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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 2/25/2020.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/25/2020

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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from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 83 residents. The sample included 18 residents with four reviewed for dignity. Based on observation, record review, and interview, the facility failed to provide dignity and quality of life for three of four sampled residents, Resident (R) 28, R36 and R71. Staff left R28 unattended on the toilet hooked to a sit to stand lift (mechanical lift used to transfer people between a bed and chair), staff obtained R36's blood sugar reading in the dining room with numerous other residents present, and staff failed to respond to R71's request for toileting assistance.

Findings included:

- On 02/16/2020 at 01:30 PM, observation revealed R28 hollered "help, help, help," the surveyor knocked on the door, and entered the residents room. Observation revealed the resident continued hollering and sat on the toilet hooked to a sit to stand lift without staff in attendance.

On 02/18/2020 at 11:40 AM, observation revealed Licensed Nurse (LN) J obtained R36's blood sugar reading at the dining room table in the main dining room prior to obtaining her meal. Observation revealed three other residents at the

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table and the dining room filled with numerous residents.

On 02/19/2020 at 10:10 AM, Administrative Nurse D verified the nurse should take R36 to her room to obtain blood sugar readings in private and R28 should not have been left on the toilet without staff in attendance.

The facility's "Privacy/Dignity" policy, dated January 2020, documented each resident will be treated in a respectful manner to maintain the privacy/dignity.

The facility failed to provide care for R28 and R36 in a manner to maintain and enhance dignity and respect, placing the resident at risk for an undignified experience.

- On 02/17/2020 at 01:50 PM, observation revealed R71 sat in his Broda chair (a tilt space positioning wheelchair) in the living room. Further observation revealed the resident with his hand in the air attempting to get the staff's attention and stated "need to go to the bathroom." Further observation revealed three different direct care staff members walked past the resident and failed to assist him.

On 02/18/2020 at 02:10 PM, observation revealed the resident sat in his Broda chair with his pants unbuttoned and his hands in his pants.

On 02/18/2020 at 03:00 PM, observation revealed the resident sat in his Broda chair by the nurse's desk, removed his wristwatch, and placed it in his chair. Certified Nurse Aide (CNA) D, CNA Q, and LN I sat at nurse's desk, surveyor alerted staff

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F 550	Continued From page 3 that resident had removed his watch and placed it in his chair. LN I stated, "We have been through a number of watches with him." Further observation revealed CNA D, CNA Q, and LN I remained seated at the desk and did not provide assistance to the resident. The facility's "Dignity" policy, dated January 2020, stated residents should be treated in a respectful and dignified manner. The facility failed to provide R71 care in a manner to maintain and enhance dignity and respect, placing the resident at risk for an undignified experience.	F 550		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 83 residents. Based on observation, record review, and interview, the facility failed to ensure the environment remained free of accident hazards when staff failed to properly store and secure chemicals. Findings Included: - On 02/16/2020 at 10:45 AM, observation during initial tour revealed an unlocked cabinet in the	F 689		

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F 689	Continued From page 4 Southwest shower room with the following items: One 16 ounce (oz) can of disinfectant cleaner spray with the warning labels "keep out of reach of children" and "harmful if swallowed, can cause burns/serious damage to mouth, throat and stomach." One 6.6 oz can of air freshener, with the warning labels "extremely flammable", "harmful by inhalation, irritating to the respiratory tract (airway for breathing), irritating to eyes, may cause skin irritation or asphyxiation (lack of oxygen)." On 02/16/2020 at 10:55 AM, License Nurse (LN) H stated the shower room cabinet should be locked at all times and the facility had seven cognitively impaired, independently mobile residents. The facility's "Storage of Chemicals" policy, dated November 2019, documented the facility would store all biologicals in a safe, secure, and orderly manner. The facility would lock drawers, cabinets, and rooms when not in use. The facility failed to ensure chemicals were kept in a locked room, placing the seven cognitively impaired, independently mobile residents who resided at the facility at risk for injury.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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F 690	Continued From page 5 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 83 residents. The sample included 18 residents with five reviewed for bowel and bladder incontinence. Based on observation, record review, and interview, the facility failed to provide care and services for two of five sampled residents who required extensive assistance with toileting, Resident (R) 71 and R7. Findings included:	F 690		

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- R71's "Quarterly Minimum Data Set" (MDS), dated 01/30/2020, recorded the resident had moderately impaired cognition and required extensive assistance from one staff for toileting.

The "Urinary Incontinence Care Area Assessment" (CAA), dated 11/06/19, recorded the resident frequently incontinent of urine and required extensive staff assistance for toileting safely, including management for the use of his incontinent products.

The "Activities of Daily Living (ADLs) Care Plan," dated 01/29/2020, recorded the resident required assistance of one staff to use the bathroom and wore medium pull up briefs during the day and night. The care plan directed staff to follow the resident's toileting schedule.

The "Toileting Schedule," dated 01/29/2020, directed staff to toilet the resident upon arising, after breakfast, lunch and dinner, and as needed.

On 02/17/2020 at 07:45 AM, observation revealed the resident sat in his Broda chair (a tilt in space positioning wheelchair) in the West dining room. Continued observation at 08:10 AM revealed the resident sat in his Broda chair in the hallway outside the West dining room. Continued observation at 08:40 AM revealed the resident sat in his Broda chair in the hallway outside the West dining room with his head to his chest and eyes closed. Continued observation from 08:40 AM until 11:10 AM revealed the resident sat in his Broda chair in the hallway outside the West dining room and no staff offered to toilet the resident.

On 02/17/2020 at 11:10 AM, observation revealed R71 sat in his Broda chair, Certified Nurse Aide

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(CNA) P propelled the resident from the hallway to the dining room, and did not toilet the resident.

On 02/17/2020 at 01:10 PM, observation revealed CNA Q propelled the resident in his Broda chair from the dining room to the living room.

On 02/17/2020 at 01:50 PM, observation revealed the resident sat in his Broda chair in the living room. Further observation revealed the resident with his hand in the air, attempted to get the staff's attention, and stated, "need to go to the bathroom." Further observation revealed three different direct care staff walked past the resident and did not stop to assist him.

On 02/17/2020 at 02:10 PM, the surveyor requested staff assist the resident to the bathroom and CNA Q stated "we just took him to the bathroom."

On 02/17/2020 at 02:10 PM, observation revealed CNA Q propelled the resident in his Broda chair to his room. Further observation revealed CNA Q propelled the Broda chair into R71's bathroom, placed a gait belt around the resident's waist then applied clean gloves. CNA Q explained to the resident he needed to stand up with CNA Q's assistance, turn, and sit on the toilet. After the resident was on the toilet, CNA Q removed R71's saturated incontinence brief.

On 02/18/2020 at 07:30 AM, observation revealed the resident sat in his Broda chair in the West dining room.

On 02/18/2020 at 09:00 AM, observation revealed CNA P propelled the resident in his Broda chair out of the dining room to the hallway and did not

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toilet the resident. Continued observation from 09:00 AM - 11:00 AM revealed the resident sat in his Broda chair in the hallway with eyes closed, chin to his chest, and no staff offered to toilet the resident.

On 02/18/2020 at 11:00 AM, observation revealed CNA P propelled the resident in his Broda chair into the dining room.

On 02/18/2020 at 01:15 PM, observation revealed CNA P propelled the resident in his Broda chair from the dining room into the living room.

On 02/18/2020 at 02:10 PM, observation revealed the resident sat in his Broda chair with his pants unbuttoned and his hand in his pants. Further observation revealed the resident stated, "bathroom." The surveyor requested staff assist the resident to the bathroom and Licensed Nurse (LN) I requested CNA P take the resident to the bathroom.

On 02/18/2020 at 02:10 PM, observation revealed CNA P propelled the resident in his Broda chair into the bathroom, applied clean gloves, placed a gait belt around the resident's waist, and asked him to stand. Further observation revealed the resident able to stand and pivoted to the toilet, CNA P removed the saturated incontinence brief.

On 02/18/2020 at 04:15 PM, observation revealed the resident sat in his Broda chair in the living room with his pants undone and both hands down the front of his pants.

On 02/19/2020 at 07:40 AM, observation revealed the resident sat in his Broda chair in the dining room. Continued observation at 08:20 AM

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revealed CNA MM propelled the resident in his Broda chair into the hallway outside of the dining room. Continued observation at 09:15 AM revealed CNA MM propelled the resident in his Broda chair into the activity room. Continued observation from 09:15 AM - 11:00 AM revealed the resident remained in the activity room and staff did not offer toileting.

On 02/19/2020 at 11:00 AM, CNA MM propelled the resident in his Broda chair from the activity room into the dining room and did not toilet the resident.

On 02/17/2020 at 08:10 AM, the resident stated, "they have to help me to the bathroom."

On 02/17/2020 at 02:20 PM, CNA Q stated she was unsure if someone had taken the resident to the bathroom after she assisted the resident out of bed that morning.

On 02/18/2020 at 08:40 AM, Administrative Nurse E stated the resident's toileting schedule directed staff to toilet the resident upon arising, after meals and as needed.

On 02/19/2020 at 09:15 AM, LN I stated the resident had a toileting schedule and she expected the CNA's to take the resident to the bathroom and change his incontinent brief per the schedule.

On 02/19/2020 at 11:00 AM, Administrative Nurse D stated he expected staff to follow the resident's toileting schedule.

The facility's "Bathroom Toileting" policy, dated February 2020, stated the resident toileting needs

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will be assessed and specific toileting needs will be care planned. Appropriate toileting needs will be provided for residents who are unable to carry out toileting independently.

The facility failed to follow R71's toileting plan, placing the resident at risk for increased incontinence and unclean personal hygiene.

- R7's "Quarterly MDS," dated 11/25/19, documented the resident had long and short term memory problems, severely impaired cognition, and rarely or never understood. The MDS documented R7 required total staff assistance with all ADLs, required the use of a full lift (mechanical lift used for transferring) for transfers, and extensive assistance for toileting.

The "ADL CAA," dated 04/01/19, documented R7 unable to perform ADLs without significant physical assistance.

The "ADL Care Plan," dated 11/25/19, documented two staff transferred the resident with a full lift. The care plan documented the resident used the bathroom but unable to use the toilet and wore incontinence briefs.

The "Bowel and Bladder Electronic Health Records" (EHR), dated 02/12/2020, documented R7 had severe cognitive impairment and dependent on two staff for transfers. The EHR instructed staff to continue the plan of care for scheduled incontinence care.

On 02/19/2020 at 07:30 AM, observation revealed CNA M propelled R7 to the sunroom adjacent to the dining area. Continued observation at 08:04

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AM, revealed CNA M propelled R7 to the dining table for breakfast. Continued observation at 09:10 AM, revealed AS Z propelled R7 to the activity room and had not toileted the resident. Continued observation at 10:08 AM, revealed AS Z propelled R7 to the sunroom, adjacent to the dining area.

On 02/19/2020 at 10:25 AM, observation revealed CNA N and CNA O transferred R7 to his bed with full mechanical lift, applied gloves, and removed a saturated incontinence brief. Observation revealed CNA N and CNA O disposed of soiled gloves, applied clean gloves, and applied a fresh brief.

On 02/19/2020 at 09:11 AM, LN G stated staff were to check and change the dependent residents incontinence briefs before and after meals, and at bedtime.

On 02/19/2020 at 10:16 AM, CNA O stated dependent residents incontinence briefs were checked and changed "every couple of hours."

On 02/19/2020 at 10:45 AM, Administrative Nurse D stated each resident should be toileted according to the facility's check and change policy.

The facility's "Bathroom Toileting Program" policy, dated February 2020, documented facility staff would review resident care plans to assess needs of the resident and specific toileting needs and appropriate care would be provided for residents who were unable to carry out toileting independently.

The facility failed to provide R7 timely bowel and

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F 690	Continued From page 12 bladder care, placing the resident at risk for incontinence and moisture related skin issues.	F 690		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: The facility had a census of 83 residents. Based on observation, record review, and interview, the facility failed to firmly secure handrails on two of five hallways. Findings included: - On 02/18/2020 at 04:30 PM, observation revealed an 18 foot hand rail attached to a brick wall on the West dining room hallway with loose brackets and hand rail. On 02/18/2020 at 04:40 PM, observation of the Northwest hallway outside Room 113 revealed the wooden hand rail with 2 inch gap area by bracket. On 02/18/2020 at 04:40 PM, observation of the Northwest hallway outside Room 116 revealed the wooden hand rail uneven with rough edges. On 02/18/2020 at 04:45 PM, Maintenance Staff U verified the above findings. The facility's "Preventative Maintenance Program" policy, dated January 2020, stated to assure continued operation in the facility of equipment and furnishings will be inspected and repaired.	F 924		

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F 924	Continued From page 13 The facility failed to maintain secure handrails on two of five hallways, placing the residents at risk for injury.	F 924		