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	095036	A. BUILDING _____ B. WING _____	04/29/2019

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F 658	Continued From page 30 ... 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 Resident #39 was admitted to the facility on April 11, 2014, with diagnoses, which include Hypertension, Diabetes Mellitus, and Cerebrovascular Accident. A review of the Quarterly Minimum Data Set [MDS] dated January 16, 2019, Section C0500 [BIMS (Brief Interview for Mental Status) Summary Scores] of "15" cognitively intact which indicates, "Resident able to make decisions". During Medpass observation on April 26, 2019, at 10:00 AM, Employee #10 was observed using her personal blood pressure machine incorrectly to measure Resident #39's blood pressure.The employee had an automatic digital wrist blood pressure and an automatic digital upper arm blood pressure machine. First, she tried the digital wrist cuff and then the digital upper arm cuff both were unable to measure the Resident #39's blood pressure because the cuff size was small. Employee#10 reapplied the digital upper arm blood pressure cuff to the resident's forearm to measure the resident's blood pressure. At the time of the observation, Employee #10 was asked if the blood pressure machines belong to the	F 658	**Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	ongoing

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F 658	Continued From page 31 facility and the process used for applying a blood pressure cuff to measure the blood pressure. Employee #10 stated both blood pressure machines belongs to her and was able to verbalize the process used to measure the resident blood pressure with the conclusion that the cuffs were too small. A face-to-face interview was conducted on April 26, 2019, at approximately 10:15 AM, with Employee #4 and Employee #10. Both employees acknowledged the findings after Employee#10 in the presence of employee #4 stated that both blood pressure machines belong to her.	F 658	**F-684 Resident #44** **Corrective action for the residents affected:** 1. The resident #44 was reassessed on 4/30/19. Resident #44 has a scheduled eye appointment date 5/2/19.	4/30/19
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 63 sampled residents, facility staff failed to provide treatment and care in accordance with professional standards of practice for Resident #44 with Glaucoma and to obtain an order for use of a hand splint to Resident #50's right hand.	F 684	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. The facility has audited all resident records with vision issues requiring intervention. Appropriate consults will be requested per audit findings. Nursing management, DON, clinical managers, and supervisors will review the 24 hrs. report logs on each unit daily to identify residents who have experience any changes regarding notifications of physicians and responsible parties. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service licensed nursing staff regarding vision services, how to obtain consults and coordination of family/resident requests for a consultation to attending physicians to ensure compliance. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON.	4/30/19 6/10/19

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F 684	Continued From page 32 The findings included . . . 1. Resident #44 was admitted to the facility on 4/24/01 (initial admission date) with diagnoses to include: Rheumatoid Arthritis, Unspecified, Unspecified Dementia with Behavioral Disturbance, Unspecified Open-Angle Glaucoma, Stage Unspecified, Hypotension Unspecified, other Iron Deficiency Anemias. Review of the Comprehensive Minimum Data Set [MDS] dated 7/19/18 showed, Section B [Hearing, Speech and Vision] Vision is not coded. Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "2" which indicates severe cognitive impairment. Section G [Functional Status] resident is coded as "3" for dressing, eating, toileting and personal hygiene which indicates extensive assistance (resident involved in activity, staff provide weight bearing support). Review of the medical record on 4/25/19 at 10:00 AM showed a care plan dated 7/27/18 (revision date, 1/27/19) Focus: Resident has impaired visual function related to Glaucoma. Further review of the medical record showed a consult request dated 6/10/17 "Exam requested by nursing home, Glaucoma." Assessment/Plan "the disc appear cupped, I recommend follow up Intraocular Pressure check in 6 months." Physician Progress note dated 4/10/19 showed "patient has baseline confusion, but verbally communicative, no blurry vision or eye pain	F 684	**Monitoring corrective action:** 4. Ophthalmology appointment for Intraocular Pressure check as per ophthalmologist's recommendation to maintain vision will be added as a nursing quality indicator to ensure compliance until 3 months of greater than or equal to 95% compliance achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months. **F-684 Resident # 50** **Corrective action for the residents affected:** 1. The resident #50 was reassessed on 4/30/19. A hand splint was put in place for resident #50 on 4/30/19. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Audit of all residents with prescribed splints was conducted by an occupational therapist to ensure compliance with therapy (4/30/19) No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service licensed nursing staff on obtaining orders for hand splint, and using it as ordered. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	Ongoing 4/30/19 4/30/19 6/10/19 Ongoing

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F 684	Continued From page 33 ...Glaucoma stable: continue current treatment plan, follow up with ophthalmologist." During an interview on 4/25/19 at 1:00 PM Employee #3 stated, "I will check with the scheduler to see if the resident had the ophthalmology appointment for the eye pressure check." Employee #3 returned at approximately 2:00 PM and stated "the scheduler could not find that the appointment was scheduled, I will tell the doctor." During an interview on 4/25/19 at 2:30 PM with Employee #20, (Physician) states "the resident is on eye treatment, his vision is stable, he did not have the eye appointment, but did you see the order, I asked staff to schedule the eye appointment right away." Facility staff failed to schedule an ophthalmology appointment for Intraocular Pressure check as per ophthalmologist's recommendation (at the resident's appointment on 6/10/17). During a face-to-face interview on 4/25/19 at 3:00 PM Employee # 3 acknowledged the finding. 2. Resident #50 was admitted to the facility on July 10, 2008 with diagnoses which included Hypertension, Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, Hemiplegia/Hemiparesis, Seizure Disorder and Depression. Review of section C0500 of the Quarterly Minimum Data Set (MDS) with a completion date	F 684		

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F 684	Continued From page 34 of October 26, 2018 showed the resident with a Brief Interview for Mental Status (BIMS) score of four (4) which is an indication that the resident was severely cognitively impaired. G 0110 Activities of Daily Living (ADL) Assistance showed that the resident was totally dependent on two or more staff for all ADL activities (mobility, transfer, dressing, toileting, personal hygiene and bathing. The resident receives nutrition via tube feeding. Resident #50 was observed lying in bed on April 17, 2019 at approximately 3:00 PM and at 4:00 PM on April 18, 2019. The fingers on the resident's right hand were clasped to his palm. The resident was unable to open his fingers or lift his hand. No splint was noted on either one the resident's hands. Resident #50 was also observed on April 23, 2019 at 2:34 PM and April 24, 2019 at 12:00 PM without a splint on his right hand. A face-to-face interview was conducted with Employee #15 at approximately 10 AM on April 26, 2019. The employee was asked whether Resident #50 wears a hand splint. The employee said he would find out but never returned to this writer with a response. Review of the physician's orders and the Treatment Administration Record (TAR) on April 26, 2019 showed no order for the use of the splint or for application of the splint. However, review of a care plan with an initiation date of August 15,	F 684		

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F 684	Continued From page 35 2018 and a revision date of April 20, 2018 specified the following, "Resident has an alteration in musculoskeletal status r/t (related to) right hand contracture and use splint." Two of the interventions for the use of the splint were; to educate staff on application of splints and monitor skin integrity before applying and after removal of splint. At approximately 11:30 AM on April 26, 2019 the resident was observed wearing a splint to the right hand. A face-to-face interview was conducted with Employee #7 at approximately 11:45 AM on April 26, 2019. The employee was asked for the order for use of the splint to the resident's hand and the schedule for the application of the splint. Employee #7 stated that the resident did not have an order for use of a splint and added that he did not know why someone applied the splint to the resident's hand. Facility staff failed to obtain an order for use of a hand splint to Resident #50's right hand. Employee #7 acknowledged the finding during a face-to-face interview at approximately 11:45 AM on April 26, 2019.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689	**F-689** **Corrective action for the residents affected:** 1. The resident in room #212A and #221A was no negative outcome. Remote bed controller cords that were frayed was repaired by facility operations Director. (4/30/19)	4/30/19

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F 689	Continued From page 36 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by remote bed controllers cords that were frayed in two (2) of 53 resident's rooms. Findings included ... During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, and on April 25, 2019, at approximately 10:40 AM, remote bed controller electrical cords were frayed in resident room #212A and #221A, two (2) of 53 resident's rooms surveyed. The uncovered electrical wires created a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on April 25, 2019, at approximately 11:30 AM, Employee #14 acknowledged the findings.	F 689	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. All remote bed controller cards in all resident's room were checked and corrected as needed by facility operations Director. **Measures to prevent reoccurrence:** 3. Building Services and clinical staff will be educated by facility operations Director on safety issues and requirements of functional remote bed controllers. Staff will be educated on a repair request process by facility operations director to ensure timely repairs are completed. Environmental Service supervisor will conduct weekly audits X4, monthly X3. Audit results will be forwarded to the Facility Operations Director. **Monitoring corrective action:** 4. Remote beds controller cords will be added as an indicator for the building service department to be monitored during weekly scheduled surveillance rounds. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing
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.	F 744	**F-744** **Corrective action for the residents affected:** 1. The care plan of resident #33 was revised to include goals and approaches to addressing the resident diagnosed with Dementia.	4/30/19

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F 744	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 63 sampled residents, facility staff failed to initiate a care plan with measurable goals and interventions to address the care and treatment for one resident with a diagnosis of Dementia. Resident #33. Findings included . . . Resident #33 was admitted to the facility on January 10, 2017, with diagnoses which included Hypertension, Hyperlipidemia, Asthma, Depression and Non-Alzheimer's Dementia. The Annual Minimum Data Set dated January 14, 2019, showed the resident with a Brief Interview for Mental Status) BIMS score of seven (7) which is an indication that the resident's cognition is impaired. A review of the resident's care plan with a focus area of Dementia showed an initiation date of March 10, 2019. However, according to the admission documentation on the record, the resident was admitted to the facility with the diagnosis of Dementia on January 10, 2017. Based on the documentation of the care plan no care plan for Dementia was developed when the resident initially admitted to the facility.	F 744	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all the resident diagnosed with Dementia were audited if a corresponding care plan is included for the resident diagnosed with Dementia. Correction made as applicable. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service the IDT team on how to initiate the care plan with measurable goals and interventions to address the care and treatment for resident with a diagnosis of Dementia. Social Service staff will conduct a weekly audit X4, monthly X3. Audit findings will be given to the Director of Social Services. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing

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F 744	Continued From page 38 Further review of the care plan showed one goal: "Recognize persons with whom routinely have contact x 90 days." The interventions to accomplish the goal were documented as: "Approach resident and speak to in a calm, positive, reassuring manner; Explain each activity and care procedure prior to beginning it; Provide cueing and prompting for such things as activities, personal care or room location. The care plan also lacked evidence that it was (person-centered) developed specifically for Resident #33, or that there was any involvement with the resident's family members in its development. The care plan also lacked measureable goals and interventions to address the care and treatment of a resident with Dementia. During a face-to-face interview with Employee #7 at approximately 2:00 PM on April 26, 2019, the employee was queried regarding the initial date of the development of the care plan, as well as the lack of additional goals, with interventions for the care of a resident with Dementia. The employee acknowledged initiating the care plan on the documented date of March 10, 2019, but gave no explanation for the lack of additional goals and/or interventions. Facility staff failed to initiate a comprehensive person centered care plan for Resident #33 with	F 744		

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F 744	Continued From page 39 a diagnosis of Dementia. Employee #7 acknowledged the finding during a face-to-face interview at approximately 2:00 PM on April 26, 2019.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755	**F-755** **Corrective action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. A review of the reconciliation process of the controlled substance was conducted. All units identified had an accurate narcotic count. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. A review of all reconciliations was completed and no other units were affected by this deficient practice. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service all licensed nursing staff on acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medication. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 4/30/19 6/10/19 ongoing

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F 755	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of four (4) nursing units, the facility staff failed to ensure that the system use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was followed. Findings included... A review of the Shift count Narcotic records on Unit 3 North was completed on April 26, 2019, at approximately 11:00 AM. On March 11, 2019, and March 27, 2019, the Narcotic count sheet, showed the spaces allotted for nurse signature going off duty to reconcile the Narcotics for the 3:30 pm to 11:30 PM shift for both dates mentioned were left blank indicating "Not Done". A review of the Reconciliation Controlled Drug Count Verification Form Showed "Shift count sheet for Narcotics balance verified by the nurse coming on duty and nurse going off duty" The evidence showed that the the system use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was not followed. A face-to-face interview was conducted with Employee #6 on April 26, 2019, at approximately 11:10 AM. After a review of the documentation, she acknowledged the findings.	F 755		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812 SS=D	Continued From page 41 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain food equipment in safe condition as evidenced by four (4) of eight (8) hood baffles that were soiled with grease, three (3) of nine (9) one-quarter full pans and two (2) of 22 sheet pans that were stored wet, a leak from the ceiling area in front of the walk-in freezer, inadequate monitoring of freezer temperatures and food items that were not totally frozen in one (1) of one (1) walk-in freezer. Findings included ... The following observations were made during a walkthrough of dietary services on April 17, 2019, thru April 23, 2019.	F 812	**F-812** **Corrective action for the residents affected:** 1. The hood baffles that were soiled with grease was cleaned immediately after being identified during the survey. • One-quarter full pans and sheet pans that were stored wet was immediately cleaned after being identified during the survey. • Raw foods that were inappropriately thawed in the walk-in freezer has been thrown away immediately after being identified during the survey. The improper food monitoring of food temperatures in the walk-in freezer has been corrected. • The freezer and walk-in boxes were serviced. • New Fahrenheit digital thermostats were installed on each of the walk-in boxes. • New temperatures logs were created for dietary staff for all the walk-in boxes and freezer box. • The staff were in-serviced to not prop any of the doors to the freezer or walk-in boxes open. • The dietary staff were also advised to pack the boxes in such a way to not impede the air flow from the evaporator fan. • The leak on the recirculating hot water line above the freezer door was contained.	4/30/19

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F 812	Continued From page 42 1. Four (4) of eight (8) hood baffles were soiled with grease residue. 2. Three (3) of nine (9) one-quarter full pans and two (2) of 22 sheet pans were stored wet on a ready-for-use shelf. 3. A clear fluid was dripping slowly and steadily from the ceiling area located in front of the walk-in freezer. 4. Record review of the facility's policy titled, "Food Temperatures," dated 01/19, showed that refrigerators and freezer temperatures are to be monitored twice a day at opening and closing. A review of the freezer truck temperature log on April 26, 2019, at approximately 8:45 AM showed that internal freezer truck temperatures were documented just once on April 23, April 24 and April 25, 2019. 5. On April 17, 2019, at 2:17 PM, temperature gauges (2) located on the inside of the walk-in freezer read 28 degrees Fahrenheit (F) and 31 degrees F. The temperature gauge located outside the walk-in freezer read 22 degrees F. This surveyor's thermometer read 30.9 degrees F. Food items such as sausage patties and muffins were soft to the touch, but two (2) of two (2) pieces of fish were frozen solid. Four (4) of four (4) large chunks of top round	F 812	**Identification of others with potential to be affected:** 2. A review was conducted by the Engineering Director and Dietary manager no other components of the kitchen equipment was impacted by this practice. A review of the walk-in freezer temperatures and all other identified issues was conducted by the Dietary manager and no other issues were identified or impacted by this practice. **Measures to prevent reoccurrence:** 3. The Dietary manager will educate the dietary staff on appropriate and required holding temperature and monitoring the sanitary condition of the kitchen. The Dietary manager will review, develop and implement training to address how to place a work-order and maintain safety and sanitary condition of the kitchen. Dietary supervisor will conduct a weekly audit X4, monthly X3. Audit findings will be given to the Dietary Manager. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing

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F 812	Continued From page 43 beef were mostly frozen throughout except at the top which was soft to the touch. On April 17, 2019, at 5:18 PM, Employee #18 from this facility's maintenance department completed a work order submitted on April 17, 2019, at 2:49 PM with an entry stating "The refrigerator thermostat is working properly, the staff are leaving does (door) open for a long time so the temperature drops that way". On April 18, 2019, at 10:03 AM, the internal temperatures of the walk-in freezer read 32 degrees F and 34 degrees F from both gauges. At the time of observation, the door to the walk-in freezer was held open by staff to store recently delivered food items. At approximately 10:12 AM, the internal temperature of the walk-in freezer was 34.8 degrees F as measured from this surveyor's thermometer but food items such as a box of chicken nuggets and four (4) of four (4) twenty-ounce bags of French fries were frozen solid. At approximately 2:30 PM on April 18, 2019, the maintenance representative from Tidewater Refrigeration informed this surveyor that he did not identify any technical issues with the walk-in freezer and the temperatures normally increase during any and all of the freezer's four (4) defrost cycles.	F 812		

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F 812	Continued From page 44 On April 19, 2019, at approximately 9:10 AM, Employee #11 presented a copy of a sign-in sheet for an in-service that was done for dietary staff in regards to keeping the refrigerator and freezer door close to maintain internal temperatures. At 4:15 PM on April 19, 2019, the outside temperature gauge of the walk-in freezer read 28 degrees F. On April 22, 2019, at 7:13 AM and at 7:38 AM, Employee #19 from this facility's maintenance department completed a work order submitted on April 20, 2019, with an entry stating "The outside thermometer was checked and it is reading the inside temperature accurately." and "No problem with thermometer". On April 22, 2019, at 9:22 AM, the temperature of the walk-in freezer was 36 degrees F. At about that time, Employee #11 informed this surveyor that the facility had rented a freezer truck on Sunday, April 21, 2019, and staff had moved all foods from the walk-in freezer to the freezer truck after it was delivered. Employee #11 was asked for a written statement to describe the events on April 19, 20th. and 21st. that led to the decision by the facility to rent a freezer truck. Employee #11 presented this surveyor with a copy of an e-mail from employee #17, a consultant for the facility.	F 812		

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According to the e-mail, Employee #17 came in to the facility on the evening of April 19th to "address temperature issues relating to the walk-in freezer" and placed a service call with Tidewater Refrigeration. "In addition the meats were placed in another cooler." The facility has a small freezer available in the kitchen.

"Tidewater came out at 11:00PM on April 19th and determined that the walk in box needed a TXV (Thermostatic expansion valve) valve. They came back at Saturday April 20th @ 8:00am and finish the repair At 1.00 PM Saturday April 16th [sic] (20th). Tidewater called me and assured that the freezer unit was working properly at that time. I stop by the site on Sunday at 8:00am and found the temps in the cooler at 21 degrees. At that point I called Tidewater Refrigeration back and they came back at 1:00PM. On Sunday morning April 21st it was decided to invest in a refrigerated freezer truck. The truck was delivered at 3:00PM on April 21st to the site."

A copy of an e-mail from Tidewater Refrigeration to the facility, dated April 22, 2019 states:

"The walk-in freezer at your location was running normally when the tech arrived. Unit at 7 degrees. This unit is made to store product that comes in frozen or from freezer to freezer. (The frozen product from another freezer into the WI freezer. The product is already

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frozen & will stay that way). It is not made to freeze product from the cooler to freezer instantly or with-in a short time frame. It will take considerable time to freeze that product."

On April 22, 2019, at 11:12 AM, the temperature inside the freezer truck was 12.5 degrees F and all foods were frozen solid.

The outside temperature of the empty walk-in freezer was monitored throughout the survey. On April 22, 2019, at approximately 11:30 AM, Employee #11 placed two (2) buckets of water inside the empty walk-in freeer as a way to test its freezing capability. The freezer was locked to prevent facility staff from opening the door and therefore causing temperatures to fluctuate.

The following are walk-in freezer temperature readings from the temperature gauge located outside the walk-in freezer throughout the survey:

Date	Time	Temperature
4-23-2019	8:50 AM	17 degrees F
4-23-2019	4:37 PM	-16 degrees F
4-24-2019	8:59 AM	16 degrees F
4-24-2019	4:21 PM	-20 degrees F
4-25-2019	9:08 AM	

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20 degrees F
4-25-2019 9:17 AM 4 degrees F
4-25-2019 4:35 PM -20 degrees F
4-26-2019 8:33 AM -20 degrees F
4-26-2019 10:24 AM -10 degrees F
4-26-2019 2:30 PM -20 degrees F
4-29-2019 9:00 AM 0 degrees F
4-29-2019 5:32 PM -21 degrees F

On April 25, 2019, at approximately 4:35 PM, this surveyor requested Employee #12 to unlock the walk-in freezer. Inside, the two (2) buckets of water that had been placed on a shelf since Monday, April 22, 2019, by Employee #11 were frozen solid. The internal gauges read -20 degrees F and -17 degrees F.

Frozen foods remained in the freezer truck where temperatures were stable and food items were frozen solid.

During a face-to-face interview on April 25, 2019, at approximately 11:00 AM, Employee #11 acknowledged these findings.

F-842 Resident #29 and #111

Corrective action for the residents affected:

1. Resident # 29 MDS was corrected to reflect the use of psychotropic medication. Resident #111 missing shower sheets could not be retroactively corrected. The involved employee will be counseled for failure to accurately document the use of Psychotropic medications, fall assessment forms and failed to maintain facility shower sheets.

F 842 SS=D	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.	F 842		4/30/19

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F 842	Continued From page 48 (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 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	F 842	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. The facility has audited all resident on Psychotropic medications, fall assessments forms and shower sheets. Correction made as applicable. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-serve licensed nursing staff and MDS coordinators on accurately documenting the use of Psychotropic medications, fall assessment forms, and shower sheets. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing

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F 842	Continued From page 49 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, medical record review and staff interview for two (2) of 63 sampled residents, facility staff failed to accurately document one resident's use of psychotropic medications on four (4) of five (5) fall assessment forms; and failed to maintain facility documents (shower sheets) that were accurate and complete to ensure medical records are maintained in a systematically organized manner. Residents #29 and #111. Findings included . . . Record review of the facility's policy titled Mobility	F 842		

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and Falls/Falls with Injury Prevention with a revised date of February, 2019, "Fall risk assessment is done upon admission and readmission and quarterly."

1. Resident #29 was admitted to the facility on April 21, 2016 with diagnoses which included Hypertension, Hyperlipidemia, Non-Alzheimer's Disease, Generalized Muscle Weakness and Paranoid Personality Disorder.

According to the quarterly Minimum Data Set (MDS) which was completed on January 13, 2019 the resident's Brief Interview for Mental Status (BIMS) score was four (4) which indicates that the resident is significantly cognitively impaired. In section G0110 Activities of Daily Living (ADL) Assistance the resident is coded as requiring supervision and support from staff for the following activities, (Bed mobility, Transfer, Locomotion on unit, Personal Hygiene, Toileting, Dressing and Eating). In section G0120 Bathing the resident needs physical help and support in part of bathing activity.

During a face-to-face interview with Employee #2 at approximately 3:00 PM on April 26, 2019 the employee informed this writer that, "Fall Assessments are done on admission, readmission, quarterly and after every fall".

Review of the current Physician's order sheet for the month of April showed that Resident #29 was initially placed on Quetiapine (Seroquel)12.5 mg (milligrams) Q (every) 12 hours for Dementia with Psychosis on October 12, 2017. A nurse's progress note dated April 4, 2019 showed that

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F 842	Continued From page 51 Seroquel was decreased to 12.5mg daily after the resident sustained a fall without injury at approximately 2:00 AM on April 4, 2019 Five (5) Fall Risk assessment forms were reviewed. Each form is divided into 11 categories: 1. Reason for Assessment Request 2. Date of Admission 3. History of Falls within last six months 4. Medication Use: Medication taken more than 3x/week including prn's 5. Memory and recall ability 6. Vision Pattern 7. Continence in last 14 days 8. Agitated Behavior 9. Confined to a chair 10. Blood Pressure: Drop in Systolic pressure 11. Gait Analysis: Assess resident's gait while standing in one spot, walking straight forward and while making a turn. Under item 4 Medication Use, 12 classes of medications are identified and Psychotropic medication is included among the medications. However, the facility staff failed to check this class of medication (Psychotropic) although the resident received Seroquel daily from October 12, 2017 to present (April 29, 2019.) The Fall Risk Assessment Forms that were not checked for the use of Psychotropic medications were dated July 20, 2018, December 30, 2018, January 20, 2019 and February 20,2019.	F 842		

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F 842	Continued From page 52 A face-to-face interview was conducted with Employee #2 at approximately 10:00 AM on April 29, 2019. During the interview Employee #2 acknowledged the finding (that the facility staff failed to document the use of Psychotropic medications on the Risk Assessment Forms. 2. Resident# 111 was admitted to the facility on 2/22/19 with diagnoses to include: Essential (Hemorrhagic) Thrombocythemia, Unspecified Wound, Left Knee, and Essential (Primary) Hypertension. Review of the Comprehensive Minimum Data Set [MDS] dated 3/1/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "13" which indicates cognitively intact. During a patient interview on 4/24/19 at 11:00 AM resident stated "I have a concern about my roommate he refuses showers and he has a bad odor he wears a diaper and he has to wait for staff to change him, I told the social worker that I want my room changed." During an interview on 4/24/19 at 11:30 AM, Employee #21 states "The resident did come to me but he did not tell me what he wanted to talk to me about, I will go back to him and see if I can address his concern." Observation on 4/24/19 at 12:00 PM showed Resident # 197 (roommate of Resident # 111), sitting quietly in a wheelchair in his room, there	F 842		

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F 842	Continued From page 53 was no odor detected and his clothing did not appear to be soiled. Resident #197 was admitted to the facility on 10/25/2005, with diagnoses to include; Hypertension, Pneumonia, Hyperlipidemia, Aphasia, Non-Alzheimer's Dementia and Hemiplegia. Review of the Comprehensive Minimum Data Set [MDS] dated 3/1/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "6" which indicates severe cognitive impairment. Section G [Functional Status] resident was coded as "4" for bathing which indicate total dependence (full staff performance every time). Review of the facility documents (shower sheets) for the month of March showed "Resident #197, shower days Tuesday and Friday" and the sheets were left blank with the exception of three days "refused" was written without a date or signature. Review of April shower sheets showed "Resident #197 shower days Tuesday and Friday" the sheets were blank. During an interview on 4/24/19 at 1:00 PM Employee #2 states "I see the sheets are blank and you can't tell if the resident received a shower or not I will talk with the staff about completing and signing the sheets" Facility staff failed to maintain facility documents (shower sheets) for accuracy and completeness to indicate whether a resident received a shower on scheduled shower days.	F 842		

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F 842	Continued From page 54 During a face-to-face interview on 4/24/19 at 1:00 PM, Employee #2 acknowledged the findings.	F 842	**F-880** **Corrective action for the residents affected:** **1.** There was no negative outcome for this deficiency practice. The facility could not retroactively correct the deficiency. The facility re-initiated the infection surveillance program. A Director of Quality Assurance was hired. The QA Director is responsible to conduct infection surveillance to identify, track, monitor and/or report infections.	4/30/19
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880	**Identification of others with potential to be affected:** **2.** All residents have the potential to be affected. The Infection Surveillance Program was reviewed by the Administrator and the DON to determine adequacy and effectiveness. Infection Surveillance Program has been developed and are being tracked to ensure a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff, volunteers, visitors, and other individuals. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service license nursing staff on Infection Surveillance Program, developing, tracking to ensure a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff, volunteers, visitors, and other individuals. Auditing the medical record will be reviewed during daily stand-up meetings and during quarterly QA meetings. Weekly audits will be performed for 3 months. Findings will be forwarded to the DON.	ongoing 6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	04/29/2019

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F 880	Continued From page 56 Findings included . . . According to the Center for Disease Control's (CDC's) definition "Surveillance is defined as the ongoing systematic collection, analysis, interpretation and dissemination of data." National Healthcare Safety Network (NHSN) Overview, Options for Long-term Care Facilities January, 2019. Facility failed to provide evidence that infection surveillance was conducted for 5 months; July, August, October, November and December of 2018. On April 29, 2019 at approximately 2:47 PM a review of the facility's Infection Control Program was conducted with Employee #2. During the interview the employee failed to present a line listing of any residents who were admitted into the facility with infections that were community acquired; residents who acquired infections while in the facility; any illnesses that required residents to be isolated; residents who required treatment with antibiotics and/or other contagious diseases for the months of July, August, October, November and December 2018. When asked about the absence of the reports the employee was not able to present them and acknowledged that no data was collected for those 5 months. The facility failed to conduct infection surveillance to identify, track, monitor and/or report infections	F 880	**Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	ongoing

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F 880	Continued From page 57 for five (5) of 12 months during the year of 2018. Employee #2 acknowledged the finding during a face-to-face interview on April 29, 2019 at approximately 2:47 PM.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain mechanical and electrical equipment in safe operating condition as evidenced by two (2) remote bed controllers and a call bell cord that were frayed in three (3) of 53 resident's rooms. Findings included ... 1. During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, and on April 25, 2019, at approximately 10:40 AM, remote bed controller electrical cords were frayed in resident room #212A and #221A, two (2) of 53 resident's rooms surveyed. 2. The call bell cord was frayed and its electrical wires were visible and accessible in one (1) of 53 resident's rooms (#115B). The uncovered electrical wires created a potential electrical shock hazard to residents, staff and the public.	F 908	**F-908** **Corrective action for the residents affected:** 1. The residents in room #212A, #221A, and #115B had no negative outcome. The remote bed controller electrical cords in room #212A, #221A that were frayed and the call bell cords that were frayed in #115B was repaired by facility operations director. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. All remote bed controller cords and call bed cords in all resident room were checked and corrected as needed by facility operations Director. **Measures to prevent reoccurrence:** 3. Building Services and clinical staff will be educated by facility operation Director on safety issues and requirements of functional remote bed controllers and call bells. Staff will be educated on the repair request process by facility operation Director to ensure timely repairs are completed. Environmental supervisor will complete audit weekly X4, monthly X3. Audit finding will be forwarded to the facility Operations Director. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 4/30/19 6/10/19 ongoing

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F 908	Continued From page 58 During a face-to-face interview on April 25, 2019, at approximately 11:30 AM, Employee #14 acknowledged the findings.	F 908		
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, the facility failed to maintain the call bell system in good working condition as evidenced by a call bell in one (1) of 53 resident's rooms that failed to alarm when tested. Findings included... During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, the call bell in one (1) of 53 resident's room (#115B) did not alarm when activated. This breakdown could prevent or delay the resident, staff or the public from alerting staff in an emergency. During a face-to-face interview, on April 18, 2019, at approximately 3:30 PM, Employee #13 acknowledged the finding.	F 919	**F-919** **Corrective action for the residents affected:** 1. Resident #115B had no negative outcome. The call bell that did not alarm when activated was repaired by the facility operations Director. (4/29/19) **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. All call bells in all residents rooms were checked to alarm when activated by facility operations director. No other non-functioning call bell was found. **Measures to prevent reoccurrence:** 3. Building services and clinical staff will be educated by facility operations director on safety issues and requirements of functional call bells. Staff will be educated on the repair request process by facility operations director to ensure timely repairs are completed. Environmental supervisor will complete audit weekly X4, monthly X3. Audit finding will be forwarded to the facility Operations Director. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/29/19 4/29/19 6/10/19 ongoing