STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at Serenity Rehabilitation and Health Center from August 26, 2019, through September 3, 2019. Survey activities consisted of a review of 70 sampled residents. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CPR- Cardiopulmonary Resuscitation CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - Deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)	F 000	**SERENITY REHABILITATION AND HEALTH 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.	11/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE LNHA

(X6) DATE 11/1/19

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 G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes	F 567	**F567** **Corrective Action for the Residents Affected:** This facility cannot retroactively correct the deficiency.	**11/22/19**

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F 567	Continued From page 2 the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on review of the facility's trial balance and	F 567	The affected Residents # 7, #14, # 17, # 32, # 37, # 38, # 63,# 65,# 94, # 108, # 119,and # 157 were re-assessed on 9/3/19.Written authorization/signatures were obtained from the affected Residents giving the facility permission to act as a fiduciary of the residents' funds The Residents 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.The Business Office Manger/ Designee will complete house wide audit of residents to identify potential resident who facility staff failed to ensure that residents who chose to deposit personal funds with the facility, completed a written authorization form giving the facility permission to act as a fiduciary of the residents' funds. 2. Any issues found during the audit will be addressed. **Measures to Prevent Recurrence** The facility Business office manager and staff will be in-serviced by Staff Development on importance of ensuring that residents who chose to deposit personal funds with the facility, completed a written authorization form giving the facility permission to act as a fiduciary of the residents' funds	11/22/19

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F 567	Continued From page 3 staff interview, for 12 of 138 sampled residents with personal fund accounts, facility staff failed to ensure that residents who chose to deposit personal funds with the facility, completed a written authorization form giving the facility permission to act as a fiduciary of the residents' funds. Findings included ... Review of the facilities trial balance showed the following residents had asterisk (*) next to their names indicating that the residents' application is missing. The residents, however, had transferring accounts (automatic transfer of care cost payments due the facility): Resident # 7 Resident #14 Resident # 17 Resident # 32 Resident # 37 Resident # 38 Resident # 63 Resident # 65 Resident # 94 Resident # 108 Resident # 119 Resident # 157 A face-to-face interview was conducted with Employee #38, Business Office Representative, on September 3, 2019, at approximately 12:00 PM. She stated the missing application is the "Resident Fund Management Service Authorization and Agreement to Handle Resident Funds" form. The resident also signs an	F 567	**Monitoring Corrective Action** The Business Office Manger/ Designee will complete house wide audit of residents to identify potential resident who facility staff failed to ensure that residents who chose to deposit personal funds with the facility, completed a written authorization form giving the facility permission to act as a fiduciary of the residents' funds 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.	11/22/19

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F 567	Continued From page 4 "Authorization Agreement for Direct Deposit" form that gives the facility permission to route the residents' social security income to the facility. Employee #38 also acknowledged that there were no authorization forms on file permitting the facility to handle the residents' funds.	F 567		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review for one (1) of 70 sampled residents, facility staff failed to ensure that Resident #112 was free from staff verbal abuse. Findings included ... Prohibition of Abuse Policy: " ...Residents must not be subjected to abuse by	F 600	**F600** **Corrective Action for the Residents Affected:** The affected Resident # 112 was Reassessed on 8/30/19.The facility obtained a written statement of the incident from the affected resident on 10/10/19. The affected 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.The Director of Social Service/Designee will complete house wide audit of residents to identify potential resident who facility staff failed to ensure freedom from staff verbal abuse. 2. The Director of Social Service/Designee will complete house wide audit of residents to identify potential resident who facility staff failed to obtain written statement of the incident from Resident during an investigation. 3. Any issues found during the audit will be addressed.	11/22/19

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F 600	Continued From page 5 anymore, including, but not limited to facility staff ... Verbal abuse- is the of oral, written or gestured language, that willfully includes disparaging and derogatory terms to a resident or their families or within their hearing distance ..." During an interview with Resident #112 on 8/26/19, at 04:08 PM the resident stated that a Certified Nursing Assistant (CNA)/Employee #39 spoke to him rudely a few days ago while providing care with activities of daily living. He cannot remember the date but he reported the matter to the nurse and "someone told me they walked her for a few days. She has not come back." Resident #112 was admitted to the facility on 10/6/16, with diagnoses to include Atrial Fibrillation, Peripheral Vascular Disease, Gout, Hypertension, Diabetes Mellitus, Osteoarthritis, Hyperlipidemia, Heart Failure, Seborrheic Dermatitis, and Age-related Nuclear Cataract. Review of Resident #112 annual Minimum Data Set [MDS] dated 7/24/19 showed Section C [Cognitive Patterns] the resident had a Brief Interview for Mental Status [BIMS] with a score of "15" which indicate she was cognitively intact. Section G 0110 ADL [activity of daily living] and under toileting, the resident was totally dependent on staff. A review of the documentation of the incident presented by the facility on 8/26/19 showed Resident reported an alleged verbal abuse that Employee #39 spoke to him using derogatory language describing in detail the employee's statement. The incident was reported to the state, after completion of the investigation the facility concluded that the incident could not be	F 600	**F600** **11/22/19** **Measures to Prevent Recurrence** **1**.Staff Development will provide in-service to facility staff on Resident Freedom from Abuse and Neglect. **2**. Staff Development will provide in-service to facility staff on importance of obtaining written statement of the incident from Resident during an investigation. **Monitoring Corrective Action** **1**.The Director of Social Service/Designee will complete house wide audit of residents to identify potential resident who facility staff failed to ensure freedom from staff verbal abuse weekly times 4, then monthly times 3 months. **2.**The Director of Social Service/Designee will complete house wide audit of residents to identify potential resident who facility staff failed to obtain written statement of the incident from Resident during an investigation weekly times 4, then monthly times 3 months. **3**.Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

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F 600	Continued From page 6 substantiated. Documented evidence showed the action taken Employee#39 was immediately suspended. At the time of the survey process, Employee # 39 did not return to the facility. There was no written statement of the incident from Resident #112 in the investigation report. A review of Employee #39's file from the Human Resource Office (HRO) included the employee's job application, background check, job description signed 3/25/18, and her CNA certification to expires on 10/31/19. Also, Employee #39 had a history of verbal confrontations with staff and unsatisfactory job performance(s). There was no evidence that facility staff ensured Resident #112 was free from verbal abuse by staff as evidenced by the investigation contained no written or recorded account of the incident from the resident. A face-to-face interview conducted 8/30/19, at approximately10:00 AM with Employee #1 and Employee #2. They acknowledged the findings.	F 600		11/22/19
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	**F656** **Corrective Action for the Residents Affected:** 1.The affected Residents' #54 was re-assessed on 8/29/19 Care plan for use of an antidepressant was developed. Resident #54 suffered no negative outcome.	11/22/19

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F 656	Continued From page 7 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 70 sampled residents, facility staff failed to develop comprehensive, person centered care plans for use of an antidepressant for one (1) resident, to address dental care t and	F 656	**2A.** The affected Residents' #95 was re-assessed on 8/27/19 Care plan for the use of anticoagulant for Resident #95 was developed. **2B**.Care plan for dental care for Resident #95 was developed. Resident #95 suffered no negative outcome. **Identification of others with the Potential to be affected:** **1.**All residents residing in the facility have the potential to be affected. **2.** Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to develop comprehensive, person centered care plans. **3.** Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of developing comprehensive, person centered care plans for 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 develop comprehensive, person centered care plans 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.	11/22/19

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F 656	Continued From page 8 the use of anticoagulant for one (1) resident. Residents' #54 and #95. Findings include . . . 1. Facility staff failed to develop comprehensive, a person centered care plan for use of an antidepressant for Resident #54. A review of Section I (Active Diagnoses) of Resident #54's annual Minimum Data Set dated 6/18/19 showed that the resident was coded for Depression. Review of Section N (Medications) of the same MDS was coded for use of an Antidepressant (Sertraline). However, review of the resident care plans failed to reveal a care plan for the use of an Antidepressant. A face-to-face interview was conducted with Employee #17 on August 29, 2019, at approximately 3:00 PM. The employee reviewed the record and acknowledged that the care plan for use of an Antidepressant was never developed. 2A. Facility staff failed to develop plan of care for Resident #95's use of anticoagulant. Resident #95 was admitted to the facility on January 10, 2018, with diagnoses which included	F 656		11/22/19

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F 656	Continued From page 9 Human Immunodeficiency Virus Disease, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Anemia, Osteoarthritis, Neuropathic pain, Anxiety, and Major Depressive Disorder. A review of of the Quarterly Minimum Data Set (MDS) completed July 17, 2019, showed a Brief Interview for Mental Status (BIMS) score of "11" which is an indication that the resident has moderately impaired cognition and is not able to make decisions. Review of the Physician's order directed, 7/15/19 "Lovenox solution 80mg/0.8ml, Inject 80mg subcutaneously one time a day for DVT[deep vein thrombosis]" A review of the physician's note dated 8/6/2019 showed " ... No rectal bleeding reported ... continue Lovenox 80 mg qd [every day], continue monitor s/s [signs and symptoms] of bleeding" A review of the medical record lacked a care plan with person-centered goals and approaches to reflect the resident's use of an anticoagulant. A face-to-face interview was conducted on August 27, 2019, at approximately 2:00 PM with Employee #18. The employee acknowledged the finding when asked about the care plan for Resident #95's use of anticoagulant.	F 656		11/22/19

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F 656	Continued From page 10 2B. Facility staff failed to develop plan of care for Resident #95's dental care. Resident #95 was admitted to the facility on January 10, 2018, with diagnoses which included Human Immunodeficiency Virus Disease, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Anemia, Osteoarthritis, Neuropathic pain, Anxiety, and Major Depressive Disorder. A review of of the Quarterly Minimum Data Set (MDS) completed July 17, 2019, showed a Brief Interview for Mental Status (BIMS) score of "11" which is an indication that the resident is moderately cognitively impaired and not able to make decisions. A review of the physician's note dated 3/5/2019 showed " Mouth multiple impacted roots on lower gum and upper gum. No gum bleeding, No oral ulcers. Oral pain due to missing teeth and impacted roots, ...dental evaluation as scheduled." Review of the Physician's order directed, 4/18/19 "Follow up with [dental office] for extraction of all remaining teeth post medical clearance" A review of the medical record lacked person-centered goals and approaches to reflect the resident's dental care. A face-to-face interview was conducted on August	F 656		11/22/19

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F 656	Continued From page 11 27, 2019, at approximately 2:00 PM with Employee #18. She acknowledged the findings when asked about the care plan for Resident #95's dental care and stated "[resident's name] refuses the dental appointments."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 657	**F657** **Corrective Action for the Residents Affected:** **1**.The affected Resident # 53 was reassessed on 8/30/19. **2**.Care plan for resident #53 was updated to reflect the changes in treatment for gastrostomy tube site care. **3**.The Resident #53 suffered no negative outcome. **Identification of others with the Potential to be Affected:** **1**.All residents residing in the facility have the potential to be affected. **2**. Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents that facility staff failed to update resident centered care plan to reflect the changes in treatment. **3**. Any issues found during the audit will be addressed.	**11/22/19**

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F 657	Continued From page 12 interview for one (1) of 70 sampled residents, facility staff failed to update care plan with goals and approaches for resident-centered care for one (1) resident's gastrostomy tube (GT). Resident #53. Findings included... Facility staff failed to update resident-centered care plan to reflect the changes in treatment for Resident #53's gastrostomy tube site care. A review of Resident #53's admission record shows that he was admitted to the facility on June 19, 2015, with diagnoses which included Hypertension, Anemia, Type 2 Diabetes Mellitus, Systemic Lupus Erythematosus, Hyperlipidemia, Gastroesophageal Reflux Disease, Cerebrovascular Disease, Cardiomegaly, Dementia, and Major Depressive Disorder. A review of the Quarterly Minimum Data Set [MDS] dated 6/15/19 showed, Section K 0510 Nutritional Approaches: B Feeding tube -nasogastric or abdominal (PEG), while a resident. A review of Physician Health Status note dated August 7, 2019, showed " .... GT [gastrostomy tube] with no hyper granular tissue, mild irritation and moderate serous drainage + minimal erythema around" add Calmoseptine ointment use for peri GT site care." A review of the care plan Focus showed "Resident has skin irritation on GT area initiated 3/26/19. On 8/7/2019 the aforementioned	F 657	**Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of updating resident-centered care plan to reflect the changes in treatment. **Monitoring Corrective Action:** 1.Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to update resident centered care plan to reflect the changes in treatment. 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.	11/22/19

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F 657	Continued From page 13 changes made to GT site care was not updated on the care plan. Facility staff failed to show evidence of an updated resident-centered care plan that reflects the changes mentioned on 8/7/2019 for Resident #53's GT site care. A face-to-face interview was conducted with Employee #18 [Nurse Manager] on August 30, 2019, at approximately 9:55 AM. She acknowledged the findings.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Medpass observation and staff interview for two (2) of four (4) sampled residents observed during medication administration, the facility staff failed to provide care in accordance with professional nursing standards as evidenced by the staff was observed to incorrectly used the blood pressure cuff to measure one (1) resident's blood pressure and administer one (1) resident eye drops. Residents' #88 and #126. Findings included... 1. Standard of Care for Administering Eye Drops:	F 658	**F658** **Corrective Action for the Residents Affected:** The facility cannot retroactively Correct this deficiency. **1.**The affected resident #88 was reassessed on 8/28/19, Education was provided to the employees on proper technique to safely administer eye drops to the resident. Resident #88 suffered no negative outcome. **2.** The affected resident #126 was reassessed on 8/28/19. Education was provided to the employees on proper techniques to measure the resident's blood pressure. Resident #126 suffered no negative outcome. **Identification of others with the Potential to be Affected:** **1.**All residents residing in the facility have the potential to be affected. **2.** Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents that facility staff failed to provide care in accordance with professional nursing standards.	11/22/19

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F 658	Continued From page 14 "Ask the patient to tilt his head slightly back and to look toward the ceiling. Turn his head slightly to the side being treated to prevent the solution or tears from flowing toward the opposite eye. Using your non-dominant hand, pull his lower eyelid down with your thumb, exposing the conjunctival sac. Place the medication bottle ½ to ¾ inch above his conjunctival sac, making sure it doesn't touch anything." https://journals.lww.com/nursing/FullText/2007/05000/Administering_eyedrops.14.aspx During Medpass observation on August 27, 2019, at 10:00 AM, Employee #25 was observed to incorrectly administer Resident #88 eye drops. The employee asked the resident to tilt her head slightly back and to look toward the ceiling. Employee #25 then squeezed the bottle [to instill the prescribed number of drops] and missed the resident eyes. At the time of the observation, Employee #25 was asked what is the technique used to safely administer eye drops. Employee #25 did not respond. Resident #88 was admitted to the facility on July 25, 2016, with diagnoses which include Alzheimer's, Hyperlipidemia, Dementia, Osteoarthritis, Hypertension, Major Depressive Disorder, and Peripheral Vascular Disease. A review of the Quarterly Minimum Data Set [MDS] dated July 15, 2019, Section C0500 [BIMS (Brief Interview for Mental Status) Summary Scores] of "12" moderately impaired cognition which indicates, "Resident not able to make decisions".	F 658	Any issues found during the assessment /audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of providing care in accordance with professional nursing standards. **Monitoring Corrective Action:** .Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to provide care in accordance with professional nursing standards 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.	11/22/19

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F 658	Continued From page 15 A review of the Physician order dated 09/16/18 that directed, "Gen Teal Solution 0.1 -0.3% (Dextran 70-Hypromellose) instill 1 drop in both eyes two times a day for dry eyes." A face-to-face interview was conducted on August 28, 2019, at approximately 10:15 AM, with Employee #18 and Employee #25. Both employees acknowledged the findings. 2. Measuring Blood Pressure Per The American Heart Association: "Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure-related risk, and to guide management. ... Selection of the correct cuff size, and proper patient positioning if accurate blood pressures are to be obtained ... In view of the consequences of inaccurate measurement, regulatory agencies should establish standards to ensure the use of validated devices, routine calibration of equipment, and the training and retraining of manual observers." Retrieved from: www.ahajournals.org/doi/full/10.1161/01.HYP.0000150859.47929.8e During Medpass observation on August 27, 2019, at 10:00 AM, Employee #24 immediately applied the blood pressure cuff to the resident's forearm to measure the resident's blood pressure. At the time of the observation, Employee #24 was asked what is the technique used for applying a blood pressure cuff to measure the blood pressure level. Employee #24 verbalize the technique used for taking accurate blood pressure and she ended	F 658		11/22/19

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F 658	Continued From page 16 by saying, "we do not have a blood pressure cuff for the resident arm size." Resident #126 was admitted to the facility on November 6, 2018, with diagnoses, which include Anemia, GERD, Goiter, Gout, Osteoarthritis, Hypertension, Diabetes Mellitus, Peripheral Vascular Disease, Depressive and Adjustment Disorder. A review of the Quarterly Minimum Data Set [MDS] dated July 31, 2019, Section C0500 [BIMS (Brief Interview for Mental Status) Summary Scores] of "15" cognitively intact which indicates, "Resident able to make decisions". A face-to-face interview was conducted on August 28, 2019, at approximately 9:15 AM, with Employee #16 and Employee #24. Both employees acknowledged the findings.	F 658		11/22/19
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692	**F692** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The affected Resident #132 was reassessed on 8/29/19. The Dietitian was reeducated on clinical assessment and monitoring/modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status Resident #132 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. The Dietitian/Designee will complete house wide assessment/audit of residents to identify potential residents that facility staff failed to provide evidence of	

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F 692	Continued From page 17 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide evidence of monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status for one (1) of 70 sampled residents (Resident #132). Findings included ... Resident #132 was admitted to the facility on 10/1/18 with diagnoses to include Hypertension, Hyperlipidemia, Peripheral Vascular Disease and Chronic Kidney Disease. Review of the Annual Minimum Data Set (MDS) dated 8/2/19 , showed Section C (Cognitive Patterns) C0500 Brief Interview for Mental Status is coded as "15", which indicates cognition intact. Section G Functional Status showed resident is coded as "0" which indicates independent with eating. Section K (Swallowing/Nutritional Status); nutrition approach is coded as "therapeutic diet." Reviews of the medical record showed resident weights were recorded as follows: 2/13/19 -132# 3/4/29- 130# 4/3/19- 136# 5/2/19- 135# 6/3/19-136# 7/1/19- 136#	F 692	monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status. Any issued found during the assessment /audit will be corrected. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of Providing evidence of monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status. **Monitoring Corrective Action:** The Dietitian/ Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to provide evidence of monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status 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.	11/22/19

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F 692	Continued From page 18 8/1/19- 128 # During an interview on 8/28/19 at 10:00 AM resident was asked have you lost weight. The resident responded "yes, I don't like the food here." Review of the meal log showed resident refused one or more meals for the month of August and or consumed 51-75% of meals. Further review of the medical record showed the following entries: Nurse practitioner note dated 7/31/19, "resident wanted to change his diet to regular, resident stated I want to have corn, meat and hot dog." Nurse practitioner's note dated 8/2/19: "resident wanted to talk to again for changing his diet, resident agreed to continue his cardiac diet again." Review of the medical record showed an interdisciplinary team meeting was held on 8/6/19 and the resident's documented weight loss of 8 lbs. nutritional issues were not addressed. Dietary note dated 8/7/19: "pt. does not like the food and has been complaining of diet, registered dietician explained to patient that preference for fried foods can be detrimental to his health and that the patient can have fried foods not more than once a week due to complaints of possible weight loss, continue current diet and Boost BID supplement." Nurse supervisor note dated 8/22/19, "resident lost 8 lbs within a month, he had a reweigh and	F 692		11/22/19

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F 692	Continued From page 19 the reweigh remain the same." Significant weight change note by registered dietician dates 8/21/19 "PO intake is 50-100 % varied appetite, patient has history of non-compliance with diet states he does not like the food." During a face-to-face interview on 8/29/19, at 11:30 AM with Employee #19 (Assistant Manger-Dietary Services) states "I am not aware the resident has refused any meals and the dietician would email us if there are any changes or alternatives, this was never discussed in the care plan meeting." During a face-to-face interview on 8/29/19, at 12:30 PM, Employee #21 (Dietician) was asked was the resident offered food alternatives, between-meals snacks or nourishments, and if she was aware the resident was refusing meals. Employee #21 stated, "I did not discuss alternatives and I did not know he was refusing his meals." Employee #21 was unable to provide evidence of monitoring or modifying interventions (as appropriate) consistent with resident needs and goals to maintain acceptable parameters of nutritional status. During a face-to-face meeting on 8/29/19 at 12:30 PM, Employee #21 acknowledged the finding.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		

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F 698	Continued From page 20 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 70 sampled residents, facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility and dialysis staff was included in the medical record for Residents' #8 and #71 Findings included... 1. Facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility staff and dialysis staff was included in Resident #8's medical record. Resident #8 was admitted to the facility on October 7, 2018, with diagnoses, which included Anemia, Cardiomyopathy, Hyperlipidemia, Cerebral Infarction, Hypertension, End-Stage Renal Disease, Arthritis, Cataract, and Presbyopia. Physician orders dated 3/5/19 directed, "Resident starts new dialysis hours 6 am on 3/6/19... Dialysis days remain the same Monday, Wednesday, and Friday ..." Review of the Resident #8's medical records from July 31, 2019 to August 28, 2019, showed that	F 698	**F698** **Corrective Action for the Residents Affected:** **1.**The affected Resident #8 was reassessed on 8/30/19.The dialysis communication forms were included in the residents' medical record. Resident #8 suffered no negative outcome. **2.**The affected Resident #71was reassessed on 8/30/19.Thedialysis communication forms were included in the residents' medical record. Resident #71 suffered no negative outcome. **Identification of others with the Potential to be Affected:** **1.**All residents residing in the facility have the potential to be affected. **2**. Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents that facility staff failed to ensure the dialysis communication form was included in the residents' medical record and not maintained in a separate binder. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of maintaining dialysis communication form in the residents' medical record and not maintained in a separate binder.	11/22/19

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F 698	Continued From page 21 the resident dialysis record for communication between the dialysis center and the facility was not included as part of the resident medical record. Observation made on August 30, 2019, at approximately 9:10 AM of the resident dialysis communication record and the medical record showed that they were maintained in a separate binder. The evidence showed that the facility staff failed to ensure the dialysis communication form was included in the residents medical record and not maintained in a separate binder. A face-to-face interview was conducted with Employee #18 on August 30, 2019, at approximately 9:55 AM. She acknowledged the findings. 2. Facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility and dialysis staff was placed in Resident #71 medical record. Resident #71 was admitted to the facility on April 23, 2015, with diagnoses, which included Peripheral vascular disease, Anemia, Cardiomegaly, Hypertension, Gout, Hyperlipidemia, Osteoarthritis, End-Stage Renal Disease, Diabetes Mellitus and Major Depression. Review of the Resident #71's medical records from June 10, 2019 to August 28, 2019, showed that the resident dialysis record for communication between the dialysis center and	F 698	**Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to ensure the dialysis communication form was included in the residents' medical record and not maintained in a separate binder. 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.	11/22/19

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F 698	Continued From page 22 the facility was not included as part of the resident medical record. Observation made on August 30, 2019 at 9:10 AM of the dialysis communication record and the medical record showed that they were maintained in a separate binder. The evidence showed that the facility staff failed to ensure the dialysis communication form was included in the residents medical record and not maintained in a separate binder. A face-to-face interview was conducted with Employee #18 on August 30, 2019, at approximately 9:57 AM. She acknowledged the findings.	F 698		
F 710 SS=E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.	F 710	**F710** **Corrective Action for the Residents Affected:** The affected Resident #66 was reassessed on 9/3//19.The Physician was educated on importance of ensuring that the residents' Insulin dosage is correctly documented The affected Resident #66 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. Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents that the physician failed to ensure that the resident's Insulin dosage was correctly documented	11/22/19

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F 710	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 70 sampled residents, the physician failed to ensure that one (1) resident's order for Humalog Insulin was written correctly. The dosage was written incorrectly x 4 months. Resident #66. Findings Include . . . Resident #66 was admitted to the facility on September 10, 2014, with diagnoses which included Anemia, Diabetes and End Stage Renal Disease. According to Section I (Diagnoses) of the annual Minimum Data Set (MDS) dated January 18, 2019 and a quarterly MDS dated April 08, 2019 the resident was documented to have a history of diabetes. Review of the physician's order for Humalog Insulin show that for the months of May 2019, June 2019, July 2019 and August 2019 the order was written as: "Humalog 100 Unit/ML (3ML vial) Inject 3 ml subcutaneously three times a day for DM (Diabetes Mellitus)..." dated 05/07/19. Humalog 100 unit/ML (3ML vial) Inject 3 unit subcutaneously three times a day for DM [Diabetes Mellitus], but the order was discontinued and reordered on May 07, 2019. Employee #30 acknowledged during a face-to-face interview on August 30, 2019 at approximately 11:00 AM that she transcribed the	F 710	Any issues found during the audit will be addressed. **Measures to prevent recurrence:** 11/22/19 Staff Development will provide education to the facility physician on importance of ensuring that the residents' Insulin dosage is correctly documented **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that the the physician failed to ensure that the Resident's Insulin dosage was correctly documented 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.	

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F 710	Continued From page 24 order incorrectly as 3ml instead of 3 units on May 07, 2019. Throughout the months of May, June, July and August 2019 the order was documented as 3 ml of Insulin instead of 3Units of Insulin. The employee added that because of the facility uses Flex pens (A device to administer Insulin that is prefilled and color coded . It allows for accurate measurement by dialing the number of units to be administered.) for dispensing the Insulin she is certain that the resident received the correct dosage. Review of Resident #66's sixty-day orders showed that the orders were signed as verified by the physician on July 01, 2019. A telephone interview was conducted with Employee #23 (Physician) at approximately 11:00 AM on September 03, 2019. In response to a query regarding the incorrect documentation of the dosage of Insulin, the physician stated that he knew no one gave the Resident 3 ml of Insulin because that would mean the resident received an entire vial of Insulin 3 times a day. However, he added that the pharmacist should have identified the problem and notified him. A face-to-face interview was conducted with Employee # 1 at approximately 11:30 AM on September 03, 2019. She acknowledged that the physician failed to ensure that the resident's Insulin dosage was correctly documented as 3 units three times a day.	F 710		11/22/19

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F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility staff failed to: (I) adequately assess a wound per professional standards of practice for one (1) of 70 sampled residents (Resident #34); and (II) correctly transcribe an	F 726	**F726** **Corrective Action for the Residents Affected:** **1.**The affected Resident #34 was reassessed on 9/30//19. The Facility Licensed Practitioner was reeducated on accurate assessment of resident wound according to professional standards of practice. Resident #34 suffered no negative outcome. **2.** The affected Resident #66 was reassessed on 8/29/19. Clarification order was obtained for insulin dosage and was correctly transcribed as ordered and started 8/30/19 Resident #66 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. Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents that the facility staff failed to adequately assess a wound per professional standards of practice. Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents that the facility staff failed to correctly transcribe an insulin order. Any issues found during the audit will be addressed.	11/22/19

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F 726	Continued From page 26 insulin order for one (1) of 70 sampled residents (Resident #66). Findings included ... 1. Facility staff failed to adequately assess a wound per professional standards of practice for Resident #34. Resident #34 was admitted on 5/24/19 (most recent date of admission) with diagnoses that include Cerebral Infarction, Sepsis, Hypertension, Unspecified Dementia, Age-related Debility. Review of the resident's current medical record revealed that the facility's staff initially documented the wound as a Stage 3 medical equipment-induced pressure ulcer. However, after more than 60 days the wound classification was changed to a full-thickness neck wound, as evidenced below: Review of the Annual Minimum Data Set (MDS) dated 8/2/19, showed Section C (Cognitive Patterns) C0100 Brief Interview for Mental Status was answered "No" resident is rarely/never understood. Section G Functional Status showed resident is coded as "4" which indicates resident is totally dependent on staff for activities of daily living independent with eating. Section M (Skin Conditions) showed resident is at risk for developing pressure ulcer and has a Stage 3 pressure ulcer. Section O (Special Treatments and Programs) showed under section respiratory treatments: oxygen, suctioning and tracheostomy care are selected.	F 726	**Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of adequately assessing a wound per professional standards of practice. Staff Development will provide education to the facility staff on importance of correctly transcribing an insulin order. **Monitoring Corrective Action:** .Assistant Director of Nursing/ Designee will complete house wide assessment / audit of residents to identify potential residents that the facility staff failed to adequately assess a wound per professional standards of practice weekly times 4, then monthly times 3 months. Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of residents to identify potential residents that the facility staff failed to correctly transcribe an insulin 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.	11/22/19

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F 726	Continued From page 27 Observation on 8/27/19 at 11:00 AM showed resident lying in bed; resident has tracheostomy collar (placed over a breathing tube incision in the throat, through which humidified oxygen is given) in place. Review of the care plan date 7/4/19 showed Focus, "resident has a back of the neck [sic] noted as Stage 3. Intervention: Notify NP (nurse practitioner) ..." Review of the nurse practitioner health status note dated 7/4/19 showed "asked to evaluate resident's neck wound, back of neck: medical equipment induced ulcer, Stage 3 1.0cm x 4.5 cm x 0.2cm, 100% granular tissue + scant fresh bloody drainage." Review of the change of condition form dated 7/4/19 at 4:13 PM showed "resident observed with back of the neck pressure ulcer Stage 3, possibly caused by oxygen mask collar, measuring 1.0 cmx 4.5cmx 0.2cm 100% granular tissue, fresh bloody drainage." Further review of the medical record showed NP Wound Note dated 7/11/19, "medical equipment induced-pressure ulcer. Healing Stage 3, 0.2 cm x 2.0 cm x 0.1 cm 100% granular tissue +scant serous drainage." During an interview on 8/30/19 at 11:00 AM with Employee #28 regarding the wound assessment notes for Resident #34 "I documented it as a full thickness wound but the practitioner has more knowledge so I deferred to her."	F 726		11/22/19

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F 726	Continued From page 28 Observation on 8/30/19 at 11:30 AM showed Resident #34 lying in bed; resident with a tracheostomy collar with a cloth material with trach ties around the neck of the resident used to hold the collar in place (over the breathing tube). Employee stated see the ties should not be tight around the resident neck. Observed an open area on the lateral aspect of the neck and Employee # 28 measured the area. During an interview on 8/30/19 at 1:00 PM Employee #29 was asked specifically about her wound assessment note. Employee #29 stated, "This was a medical equipment-induced pressure ulcer because of the trach collar it may have been too tight I wrote it in my notes." During an interview on 8/30/19 at 2:00 PM with Employee #16 stated "I will have to talk to the nurse practitioner about her wound assessment note." On 8/30/19 at 5:20 PM Employee #29 addressed the writer and said,"I changed my notes (writer provided a copy of the note) it was supposed to be a full thickness wound not a Stage 3 ulcer." The employee also said, "I don't know about the wounds that is why they are going to take that from me. I won't be doing the wounds anymore. I have too much to do with the patients." On 08/30/19 at 5:20 PM, after Employee #29, Nurse Practitioner (NP), handed this writer the health status note dated 07/04/19, a second review showed that the NP changed the note by drawing an electronic line through her previous documentation of : " asked to evaluate resident's neck wound, back of neck: medical equipment	F 726		11/22/19

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F 726	Continued From page 29 induced ulcer, Stage 3 1.0 cm x4.5 cm 0.2 cm, 100% granular tissue + scant fresh bloody drainage... Medical equipment induced-pressure ulcer Healing Stage 3, 0.2 cm x 2.0 cm x 0.1 cm 100% granular tissue +scant serous drainage." The strike out date is 8/30/19 at 4:59 PM PM (56 days after the initial note). Facility staff failed to adequately assess a resident's wound in accordance with professional standards of practice. During a face-to face interview on 8/30/19 at 5:30 PM, Employee # 29, NP, acknowledged the finding. 2. Facility staff failed to correctly transcribe an insulin order for Resident #66. A review of the Resident #66's current medical record showed a verbal physician order for "Novolog [Humalog] Solution (Insulin Aspart) 3Units SQ (subcutaneous) TID (three-times-a-day)", dated 05/07/19. Continued review of the medical record revealed Medication Administration Record (MAR) from 05/07/19 through 08/29/19 the Humalog order was written as, "Humalog 100 unit/ML (3ML vial) Inject 3 ml subcutaneously three times a day for DM (diabetes mellitus)" and not the 3Units TID ordered by the physician on 05/07/19. Further review of the previously mentioned MARs revealed that the facility's nursing staff documented that Humalog 3mls was administered from 05/07/19 through 08/29/19.	F 726		11/22/19

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F 726	Continued From page 30 On 08/30/19 at approximately 11:00 AM Employee #30, LPN, approached this writer and acknowledged that she was the individual who transcribed the order incorrectly. The LPN also stated that the facility uses Flex Pens (a trade mark device to administer insulin that is pre-filled and colored coded. It allows for accurate measurement by dialing the number of units to be administering) and she was certain that Resident #66 received the correct dosage. On 08/30/19 at 11:10 AM observation showed that Resident #66 had a Flex Pen for administration of his insulin. A face-to-face interview was conducted with Employees #2 on September 03, 2019 at approximately 10:30 AM. The employee acknowledged that facility staff failed to perform transcription of medical orders (Insulin) in accordance with professional standards.	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 70 sampled residents, the facility staff failed to develop a care plan with individualized, person-centered approaches to address Resident #120 with a diagnosis of Dementia.	F 744	**F744** **Corrective Action for the Residents Affected:** The affected Resident #120 was reassessed on 9/3//19. Individualized person-centered care plan was developed to address Resident #120 diagnosis of Dementia. The affected Resident #120 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. Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents	11/22/19

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F 744	Continued From page 31 Findings included... Resident #120 was admitted to the facility on 7/30/19 with diagnoses to include Dementia, Hypertension, Arthritis, and Diabetes Mellitus. Review of the Annual Minimum Data Set (MDS) dated 8/6/19 , showed Section C (Cognitive Patterns) C0500 Brief Interview for Mental Status coded as "12", which indicates moderate cognitive impairment. Review of discharge summary from [hospital name] dated 7/22/19 showed "patients' mental status was attributed to underlying dementia with frontal lobe component. Hospital course: Altered Mental Status, Dementia with Agitation. Review of physicians order dated 8/12/19 showed "psychiatric consultation for resident with Dementia and Behavioral Disturbance ..." Further review showed "monitor resident behavior every 4 hours for Dementia with behavioral disturbance." Review of the care plan showed, "Focus: Resident has a history of Dementia, Interventions: monitor weight, PO (by mouth) intake, skin integrity, labs, provide mechanical soft diet with chopped meats, thin liquids consistency." The facility failed to develop a care plan with individualized, person-centered, interventions/ approaches to address a resident with a diagnosis of Dementia.	F 744	the facility staff failed to develop a care plan with individualized, person-centered approaches to address Resident with a diagnosis of Dementia. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of developing a care plan with individualized, person-centered approaches to address Resident with a diagnosis of Dementia. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment / audit of residents to identify potential residents that the facility staff failed to develop a care plan with individualized, person-centered approaches to address Resident with a diagnosis of Dementia 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.	11/22/19

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F 744	Continued From page 32 During a face-to-face interview on 9/3/19 at 12:30 PM, Employee #17 acknowledged the finding and added, "I will review and update the care plan."	F 744		
F 756 SS=E	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 the resident's medical record. §483.45(c)(5) The facility must develop and	F 756	**F756** **Corrective Action for the Residents Affected:** .The affected Resident #66 was Re-assessed on 9/3/19.The Consultant Pharmacist was educated on the importance of identifying and making recommendations to correct the insulin dosage. .The affected 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. . Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents the consultant pharmacist failed to identify and make recommendations to correct the Insulin dosage. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the Consultant Pharmacist on the importance of identifying and make recommendations to correct the Insulin dosage.	11/22/19

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F 756	Continued From page 33 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 observation, record review and staff interview for one (1) of 70 sampled residents, the consultant pharmacist failed to identify and make recommendations to correct the Insulin dosage for Resident #66. Findings include . . . A review of the Humalog Insulin order for Resident #66 for May 2019 showed that the dosage of the Insulin was documented as 3 ml instead of 3 units. A review of Insulin order for June, July and August were also documented incorrectly as 3 ml instead of 3 units. A review of the facility's policy titled "Pharmacy Recommendation Follow-Up /Review" Revised 07/2019 depicts the following: 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 2. This review must include a review of the	F 756	**Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment / audit of residents to identify potential residents that the Consultant Pharmacist failed to identify and make recommendations to correct the Insulin dosage 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.	11/22/19

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F 756	Continued From page 34 resident's medical chart. 3. The pharmacist must report any irregularities to the attending physician and the facilities medical director and the director of nursing and these reports must be acted upon. Review of the Medication Regimen Review record for Resident #66 showed that the pharmacist reviewed the resident's medical records on May 15, June 17, July 18 and August 14, 2019. However, the consultant pharmacist failed to identify the incorrect order and or, make recommendations to the physician, and to the DON to correct the order. A telephone interview was conducted with the consultant pharmacist on September 03, 2019 at approximately 12:30 PM. After reviewing the orders in the computer he acknowledged the finding and stated that he would implement an audit system to ensure that this problem will not reoccur.	F 756		11/22/19
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761	**F761** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. **A.** .All medications in the medication carts without date on the labels of vials/medication containers when they were first accessed were removed from the medication cart. Reordered and dated when first accessed. **B.** The expired medication was removed immediately from the cart on 8/29/19. The affected Resident suffered no negative outcome.	11/22/19

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F 761	Continued From page 35 §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 by: Based on observation of medications stored and staff interview for one (1) of three (3) medication carts on August 29, 2019, at approximately 12:30 PM the facility staff on the first floor failed to date the labels of seven (7) of 12 multi-dose vials/medication containers when they were first accessed; and to remove an expired medication for one (1) resident from a medication cart on the second floor. Findings included... A. The following medications were opened. All of the containers lacked the dates on which they were initially accessed.	F 761	**Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. **A.** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of medications to identify potential medications that the facility staff failed to date the labels of vials/medication containers when they were first accessed. **B.** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of medications to identify potential expired medications that the facility staff failed to remove from the medication cart. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** **A**..Staff Development will provide education to the facility licensed nurses on importance of labeling of vials/medication containers when they are first accessed. **B.** Staff Development will provide education to the facility licensed nurses on importance of removing expired medications from the medication cart. **Monitoring Corrective Action:** **A.** Assistant Director of Nursing/ Designee will complete house wide assessment / audit of residents to identify potential medications that the facility staff failed to date the labels of vials/medication containers when they were first accessed. weekly times 4, then monthly times 3 months.	11/22/19 11/22/19

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F 761	Continued From page 36 Ferrous Sulfate 16 oz. bottle/8 oz. remained Expiration date 01/22 Ranitidine 300 ml bottle/140 ml remaining date of Expiration 4/1/20 Manantine 150ml bottle/30 ml left Expiration 3/30/20 Keppra 16 oz. bottle/12 oz. remaining Expiration date 03/22 Ferrous Sulfate 16 oz. bottle/12 oz. left Expiration date 01/20 Chlorhexidine Gluc. (Peridex) 0.2 % solution 16 oz. bottle/4 oz. left Expiration date Feb. 2022 Docusate Sodium 16 oz. bottle/15 oz. left Expiration date 1/21. B. Facility staff failed to remove one (1) expired medication from the medication care. Labetelol 100mg six (6) tablets with a "Use by date " of 6/01/19 was observed on the medication cart during review of medication storage on August 29, 2019 at approximately 1:00 PM. Review of the resident's medication orders revealed that the Labetelol was prescribed for the resident on June 27, 2018. The prescriber wrote "Labetalol HCL Tablet 100mg give 1 tablet orally two times a day for HTN [Hypertension] hold if SBP [Systolic Blood Pressure <110 [less than] or HR [Heart Rate] <60 [less than]. The medication was discontinued on July 31, 2018. Further	F 761	Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of medications to identify potential expired medications that the facility staff failed to remove from the medication cart 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.	11/22/19

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F 761	Continued From page 37 review of the Physician's order and the MAR failed to reveal a current order for the Labetelol. A face-to-face interview was conducted with Employee #17 at approximately 3:00 PM on August 29, 2019. During the interview the employee stated that the resident was no longer taking the medication and acknowledged that the expired medication should have been removed from the medication cart. A face-to-face interview was conducted with Employee # 16 at approximately 3:00 PM on August 29, 2019. During the interview the employee stated that the resident was no longer taking the medication and acknowledged that the expired medication should have been removed from the medication cart.	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency	F 790	**F790** **Corrective Action for the Residents Affected:** The affected Resident #95 was reassessed on 8/27//19. Dental Appointment for Resident #95 has been scheduled for 11/4/19 Resident #95 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. Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential resident that the facility's staff failed to assist in obtaining dental care.	11/22/19

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F 790	Continued From page 38 dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one the facility's staff failed to assist one (1) of 70 sampled resident in obtaining dental care (Resident #95). Findings included... Resident #95 was admitted to the facility on January 10, 2018, with diagnoses which included Human Immunodeficiency Virus Disease, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Anemia, Osteoarthritis, Neuropathic pain, Anxiety, and Major Depressive	F 790	Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of assisting the resident in obtaining dental care. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential resident that the facility's staff failed to assist in obtaining dental care 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.	11/22/19

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F 790	Continued From page 39 Disorder. A review of of the Quarterly Minimum Data Set (MDS) completed 07/19/19, showed a Brief Interview for Mental Status (BIMS) score of "11" which is an indication that the resident is moderately impaired cognition and not able to make decisions. A review of the physician's note dated 03/05/19 showed the physician documented, " Mouth multiple impacted roots on lower gum and upper gum. No gum bleeding, No oral ulcers. Oral pain due to missing teeth and impacted roots, ...dental evaluation as scheduled." Review of the Physician's order dated 04/18/19 directed the staff to have the resident to "Follow up with [Dental Office Name] for extraction of all remaining teeth post medical clearance" Continued review of Resident #95's current medical record lacked documented evidence that the facility staff scheduled a dental appointment or the resident received dental care post the physician order on 4/18/19. A face-to-face interview was conducted on August 27, 2019, at approximately 2:00 PM with Employee #18. She acknowledged the findings. When asked about Resident #95's dental care, the employee stated "[resident's name] refuses the dental appointments."	F 790		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812	**F812** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency **A .**The Twelve (12) of twelve (12) baffles from the kitchen exhaust hood system were soiled with grease were cleaned on 8/27/19 **B.** Hot food temperatures tested on 8/28/19 Degrees were within the required temperature range. The affected Residents suffered no negative outcome.	11/22/19

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F 812	Continued From page 40 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to prepare and serve foods under sanitary conditions as evidenced by 12 of 12 baffles from the kitchen hood system that were soiled with grease deposits and hot foods that tested at less than 135 degrees Fahrenheit (F) during a test tray assessment. Findings included ... 1. Twelve (12) of twelve (12) baffles from the kitchen exhaust hood system were soiled with grease. 2. Hot food temperatures tested at less than 135 degrees Fahrenheit (F) during a test tray assessment on August 27, 2019, at approximately 1:10 PM. A serving of	F 812	**F812** **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. **A.** The Director of Food and Nutrition Services/Designee will complete house wide audit to identify potential baffles from the kitchen exhaust hood system are soiled with grease **B.** The Director of Food and Nutrition Services/Designee will complete a random test tray of Hot food temperatures to identify potential Hot food temperatures that is less than 135 degrees Fahrenheit (F). Any issues found during the audit will be addressed. **Measures to prevent recurrence:** .Staff Development will provide education to the Food and Nutrition Services staff on the importance of preparing and serving foods under sanitary conditions. **Monitoring Corrective Action:** The Director of Food and Nutrition Services/Designee will complete house wide audit to identify potential baffles from the kitchen exhaust hood system are soiled with grease weekly times 4, then monthly times 3 months. The Director of Food and Nutrition Services/Designee will complete a random test tray of Hot food temperatures to identify potential Hot food temperatures that is less	**11/22/19.**

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F 812	Continued From page 41 chicken breast was at 123.6 degrees F and a serving of broccoli and cauliflower mix tested at 112.4 degrees F. Employee #19 acknowledged the above findings during a face-to-face interview on August 27, 2019 at approximately 3:00 PM.	F 812	than 135 degrees Fahrenheit (F) 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 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842	**F842** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. **A.**The affected Resident #8 was reassessed on 8/30/19,The Education was provided to the licensed staff on importance of completing post dialysis section of the dialysis communication form. Resident #8 suffered no negative outcome. **B.** The affected Resident **#66** was reassessed on 8/30/19, Clarification order was obtained for insulin dosage and was correctly transcribed as ordered and started 8/30/19.Education was provided to facility's staff on importance of accurately carrying over Insulin orders from one month to another. The Resident #66 suffered no negative outcome. **C.** The affected Resident #71 was reassessed on 8/30/19.The Education was provided to the licensed staff on importance of completing every section (Pre and Post) of the dialysis communication form. Resident #71 suffered no negative outcome.	11/22/19

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F 842	Continued From page 42 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 70 sampled residents,	F 842	**D.** The affected Resident #108 was reassessed on 9/3/19, Education was provided the facility's staff on importance of ensuring that recorded weights for resident's are correctly documented in the resident's clinical records the Resident #108 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. **A.** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential resident that the facility's staff failed to accurately carry over Insulin orders from one month to another. **B.** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential resident that the facility's staff failed to complete the dialysis communication form. **C.** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential residents that the facility's staff failed to ensure that recorded weights for residents are correctly documented in the resident's clinical records. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** .Staff Development will provide education to the facility Licensed Nurses on importance of accurately carrying over	11/22/19

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F 842	Continued From page 43 facility staff failed to accurately "carry over" Insulin orders for one (1) resident from one month to another, to complete the dialysis communication form for two (2) dialysis residents, and failed to ensure that recorded weights for one (1) resident were correctly documented in the resident's clinical records. Residents' #8, #66, #71 and #108. Findings include . . . 1. Review of Resident #8's current medical record showed that the resident was admitted on 10/07/18 with multiple diagnoses, including End-Stage Renal Disease and Left Arm AV (arteriovenous) Graft. Further review of the record revealed a care plan with an initiated date of 10/16/19. The aforementioned care plan documented that the resident received hemodialysis treatments three times a week (Mondays, Wednesdays, and Fridays). Review of Resident #8's, Dialysis Communication Forms showed that the facility's staff failed to complete the post-dialysis section of the forms for the following dates: 08/02/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level; 08/09/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level; 08/14/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level;	F 842	physician orders from one month to another. Staff Development will provide education to the facility Licensed Nurses on importance completing the dialysis communication form. Staff Development will provide education to the facility Licensed Nurses on importance of ensuring that recorded weights for residents are correctly documented in the resident's clinical records. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential resident that the facility's staff failed to accurately carry over Insulin orders from one month to another weekly times 4 then, monthly times 3 months Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential resident that the facility's staff failed to complete the dialysis communication form weekly times 4 then, monthly times 3 months Assistant Director of Nursing/ Designee will complete house wide assessment/ audit to identify potential residents that the facility's staff failed to ensure that recorded weights for residents are correctly documented in the resident's clinical records 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	11/22/19

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F 842	Continued From page 44 08/16/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level; 08/19/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level; 08/21/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level; 08/23/19 - The form lacked the time the resident returned, the resident's status, vital signs, and glucose level; 08/26/19- The form lacked the glucose level; and 08/28/19- The form lacked the time the resident returned, the resident's status, vital signs, and glucose level. A face-to-face interview was conducted with Employee #18 on August 30, 2019, at approximately 9:55 AM. She acknowledged the findings. 2. Resident #66 was admitted to the facility with diagnoses which include Type 2 Diabetes, Transient Ischemic Attack (TIA), Cerebral Infarction without residual deficits, Severe Psychotic Symptoms and Hemodialysis. Review of the physician's order for Insulin dated April 28, 2019 showed the following, "Humalog 100 unit/ML (3ML vial) Inject 3 unit subcutaneously three times a day for DM. Hold for BS <100" through May 03, 2019. The Insulin was reordered on May 07, 2019 and from May 07 through August 30, 2019 the Insulin was transcribed as "Humalog 100 Unit/ML (3ML vial) Inject 3 ml subcutaneously three times a day for DM. Hold for BS less than 100".	F 842		11/22/19

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F 842	Continued From page 45	F 842		11/22/19

A face-to-face interview was conducted with Employee #17 at approximately 2:00 PM on August 30, 2019 to determine who transcribed the order as 3ml instead of 3 units. The employee said she was not sure who transcribed the order as 3ml instead of 3 units but she was certain that the resident received the correct dose of 3units. The employee further explained that the facility only uses the Flex pen to administer Insulin and the doses are premeasured.

Review of documentation in the clinical record showed that the resident suffered no side effects from the administration of the Insulin.

Face-to-face interviews were conducted with the day and evening charge nurses (Employees #30 and 31) who cared for the resident. The nurses showed the Flex Pen and demonstrated how the pen is used to administer the Insulin.

Employee #30 acknowledged that she initially made the error by writing the order for 3ml instead of 3units and signing that 3ml and not 3units was administered. The other nurses also stated that they failed to determine that they administered 3 units but signed for 3 mls.

3. Resident #71 was admitted to the facility on April 23, 2015, with diagnoses, which included Peripheral vascular disease, Anemia, Cardiomegaly, Hypertension, Gout, Hyperlipidemia, Osteoarthritis, End-Stage Renal Disease, Diabetes Mellitus and Major Depression.

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F 842	Continued From page 46 Review of the record revealed a care plan with an initiated date of 12/11/17 and last updated 8/2/18. The aforementioned care plan documented that the resident received hemodialysis treatments three times a week (Mondays, Wednesdays, and Fridays). Has AV graft on the left arm. Review of Resident #71's, Dialysis Communication Form showed that the facility's staff failed to complete the pre and post-dialysis section of the forms for on the following dates: 08/14/19 - The form lacked: Before leaving the facility for dialysis resident status, time medication was administered, assessment for the thrill, and time ate. Post Dialysis: the time the resident returned, the resident's status upon return, vital signs, glucose level and nurse's signature. 08/16/19 - The form lacked: Post Dialysis: the time the resident returned, the resident's status, vital signs, and glucose level and nurse's signature. 08/19/19 - The form lacked Post Dialysis: the time the resident returned, the resident's status, vital signs, glucose level and nurse's signature. 08/21/19 - The form lacked: Before leaving the facility for dialysis resident respiration, time the vital sign was taken, and resident problem or complaint. Post Dialysis: the time the resident returned, the resident's status, vital signs, and glucose level and nurse signature. 08/23/19 - The form lacked: Before leaving the facility for dialysis, time resident received medication, glucose level, time the vital sign was taken, and resident problem or complaint. Post Dialysis: the time the resident returned, the resident's status, vital signs, and glucose level	F 842		11/22/19

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F 842	Continued From page 47 and nurse signature. 08/26/19- The form lacked: Before leaving the facility for dialysis, resident status, medication is given, time medication was administered, assessment for the thrill and time ate, the glucose level, and resident problem or complaint. Post Dialysis: the time the resident returned, the resident's status, vital signs, and glucose level and nurse signature. 08/28/19- The form lacked: Before leaving the facility for dialysis, resident's status, medications administered, and time medication was administered, Vital signs, glucose level, assessment for the bruit and thrill, time ate, and resident's problem or complaint. Post Dialysis: the time the resident returned, the resident's status, vital signs, glucose level and nurse signature. A face-to-face interview was conducted with Employee #18 on August 30, 2019, at approximately 9:55 AM. She acknowledged the findings. 4. Facility staff failed to ensure that Resident #108's weights were accurately documented in the resident's clinical record. The resident was admitted to the facility on July 27, 2019. A review of the admission progress note showed the resident's weight as 83 lb. A review of the admission Minimum Data Set (MDS) dated August 02, 2019 showed the resident's weight as 93 lb.	F 842		11/22/19

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F 842	Continued From page 48	F 842		11/22/19

A review of a record of the resident's weight (received from the facility) as recorded in the electronic record showed the following:

Date	Time	Weight	Measuring Device
07/27/2019	00:13	96.2 lb.	Wheel chair
07/27/2019	13:51	96.1 lb.	Bed Scale
08/02/2019	14:42	93 lb.	Bed Scale
08/03/2019	00:31	96 lb.	Wheel chair
08/22/2019	22:12	80.3 lb.	Bed scale
08/23/2019	01:16	80.3 lb.	Bed scale
08/27/2019	13:38	80.3 lb.	Bed scale
08/27/2019	11:27	80.3 lb.	Bed scale

Review of the record failed to show any evidence that the resident's weight was ever rechecked to determine which weights were accurate and to consistently weigh the resident on the same device; until approximately one month after the resident's admission to the facility.

On 7/27/19 at 00:13 the resident was weighed on a wheel chair.
On 7/27/19 at 13:51 the resident was weighed on a bed scale.
On 8/2/19 the resident was weighed on a bed scale and on 8/3/19 the resident was weighed on a wheel

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F 842	Continued From page 49 resident was weighed on a bed scale. There was no documented evidence to show that the staff recognized the variances in the resident's weight and rechecked the weights and the devices (bed scales/wheel chairs) to determine which was correct prior to documenting the weights in the resident's clinical record. A face-to-face interview was conducted with Employees #17 and #26 on September 03, 2019 at approximately 10:30 AM. Both employees acknowledged that facility staff failed to accurately "carry over" the Insulin orders for one resident and accurately transcribe the weights of another resident.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880	**F880** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. **A.** Facility staff was in-serviced on importance of developing a system of surveillance to identify infections or communicable diseases; and corrective action taken to minimize the spread of the infection. **B.** The soiled ice machine on One (1) of three (3) residents care units was cleaned on 9/27/19 Facility staff will be in-serviced on importance of maintaining a safe, sanitary environment	11/22/19

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F 880	Continued From page 50 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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.	F 880	The affected Residents 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. **A.**Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to develop a system of surveillance to identify infections or communicable diseases. **B.** Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to show how corrective action is taken to help minimize the spread of the infection. **C.**. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential soiled Ice machine that facility staff failed to maintain in a safe sanitary condition. Any issue found during this audit will be corrected. **Measures to prevent recurrence:** .Staff Development will provide education to the facility staff on importance of developing a system of surveillance to identify infections or communicable diseases; and corrective action taken to minimize the spread of the infection. Facility staff will be in-serviced on importance of maintaining a safe, sanitary environment.	11/22/19

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F 880	Continued From page 51 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a system of surveillance to identify infections or communicable diseases; and staff failed to maintain a safe, sanitary environment as evidenced by a soiled ice machine on one (1) of three (3) resident care units. The census on the first day of survey was 175. Findings included... 1. Facility failed to develop a system of surveillance to identify infections or communicable diseases. Review of the facility's Infection Control Surveillance logs showed the following: May 2019 there were 25 facility-acquired infections to include chin abscess, vaginitis, boil at right chest, conjunctivitis, urinary tract infections related to E. Coli, resident on isolation for urinary tract infection, skin dermatitis, MRSA of the eyelid, fungal irritation, related to incontinence, and pneumonia.	F 880	**Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to develop a system of surveillance to identify infections or communicable diseases weekly times 4 then, monthly times 3 months. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to show how corrective action is taken to help minimize the spread of the infection weekly times 4 then, monthly times 3 months. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential soiled Ice machine that facility staff failed to maintain in a safe sanitary condition 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.	11/22/19

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F 880	Continued From page 52 June 2019 there were 23 facility-acquired infections to include vaginitis, boil at right chest, conjunctivitis, urinary tract infections, and fungal irritation - no locations listed. July 2019 there were 21 facility-acquired infections to include Urinary tract Infections and conjunctivitis. Based on the surveillance data, facility staff failed to show how corrective action taken to help minimize the spread of the infection (e.g., staff education and competency assessment). During a face-to-face interview on August 29, 2019 at approximately 11:30 AM, Employee # 27 acknowledged the findings. 2. Facility staff failed to maintain a safe, sanitary environment as evidenced by a soiled ice machine on one (1) of three (3) resident care units. During an environmental walkthrough of the facility on August 27, 2019, between 10:30 AM and 3:00 PM, the access door to one (1) of one (1) ice machine located on the third floor pantry was soiled on the inside. This deficient practice could potentially contaminate beverages consumed by residents or staff. Employee #8 acknowledged the above findings during a face-to-face interview on August 27, 2019 at approximately 3:00 PM.	F 880		11/22/19
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		

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F 908	Continued From page 53 §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 observation and staff interview facility staff for one (1) of 70 sampled residents facility staff failed to provide Resident #65 with a wheelchair with operable parts (leg rest). Findings included... Resident #65 was admitted on 6/28/17 with diagnoses that include Dysphagia, Hyperkalemia, Acute Kidney Failure, Constipation, and Type II Diabetes Mellitus. Findings included... During a family interview on 8/26/19 at 11:00 AM resident's wife stated "the left pedal on his wheelchair is not working I told them about it." Review of the Annual Minimum Data Set (MDS) dated 6/22/19, showed Section C Cognitive Patterns C0500 Brief Interview for Mental Status coded as "6", which indicates severe cognitive impairment. Section G Functional Status showed mobility devices "wheelchair" is selected. Observation on 8/26/19 at 11:30 AM showed a wheelchair in the resident's room with the leg rest in the seat of the wheelchair. The resident was asked would this be your wheelchair the resident responded "it don't work if I use it my knees are in my chest."	F 908	**F908** **Corrective Action for the Residents Affected:** The affected Resident #65 was reassessed on 8/26/19. Resident #65 wheelchair leg rest was replaced on 8/26/19 The affected Residents 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. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to provide with a wheelchair with operable parts (leg rest). Any issue found during this audit will be corrected. **Measures to prevent recurrence:** .Staff Development will provide education to the facility staff on importance of providing residents with a wheelchair with operable parts (leg rest). **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to provide with a wheelchair with operable parts (leg rest) weekly times 4 then, monthly times 3 months.	11/22/19

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F 908	Continued From page 54 During an interview with Employee #22 (while in the resident's room), Employee #22 was asked what can you tell me about the residents' wheel chair and the Employee #22 stated "I fixed the leg rest and here is the paperwork but those are not the leg rests I placed on the wheelchair, someone remove them." Employee # 22 attempted to place the leg rest on the chair, and the leg rest would not attach to the wheelchair." However, review of the facility document dated 7/11/19 showed "leg rest completed." Facility staff failed to provide Resident #65 with a wheelchair with operable parts (leg rest). During a face-to-face interview on 8/26/19 at 11:30 AM Employee #22 acknowledged the finding.	F 908	Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by a call bell in three (3) of 38 resident's rooms that did not emit	F 919	**F919** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The affected call bells in resident rooms' #209B, #241A and #309A were replaced on 8/27/19. The affected Residents 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. The Director of Maintenance/ Designee will complete house wide Assessment/	11/22/19

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F 919	Continued From page 55 an audio or visual alarm when tested. Findings included... During an environmental walkthrough of the facility on August 27, 2019, between 10:30 AM and 3:00 PM, call bells in resident rooms #209B, #241A and #309A did not alarm when tested , three (3) of 38 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. Employee #8 acknowledged the above findings during a face-to-face interview on August 27, 2019 at approximately 3:00 PM.	F 919	**F919** Audit to identify potential resident room that facility staff failed to maintain the call bell system in good working condition. Any issue found during this audit will be corrected. **Measures to prevent recurrence:** .Staff Development will provide education to the facility staff on importance of maintaining the call bell system in good working condition. **Monitoring Corrective Action:** The Director of Maintenance/ Designee will complete house wide Assessment/ Audit to identify potential resident rooms that facility staff failed to maintain the call bell system in good working condition 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	11/22/19
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947	**F947** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The staff development was educated on importance of ensuring that annual in-services sheets record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who	

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F 947	Continued From page 56 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to ensure annual in-services sheets failed to record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training in four (4) of four (4) in-service(s) reviewed. Findings included ... Record review of the staff annual/mandatory in-service records on 09/03/19 at 1:00 PM showed the facility provided education on four (4) topics, as listed below: Abuse Training - 01/26/19, 01/27/19, 01/30/19, 01/31/19, 02/02/19, and 02/03/19; Dementia/Alzheimer's - 02/04/19 and 05/09/19; Podiatry/Geriatric Foot Care - 04/17/19 and 04/19/19; and Elder Justice, Abuse, and Neglect - 05/09/19. Continued review of the previously mentioned training documents revealed twenty-seven (27) "In-Service Training Sign-in Sheets" that showed the following: 1.Twenty (27) of 27 sign-in sheets lacked documented evidence of the amount of in-service hours employees received from the previously mentioned in-service training. 2. Two (2) of the 27 sign-in sheets lacked	F 947	Conducted the training. Health Care Academy was contacted to correct the error on their competencies from credits to contact hours for CNA Competencies/Training The affected Residents suffered no negative outcome. **Identification of others with the Potential to be Affected:** **1.** All residents residing in the facility have the potential to be affected. **2.** The Director of Staff Development/ Designee will complete house wide Assessment/ Audit to identify potential annual in-services sheets that failed to record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training. **3.** Any issue found during this audit will be corrected. **Measures to prevent recurrence:** The Director of Nursing/Designee will provide education to the Staff Development on importance of ensuring that annual in-services sheets record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training. **Monitoring Corrective Action:** **1.** The Director of Staff Development/ Designee will complete house wide Assessment/ Audit to identify potential	11/22/19

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F 947	Continued From page 57 documented evidence of the subject, the date, the time, the purpose, and who conducted the training. The only information on the two (2) sing-in sheets were 41 employee signatures. 3. One (1) of the 27 sign-in sheets lacked documented evidence of the subject, the date, the time, the purpose, and who conducted the training. The one (1) sign-in sheet, however, did have the name of the person who conducted the training and twenty-five employee signatures. 4. Sixteen (16) of the 27 sign-in sheets lacked documented evidence of the time the training was provided. During a face-to-face interview on 09/02/19, at 2:45 PM, the Employee #4, acknowledged the findings.	F 947	annual in-services sheets that failed to record the mandatory 12 hours of training the subject, the date, the time/duration, the purpose, and/or who conducted the training 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.	11/22/19