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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 09/13/19. A revised 2567 was electronically sent to the facility on 09/16/19.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/13/2019

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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provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 59 residents with 17 selected for review. Based on observation, interview and record review, the facility failed to ensure one resident, Resident (R) 42's, health information regarding her diagnosis of Bipolar Disorder (major mental illness that caused people to have episodes of severe high and low moods) remained confidential and private.

Findings included:

- Review of R42's "Physician Order Sheet," dated 08/02/19, indicated a diagnosis of Bipolar Disorder.

Observation, on 09/04/19 at 12:31 PM, revealed the resident seated in the common dining room finishing her noon meal. Another unidentified resident and Certified staff P remained in the dining room with various staff and residents walking by the dining area. Consulting staff GG began conversing with the resident, in a normal voice, to encourage the resident to go outside. Staff GG stated, to the resident, "Research shows that people with Bipolar Disorder benefit from being outside."

Interview, on 09/05/19 at 4:30 PM, with administrative nursing staff D, indicated the

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F 583	Continued From page 2 expectation that all staff ensure confidentiality of resident diagnoses. Interview, on 09/09/19 at 1:30 PM, with Consulting staff GG, revealed he realized he violated the resident's right to privacy when he spoke about Bipolar Disorder to the resident. The facility policy titled, "Notice of Privacy Information Practices," dated 9-23-13, indicated confidential information about residents to unauthorized persons is strictly prohibited. The facility failed to ensure staff kept this resident's health information including her diagnosis of Bipolar Disorder confidential and private.	F 583		
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	F 657		

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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:
The facility reported a census of 59 residents, with 17 selected for review. Based on observation, interview, and record review the facility failed to review and revise the care plans to acurately provide the care for two Residents (R) 20, related to fall prevention, and R6 related to the use of geri sleeves.

Findings Included:

- The "Physician Order Sheet," indicated Resident (R) 20 had the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, insomnia (inability to sleep), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The Significant change "Minimum Data Set" (MDS), dated 10/11/18, recorded the resident admitted on 05/02/18. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely

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impaired cognition and she had a short and long-term memory problem. She had range of motion impairment on one side of her upper extremity and impairment to both sides of her lower extremities. She required extensive assistance of two staff members with bed mobility, transfers, dressing, and toileting, required the extensive assistance of one staff member for locomotion on and off the unit, and with her personal hygiene. She had 2 or more falls since the prior assessment with one injury, not major, and one major injury.

The Quarterly "MDS," dated 07/03/19, indicated the resident had a BIMS score of 99, which indicated severely impaired cognition. She had disorganized thinking, inattention present and that did not fluctuate through the day and wandered daily. Her balance while walking was not steady and was only able to stabilize with extensive assistance of one staff member. She required extensive assist of 1 staff for transfer and ambulation. She had one fall with injury since prior assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 10/11/18, indicated the staff were unable to complete the BIMS as the resident "simply smiled" at the nurse when she attempted to ask her questions.

The "Falls CAA," dated 10/11/18, indicated staff used a motion sensor remote alarm as the resident's dementia was profound and that she did not use the call light. She had no safety awareness and simply got up to move to do what she needed (such as toileting). The CAA indicated that the alarm in no way limited her movements and that it did not keep her from

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doing what she was trying to do. The alarm simply alerted the staff of her movements to allow the staff to go and help with her needs.

The "Fall Risk Assessment," identified a score of 10 to 99 indicated the resident was at a high risk for falls. "Fall Risk Assessment's" completed and scored as follows:
12/13/18 score of 21; 01/01/19 score of 21; 01/29/19 score of 26; 03/28/19 score of 25; 05/21/19 score of 28; 08/01/19 score of 28; 08/11/19 score of 32; and 09/08/19 score of 32. A fall risk assessment for the fall on 03/10/19 was not completed.

The fall care plan, dated 05/21/19, indicated the resident had falls on 01/01/19; 01/29/19; 03/10/19; 03/28/19; and 05/21/19. The care plan had written in notes for falls on 08/01/19; and 08/11/19. The care plan lacked an update after the fall on 12/13/18 in which the resident was wearing slip on shoes and
included the following interventions:

10/14/18 - staff were to encourage her to wear tennis shoes and not to wear slip on shoes
10/17/18 - was to wear non-skid footwear
01/29/19 -place a pressure sensitive alarm to her bed, wheelchair and recliner,
(no date documented) - place an auto locking brake system on her wheelchair.
03/28/19 - Encourage resting in visible areas to promote safety.
08/01/19 - Staff to keep floor free of small items. (Already put into place on fall investigation dated 12/13/18).
08/11/19 - Keep resident close as she is very unsteady (Same as 03/28/19).

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The facilities "Fall Investigation," dated 12/13/18, recorded a fall on 12/13/18. R20 had been sleeping in a chair in her room, and staff found the resident lying on her right side on the floor, next to the chair, in front of the closet door. The investigation further documented there was a small piece of food next to her on the floor, she had on slip on shoes (care planned 10/14/18 not to wear slip on shoes), and had been toileted at approximately 09:30 PM. The indicated intervention directed staff to ensure there was no debris left on the floor by the resident. The care plan lacked evidence of an updated intervention for this fall.

The "Nursing Note," dated 03/28/19 at 07:32 PM, documented the resident attempted to stand from the recliner, landing on her knees with no injury noted. Intervention was to rest in populated areas.

The "Nursing Note," dated 05/21/19 at 02:49 AM, indicated the resident had a fall resulting in a laceration to her forehead requiring sutures. The note indicated that the resident was observed by facility staff to stand up from her wheelchair and fall forward, with the alarm sounding. The intervention directed when staff noticed the resident becoming restless to offer her a change. For example, help her to a different chair or take her to the bathroom .

The "Nursing Note," dated 08/01/19 at 10:02 PM, indicated the resident had a fall when she attempted to pick up small debris from the floor around the trash can. The intervention noted on the care plan was to continue to keep small trash off the floor around the resident. This was a

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repeat of the resident's action for the fall on 12/13/18 .

The "Nursing Note," dated 08/11/19 at 09:13 PM, indicated that R20 had a fall after she stood up from the recliner and lost her balance. The resident's personal alarm alerted staff. The intervention was to keep her close as she is unsteady. This was a repeat intervention from the fall on 03/28/19 (Encourage resting in visible areas to promote safety).

Observation, on 09/04/19 at 11:13 AM, R20 observed with aid of Certified Nurse Aide (CNA) O and Licensed Nurse (LN) G stand up from the recliner in West POD area and ambulated her. R20 had a steady gait, a gait belt in place, one staff assisted and one pushed wheelchair behind, to her bathroom.

On 09/05/19 at 01:30 PM, (CNA) O, reported R20 was to have an alarm in place, and to keep her busy. She stated R20 had multiple falls and she knows to look at the care plan for new interventions.

On 09/05/19 at 03:03 PM, Licensed Nurse (LN) G, stated the intervention and update of the care plan was the responsibility of the nurse present at the time of the fall. She stated she did check as she was performing her tasks by asking the CNA's if they had followed the planned interventions. She stated the new interventions are shared to all staff through emails, clip board (tool used to report resident status at the end of the shift), and report. She confirmed that the interventions on both the 08/01/19 and the 08/11/19 falls were duplicates of previous falls.

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Observation, on 09/09/19 at 07:40 AM, revealed R20 sitting in the recliner in West POD area, alarm in place, call light within reach, shoes on. R20 had a dressing in place above her right eye, with bruising noted over her right eye and down her right cheek.

On 09/09/19 at 02:00 PM, Administrative Nurse D, indicated the interventions, even though duplicated, were appropriate for the falls. Staff D stated it was unrealistic to expect new interventions if there was an intervention in place that worked for that fall. Staff D indicated R20 had a fall on 09/08/19, and the intervention was to have two staff with all planned transfers.

On 09/09/19 at 02:00 PM, Administrative Nurse D, stated the interventions, even though duplicated, were appropriate for the falls. He stated that it was unrealistic to expect new interventions if there was an intervention in place that worked for that fall. He did indicate he knew R20 had a fall on 09/08/19, and that he knew the intervention was to have two staff with all planned transfers.

Review of the facility's undated policy titled, "Changes to Care Plan," indicated the procedure for falls would be that the care plan will be revised after every fall to include specific instructions to the staff based on the causal factors identified at the time of the occurrence and during the fall investigatory process to prevent or reduce the possibility for recurrence of a fall.

Review of the facility's undated policy titled, "Fall Prevention and Fall Follow-up," indicated the procedure of a prevention protocol will be initiated with documentation on the care plan.

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The facility failed to review and revise the fall care plan for this resident to ensure the resident remained free of repeated falls.

- Review of Resident (R) 6's "Physician Order Sheet", dated 07/29/19, indicated diagnoses included cerebral vascular accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis (muscular weakness of one half of the body) and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

Review of the admission "Minimum Data Set" (MDS), dated 08/22/19, indicated the resident's Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS indicated the resident required extensive assistance of 1 staff for bed mobility, transfer and dressing. The resident had impairment in range of motion in both upper and lower extremities bilaterally. This MDS indicated the resident admitted to the facility with a stage two pressure ulcer and a skin tear.

The quarterly MDS, dated 08/22/19, indicated the resident's BIMS score of 14, required extensive assistance of 1 staff for bed mobility, transfer and dressing. The resident had impairment in range of motion in his upper and lower extremities.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 6-7-19, assessed the resident with multiple bruises on both arms as well as scabs on skin. Nursing staff presented the resident with

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gerisleeves (soft protective sleeve like devises to protect skin) and the resident agreed to wear the sleeves to help prevent skin tears and bruising.

The care plan, dated 05/28/19 advised staff of the resident's fragile skin and staff were to assist him with position changes. The care plan lacked evidence instructing staff to assist the resident to apply the gerisleeves to protect the resident's fragile skin.

A nurses' note, dated 08/12/19, indicated the resident had a skin tear to his left forearm from a change in clothing and staff cleaned the area and applied a dressing. This note lacked measurements of the skin tear or the dressing type.

Observation, on 09/03/19 at 10:51 AM, revealed the resident seated in his recliner in his room. The resident had an approximate six centimeter (cm) bruise on his left forearm with a darker blue/purple raised area in the center of the bruise. The resident did not have gerisleeves on. The resident appropriately answered questions and stated he did not know how or when the bruise occurred. The resident stated he had a skin tear several weeks ago on his left arm. The resident stated he did not think the skin tear was in the area of the bruise.

Interview, on 09/05/19 at 10:00 AM with Licensed Nurse G revealed she did not know how or when the resident obtained the bruise on his left forearm.

Observation, on 09/05/19 at 10:00 AM, revealed the resident seated in his recliner in his room. The resident did not have gerisleeves on.

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Licensed Nurse G measured the bruise area, at that time, as. Staff G noted the darker raised area in the bruise and measured it as 2.3 cm by 2.4 cm. Staff G stated she would document the bruise in the electronic record.

Interview, on 09/05/19 at 11 :00 AM, with Certified Nurse Aide M, revealed she did not know the resident had a bruise on his left forearm, but that the resident usually did have areas of bruising on his arms.

Interview , on 09/09/19 at 02:24 PM with Licensed Nursing Staff G, stated she did assess the resident, on 08/12/19, for a skin tear and documented this in a nurses' note dated 8-12-19. Staff G stated skin tears should be monitored daily and measured weekly on the MAR/TAR or under the "Skin Assessment" tab. Staff G did not enter and intervention on the care plan as the resident. Staff G stated the Certified Nurse Aides report skin irregularities to the charge nurse when they bathe the resident or at any other time such as when assisting the resident with dressing. Staff G stated the resident received a bath on evening shift on Tuesdays and Fridays.

Interview, on 09/09/19 at 11:00 AM with Administrative Nurse D, confirmed the CAA for Pressure ulcers, dated 6-10-19, indicated gerisleeves should be applied to the resident's arms, but was not written on the care plan. Staff D stated staff should document skin tears and bruises on the MAR or "Skin Assessment Sheet" for monitoring and confirmed this was not done for the skin tear the resident obtained on 08/12/19. Staff D confirmed nursing staff did not document the left forearm bruising until 09/05/19 or put any interventions in place on the care plan.

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F 657	Continued From page 12 The facility "Changes to Care Plan" policy, undated, instructed staff that changes due to an adverse event may require an update to the plan of care. The facility failed to review and revise this resident's plan of care to include gerisleeves after the resident experienced a skin tear (8-12-19) and left forearm bruise (6.1 centimeter (cm) by 9.4 cm.) and failed to ensure staff assisted the resident to apply the protective gerisleeves to prevent further bruising and skin tears.	F 657		
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: The facility reported a census of 59 residents with 17 selected for review which included one resident reviewed for skin conditions. Based on observation, interview and record review, the facility failed to ensure monitoring for the one resident reviewed, Resident (R) 6's skin tear and right forearm bruise. Findings included: - Review of Resident (R) 6's "Physician Order	F 684		

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Sheet", dated 07/29/19, indicated diagnoses included cerebral vascular accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis (muscular weakness of one half of the body) and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

Review of the admission "Minimum Data Set" (MDS), dated 08/22/19, indicated the resident's Brief Interview for Mental Status (BIMS) score of 14, indicatingintact cognition. The MDS indicated the resident required extensive assistance of 1 staff for bed mobility, transfer and dressing. The resident had impairment in range of motion in both upper and lower extremities bilaterally. This MDS indicated the resident admitted to the facility with a stage two pressure ulcer and a skin tear.

The quarterly MDS, dated 08/22/19, indicated the resident's BIMS score of 14, required extensive assistance of 1 staff for bed mobility, transfer and dressing. The resident had impairment in range of motion in his upper and lower extremities.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 6-7-19, assessed the resident with multiple bruises on both arms as well as scabsoskin. Nursing staff presented the resident with gerisleeves (soft protective sleeve like devises to protect skin) and the resident agreed to wear the sleeves to help prevent skin tears and bruising.

The care plan, dated 05/28/19 advised staff of the

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resident's fragile skin and staff were to assist him with position changes. The care plan lacked evidence instructing staff to assist the resident to apply the gerisleeves to protect the resident's fragile skin.

A nurses' note, dated 08/12/19, indicated the resident had a skin tear to his left forearm from a change in clothing and staff cleaned the area and applied a dressing. This note lacked measurements of the skin tear or the dressing type.

Review of the electronic medical record under the tab "Skin Assessment," lacked documentation of the skin tear.

Review of the" Medication Administration Record" (MAR) and the "Treatment Administration Record," for August 2019 lacked documentation of the skin tear.

Observation, on 09/03/19 at 10:51 AM, revealed the resident seated in his recliner in his room. The resident had an approximate six centimeter (cm) bruise on his left forearm with a darker blue/purple raised area in the center of the bruise. The resident did not have gerisleeves on. The resident appropriately answered questions and stated he did not know how or when the bruise occurred. The resident stated he had a skin tear several weeks ago on his left arm. The resident stated he did not think the skin tear was in the area of the bruise.

Interview, on 09/05/19 at 10:00 AM with Licensed Nurse G revealed she did not know how or when the resident obtained the bruise on his left forearm.

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Observation, on 09/05/19 at 10:00 AM, revealed the resident seated in his recliner in his room. The resident did not have gerisleeves on. Licensed Nurse G measured the bruise area, at that time, as 6.1 cm by 9.4 cm. Staff G noted the darker raised area in the bruise and measured it as 2.3 cm by 2.4 cm. Staff G stated she would document the bruise in the electronic record.

Interview, on 09/05/19 at 11 :00 AM, with Certified Nurse Aide M, revealed she did not know the resident had a bruise on his left forearm, but that the resident usually did have areas of bruising on his arms.

Interview, on 09/09/19 at 02:24 PM with Licensed Nursing Staff G, stated she did assess the resident, on 08/12/19, for a skin tear and documented this in a nurses' note dated 8-12-19. Staff G stated skin tears should be monitored daily and measured weekly on the MAR/TAR or under the "Skin Assessment" tab. Staff G stated the Certified Nurse Aides report skin irregularities to the charge nurse when they bathe the resident or at any other time such as when assisting the resident with dressing. Staff G stated the resident received a bath on evening shift on Tuesdays and Fridays.

Interview, on 09/09/19 at 11:00 AM with Administrative Nurse D, confirmed the , dated 6-10-19, indicated gerisleeves should be applied to the resident's arms, but was not written on the care plan. Staff D stated staff should document skin tears and bruises on the MAR or "Skin Assessment Sheet" for monitoring and confirmed this was not done for the skin tear the resident obtained on 08/12/19. Staff D confirmed nursing

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F 684	Continued From page 16 staff did not document the left forearm bruising until 09/05/19 or put any interventions in place. Interview, on 09/09/9 at 11:00 AM, with Administrative Nursing staff F, revealed she offered the gerisleeves to the resident today . The facility "Skin and Wound" policy, dated 9/2019, indicated a resident with a noted alteration in skin integrity will receive treatment per facility protocol to promote optimal healing. Bruises will be entered onto the MAR and monitored for at least 5 days. This policy indicated staff to monitor wounds daily. The facility failed to monitor this resident's skin tear (8-12-19), failed to identify the left forearm bruise (6.1 centimeter (cm) by 9.4 cm.) and failed to ensure staff assisted the resident to apply the protective gerisleeves to prevent further bruising and skin tears.	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 - §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 reported a census of 59 residents, with 17 selected for review, including five residents reviewed for accidents. Based on observation, interview, and record review the	F 689		

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facility failed to ensure one of the five residents reviewed received supervision and assistive devices to remain free of accidents, including Resident (R) 20 who experienced falls with repeated ineffective interventions implemented including keeping debris picked up around the resident, keeping the resident close and in populated areas during periods of rest and ensure the resident did not wear slip on shoes.

Findings Included:

- The "Physician Order Sheet," indicated Resident (R) 20 had the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, insomnia (inability to sleep), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The Significant change "Minimum Data Set" (MDS), dated 10/11/18, recorded the resident admitted on 05/02/18. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition and she had a short and long-term memory problem. She had range of motion impairment on one side of her upper extremity and impairment to both sides of her lower extremities. She required extensive assistance of two staff members with bed mobility, transfers, dressing, and toileting, required the extensive assistance of one staff member for locomotion on and off the unit, and

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with her personal hygiene. She had 2 or more falls since the prior assessment with one injury, not major, and one major injury.

The Quarterly "MDS," dated 07/03/19, indicated the resident had a BIMS score of 99, which indicated severely impaired cognition. She had disorganized thinking, inattention present and that did not fluctuate through the day and wandered daily. Her balance while walking was not steady and was only able to stabilize with extensive assistance of one staff member. She required extensive assist of 1 staff for transfer and ambulation. She had one fall with injury since prior assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 10/11/18, indicated the staff were unable to complete the BIMS as the resident "simply smiled" at the nurse when she attempted to ask her questions.

The "Falls CAA," dated 10/11/18, indicated staff used a motion sensor remote alarm as the resident's dementia was profound and that she did not use the call light. She had no safety awareness and simply got up to move to do what she needed (such as toileting). The CAA indicated that the alarm in no way limited her movements and that it did not keep her from doing what she was trying to do. The alarm simply alerted the staff of her movements to allow the staff to go and help with her needs.

The "Fall Risk Assessment," identified a score of 10 to 99 indicated the resident was at a high risk for falls. "Fall Risk Assessment's" completed and scored as follows:
12/13/18 score of 21; 01/01/19 score of 21;

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01/29/19 score of 26; 03/28/19 score of 25; 05/21/19 score of 28; 08/01/19 score of 28; 08/11/19 score of 32; and 09/08/19 score of 32. A fall risk assessment for the fall on 03/10/19 was not completed.

The fall care plan, dated 05/21/19, indicated the resident had falls on 01/01/19; 01/29/19; 03/10/19; 03/28/19; and 05/21/19. The care plan had written in notes for falls on 08/01/19; and 08/11/19. The care plan lacked an update after the fall on 12/13/18 in which the resident was wearing slip on shoes and
included the following interventions:

10/14/18 - staff were to encourage her to wear tennis shoes and not to wear slip on shoes
10/17/18 - was to wear non-skid footwear
01/29/19 -place a pressure sensitive alarm to her bed, wheelchair and recliner,
(no date documented) - place an auto locking brake system on her wheelchair.
03/28/19 - Encourage resting in visible areas to promote safety.
08/01/19 - Staff to keep floor free of small items. (Already put into place on fall investigation dated 12/13/18).
08/11/19 - Keep resident close as she is very unsteady (Same as 03/28/19).

The facilities "Fall Investigation," dated 12/13/18, recorded a fall on 12/13/18. R20 had been sleeping in a chair in her room, and staff found the resident lying on her right side on the floor, next to the chair, in front of the closet door. The investigation further documented there was a small piece of food next to her on the floor, she had on slip on shoes (care planned 10/14/18 not to wear slip on shoes), and had been toileted at

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approximately 09:30 PM. The indicated intervention directed staff to ensure there was no debris left on the floor by the resident. The care plan lacked evidence of an updated intervention for this fall.

The "Nursing Note," dated 03/28/19 at 07:32 PM, documented the resident attempted to stand from the recliner, landing on her knees with no injury noted. Intervention was to rest in populated areas.

The "Nursing Note," dated 05/21/19 at 02:49 AM, indicated the resident had a fall resulting in a laceration to her forehead requiring sutures. The note indicated that the resident was observed by facility staff to stand up from her wheelchair and fall forward, with the alarm sounding. The intervention directed when staff noticed the resident becoming restless to offer her a change. For example, help her to a different chair or take her to the bathroom .

The "Nursing Note," dated 08/01/19 at 10:02 PM, indicated the resident had a fall when she attempted to pick up small debris from the floor around the trash can. The intervention noted on the care plan was to continue to keep small trash off the floor around the resident. This was a repeat of the resident's action for the fall on 12/13/18 .

The "Nursing Note," dated 08/11/19 at 09:13 PM, indicated that R20 had a fall after she stood up from the recliner and lost her balance. The resident's personal alarm alerted staff. The intervention was to keep her close as she is unsteady. This was a repeat intervention from the fall on 03/28/19 (Encourage resting in visible

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areas to promote safety).

Observation, on 09/04/19 at 11:13 AM, R20 observed with aid of Certified Nurse Aide (CNA) O and Licensed Nurse (LN) G stand up from the recliner in West POD area and ambulated her. R20 had a steady gait, a gait belt in place, one staff assisted and one pushed wheelchair behind, to her bathroom.

On 09/05/19 at 01:30 PM, (CNA) O, reported R20 was to have an alarm in place, and to keep her busy. She stated R20 had multiple falls and she knows to look at the care plan for new interventions.

On 09/05/19 at 03:03 PM, Licensed Nurse (LN) G, stated the intervention and update of the care plan was the responsibility of the nurse present at the time of the fall. She stated she did check as she was performing her tasks by asking the CNA's if they had followed the planned interventions. She stated the new interventions are shared to all staff through emails, clip board (tool used to report resident status at the end of the shift), and report. She confirmed that the interventions on both the 08/01/19 and the 08/11/19 falls were duplicates of previous falls.

Observation, on 09/09/19 at 07:40 AM, revealed R20 sitting in the recliner in West POD area, alarm in place, call light within reach, shoes on. R20 had a dressing in place above her right eye, with bruising noted over her right eye and down her right cheek.

On 09/09/19 at 07:45 AM, CNA O stated R20 had a fall on 09/08/19 when she stood up from her wheelchair and she (CNA O) removed the

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pressure pad alarm. CNA O assisted the resident to sit back in the wheelchair. CNA O turned around to place and connect the alarm pad in the recliner, the resident stood up, tripped over CNA O's foot, and hit her head/ face on the tv stand in the POD (an open area in the facility for the residents to relax). The facility sent the resident to the emergency room for evaluation and treatment. Her daughter brought her back to the facility. The printed paper "Care Plan" recorded the new intervention directed staff to have two people present for all planned transfers with the resident.

On 09/09/19 at 02:00 PM, Administrative Nurse D, indicated the interventions, even though duplicated, were appropriate for the falls. Staff D stated it was unrealistic to expect new interventions if there was an intervention in place that worked for that fall. Staff D indicated R20 had a fall on 09/08/19, and the intervention was to have two staff with all planned transfers.

Review of the facility's undated policy titled, "Fall Prevention and Fall Follow up," indicated the objective was to assess residents for the potential of falls and to identify causal factor, if any, after initial falls. A prevention protocol will be initiated with documentation on the care plan. "Prevention protocol 1) Root cause analysis for will be completed for all falls. 4) Keep all items [i.e.: call light, bathroom lights on at night, water, etc.] within reach. 6) In limited circumstances, the use of a personal alarm, bed and/or chair alarms may be indicated."

The facility failed to implement appropriate interventions to prevent further falls for R20 when they repeated interventions already in place which

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F 689	Continued From page 23 failed to prevent the resident from experiencing further falls.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 59 residents with 17 selected for review, including 5 residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to notify the physician for further instruction of one of the 5 resident's reviewed, Resident (R) 13's continued refusal of a respiratory medication to prevent respiratory complications. Findings included: - Review of Resident (R)13's "Physician Order Sheet", dated 08/07/19, indicated diagnoses of chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and anxiety (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).	F 695		

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The annual "Minimum Order Set" (MDS), dated 9-27-18, assessed the resident's Brief Interview for Mental Status (BIMS) score of 13 indicating normal cognitive function (12-15) and received 7 days of antianxiety and antidepressants in the 7 day look-back period.

The quarterly MDS, dated 6-20-19, assessed the resident's BIMS score of 15.

The care plan, updated 6-25-19, advised staff Breo Ellipta (corticoid steroid [a medication to decrease inflammation] and a bronchodilator [a medication used to open airways] administered by an inhaled device) may cause issues related to pulse, muscle spasms shortness of breath and infection. Staff advised of a Black Box Warning for this medication.

A physician's order, dated 05/13/19, instructed staff to administer Breo Ellipta 100 micrograms (mcg)-25 mcg/dose powder for inhalation daily.

Review of the "Medication Administration Record" (MAR), revealed the following refusals of the physician ordered BreoEllipta:

June 2019; refused 11 times.
July 2019; refused 13 times.
August 2019; refused all 31 days.
September 2019; refused 7 times as of 09/08/19.

A care plan meeting notes, dated 6-25-19, documented "the resident doesn't want to use her inhaler anymore ....)

A faxed note sent to the pulmonologist. on 6-26-19, documented the resident refused her Breo inhaler every day for the past 6 days.

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A pulmonologist assessment, dated 7-1-19, instructed staff to continue administration of the Breo inhaler

A physician visit, dated 07/03/19, documented "COPD. This seems to be stable with regular nebulizer treatments."

A physician visit, dated 08/07/19, documented the physician reviewed the nursing home records/chart including the resident's allergies and medications/MAR.

Interview, on 09/05/19 at 02:33 PM, with Licensed nurse H, revealed she thought the physician was aware of the resident's refusal of Breo Ellipta as the resident's physicians (pulomonologist and primary care physician) made multiple changesof the resident's in halers . LN H stated he /she spoke to the resident about the need for the inhaler and explained the consequences of refusal and offered techniques to combat side effects.

Interview, on 09/09/19 at 03:00 PM, with Consultant HH revealed he did not notice the resident's pattern of refusal of Breo Ellipta and thought the facility may want to notify the physician of the extent of the refusal .

Interview, on 09/09/19 at 10:30 AM with Administrative Nurse E, revealed staff failed to notify the physician of the resident's refusal for the 31 days of August and staff should have

The "Medication Administration" policy, revised 2019, instructed staff if a resident refused medication to document the refusal and the

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F 695	Continued From page 26 reason why.This policy did not address when to notify the physician of the resident's refusal. The facility failed to notify the physician of the resident's continuous refusal of the physician ordered Breo Ellipta inhaler for 31 days in August 2019 for further instruction to ensure the resident's respiratory status remained stable.	F 695		
F 880 SS=D	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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175402	A. BUILDING _____ B. WING _____	09/09/2019

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F 880	Continued From page 27	F 880		

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of 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:
The facility reported a census of 59 residents

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F 880	Continued From page 28	F 880		

with 17 selected for review which included one resident reviewed for skin conditions. The facility failed to ensure and maintain an infection control program to reduce transmissions of infections for the one resident reviewed, Resident (R) 6 during a dressing change procedure to a pressure ulcer wound.

Findings included:

- Review of Resident (R) 6's "Physician Order Sheet," dated 07/29/19, indicated diagnoses included cerebral vascular accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis (muscular weakness of one half of the body), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).

Review of the admission "Minimum Data Set" (MDS), dated 06/07/19, indicated the resident's Brief Interview for Mental Status (BIMS) score of 14, indicating normal cognitive status. The MDS indicated the resident required extensive assistance of one staff for bed mobility, transfer, and dressing. The resident had impairment in range of motion in both upper and lower extremities bilaterally. The MDS indicated the resident admitted to the facility with a stage two pressure ulcer.

The quarterly MDS, dated 08/22/19, indicated the resident's BIMS score remained 14 and he required extensive assistance of one staff for bed mobility, transfer, and dressing. The resident had impairment in range of motion in his upper and

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lower extremities.

Observation, on 09/05/19 at 10:00 AM, revealed Licensed Nurse (LN) G assisted the resident to stand and ambulate to the bathroom. Observed on the resident's right buttocks was a dressing rolled up and no longer intact around all of the four edges. LN G then donned two pair of gloves and removed the dressing, then removed the first pair of gloves and was about to cleanse the pressure area with normal saline. After questioned if that was an approved procedure LN G removed gloves, sanitized her hands, and applied clean gloves.

The facility policy "Glove Use," dated 11/17, directed the staff to change gloves during resident cares if moving from a contaminated body site to a clean body site. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient.

The facility failed to ensure and maintain an infection control program to reduce transmissions of infections for R6 during a dressing change procedure to a pressure ulcer wound.