corrective action:

1 Assistant Director of Nursing/Designee will complete house wide assessment / audit of residents to identify potential residents that facility staff failed to maintain infection control standard of practices by failing to use appropriate personnel protective equipment (PPE) when providing Foley catheter care for resident with VRE; weekly times 4, then monthly times 3 months.

2. The Director of Maintenance and Director of Housekeeping services will complete house wide assessment /audit of electrical fans in use in the facility to identify potential blade guards for electrical fans in use that are soiled with dust; weekly times 4,

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F 880	Continued From page 64 Retrieved from: https://www.cdc.gov/infectioncontrol/guidelines/mdro/prevention-control.html 1. Resident # 591 admitted to the facility on 3/15/19 with diagnoses which include: Malignant Neoplasm of the Prostate, End Stage Renal Disease, and Urinary Tract Infection. Review of the medical record nurse practitioner note dated 3/21/19 showed " resident was admitted to the facility with a diagnosis of VRE in the urine, completed Fosfomycin (antibiotic) but hospital faxed new orders on 3/21/19 that treatment was not sensitive to Fosfomycin and to start patient on Zyvox (antibiotic) patient has Foley catheter." Review of nurse administration order note dated 3/25/19 showed "empty drainage bag every shift as needed (record amount on Treatment Administration Record every shift)." Review of the care plan dated 3/18/19 showed "focus; use of indwelling urinary catheter due to disease process, interventions catheter care as medical doctor orders, provide and change as needed "dignity bag" for collection bag." Observation on 3/25/19 at 11:30 AM showed resident lying in bed with a Foley catheter bag concealed with a light blue covering and the bag was attached to the lower end of the resident' s bed. Upon entering the resident's room writer did not observe a PPE station, or evidence gowns were being worn by staff providing care.	F 880	**F880** then monthly times 3 months. 2. The Director of Maintenance and Director of Housekeeping services will complete house wide assessment /audit of electrical fans, in use in the facility to identify potential blade guards to electrical fans, in use that are soiled with dust weekly times 4, then monthly times 3 months . 3. The Director of Maintenance and Director of Housekeeping services will complete house wide assessment /audit of exhaust vents, in use in the facility to identify potential exhaust vents that are soiled with dust weekly times 4, then monthly times 3 months. 4. The Food Service Director/Assistant Director /Dietitians will complete house wide assessment /audit of sheet pans to identify potential sheet pans that are stored wet, on a ready-for-use shelf; weekly times 3, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5/17/19

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F 880	Continued From page 65 During an interview on 3/25/19 at 1:00 PM, Employee# 7 was asked about the resident testing positive for VRE in the urine and how the staff provides Foley catheter care for the resident. Employee# 7 stated " the staff wear gloves empty the Foley bag, document the output, clean the catheter tubing and wash their hands, should they do something else"? Employee #7 stated, "no the staff do not wear gowns when they are providing Foley catheter care". Facility staff failed to maintain infection control practices by failing to wear PPE when providing Foley catheter care to a resident with VRE in the urine. During a face-to-face interview on 3/25/19 at 1:00 PM, Employee# 7 acknowledged the findings. 2. During observations in the laundry room on March 20, 2019, at approximately 11:00 AM, blade guards to two (2) of two (2) electrical fans, in use in the clean laundry area, were soiled with dust throughout. This could potentially expose clean laundry, including resident's personal clothing, to scattered dust particles. 3. Four (4) of four (4) exhaust vents located in the clean area of the laundry room were soiled with dust. 4. During a walkthrough of the kitchen on March 18, 2019, at approximately 9:00 AM, Fifteen of nineteen nine-inch sheet pans were stored wet, on a ready-for-use	F 880	**F908** **Corrective Action for the Residents Affected:** The affected door gaskets to two (2) of two (2) steamers that were worn, torn, and damaged in the dietary services were corrected on 3/26/19 Education will be provided to the facility staff to ensure that all mechanical, electrical and patient care equipment are in safe operating condition. No resident suffered any negative outcome. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. The Director of Food service will complete house wide assessment /audit of all steamers door gaskets to identify	5/17/19

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F 880	Continued From page 66 shelf. This practice could lead to bacterial growth on the surfaces of the sheet pans, potentially subjecting resident's meals to contamination. During a face-to-face interview on March 20, 2019, at approximately 11:30 AM, Employee #14 acknowledged these findings.	F 880	**F908** potential door gaskets that are worn, torn, and damaged. Any issue found will be addressed. **Measures to prevent recurrence:** 1.Staff Development will provide education to Food service to ensure that al door gaskets, mechanical, electrical and patient care equipment in safe operating condition.	5/17/19
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, facility staff failed to maintain essential equipment in safe condition as evidenced by torn and worn door gaskets from two (2) of two (2) steamers in Dietary Services. Findings included ... During a walkthrough of the kitchen on March 20, 2019, at approximately 9:00 AM, door gaskets to two (2) of two (2) steamers were worn, torn, and damaged. During a face-to-face interview on March 20, 2019, at approximately 11:30 AM, Employee #13 and/or Employee #14 acknowledged these findings.	F 908	**Monitoring corrective action:** The Director of Food Service will complete house wide assessment /audit of all steamers door gaskets to identify potential door gaskets that are worn, torn, and damaged; weekly times 3, then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	