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F 000	INITIAL COMMENTS The following citations represent the findings of a health Resurvey and Complaint Investigations # 142344 and # 143675. This 2567 was electronically sent to the facility on 8/21/19.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 73 residents. The sample included 23 residents with one Resident (R)20 selected for review related to resident rights. Based on observation, interview , and record review the facility failed to ensure the resident right to retain and use her personal possessions of two glass jars of honey. Findings include: - Resident (R)20's Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident with a BIMS (brief interview for mental status) score of 15, indicating cognitively intact. The resident reported it was very important to take care of her personal belongings or things.	F 557		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 557	Continued From page 1 On 08/05/19 at 09:17 AM, R20 reported the facility made her send two Mason Jars with honey, home with her family member. She stated the reason she was told she could not keep them was due to safety. On further inquiry, she stated the facility told her they were made of glass and could break and would be a safety hazard, therefore she could not keep them. On 08/07/19 at 03:05 PM, Social Service Staff X verified the Mason Jars had been sent home with the resident's family member due to safety, but she did not realize that was an issue for the resident. When asked for clarification Social Service Staff X stated the facility had a corporate survey the end of June 2019, during the survey a Mason Jar noted on the back of a toilet for another reason, and the team identified the potential danger if the glass broke. On 08/12/19 at 08:31 AM, Administrative Nurse D and Administrative Nurse E confirmed the corporate team identified a concern with another resident that had an empty Mason Jar on the back of a toilet as a safety hazard due to the potential for breaking. Staff D and E agreed R20 had the right to her personal property, and the Mason Jars did not pose a safety hazard for the resident. Furthermore, the facility staff should not have removed the resident's Mason Jars of honey. The facility policy for Resident Rights, dated 07/2018, documentation included "It is the policy of [the facility] to promote and protect the rights of resident's residing in our ministry. Residents are entitled to exercise their personal and legal rights and privileges. . .state specific resident rights are provided, per state requirements."	F 557		

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F 557	Continued From page 2 The facility failed to ensure the resident the right to retain and use her personal possessions, including the 2 Mason Jars of honey.	F 557		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		

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State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 73 residents with 23 residents sampled. Based on observation, interview, and record review, the facility failed to notify the physician of one sampled Resident (R) 2's acute, significant weight loss.

Findings included:

- Resident (R) 2's signed "Physician Orders" dated 07/22/19, included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral issues, major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), hypertension (high blood pressure), gastro esophageal reflux disorder (backflow of stomach contents to the esophagus), history of falling, cardiac arrhythmia (irregular heart rate), hyperlipidemia, muscle

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weakness, communication deficit, and history of UTI (urinary tract infection).

The Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident admitted 03/08/17, from an acute hospital with a BIMS (brief interview for mental status) score of seven indicating severe cognitive impairment. The resident lacked exhibited depression mood indicators or behaviors. The resident required the staff to set-up meals and provide supervision with eating. The resident had no functional limitation in range of motion ROM in the upper or lower extremities. R2's height of 62 inches and weight of 139 pounds (lbs.), did not indicate a weight gain or loss. R2 received a therapeutic mechanical altered diet. The resident had no natural teeth or tooth fragments. The resident received anti-anxiety and antidepressant medication for seven days of the look back period.

The Quarterly MDS, dated 07/11/19, documented changes included BIMS score of five, indicating severe cognitive impairment. The resident had a depression indicator score of one related to feeling down, depressed or hopeless for two-six days of the look back period. The resident's weight of 129 documented the resident experienced a significant weight loss and was not on a physician prescribed weight loss regimen. The resident received antibiotics for four days of the look back period.

The Nutrition "Care Area Assessment" dated 02/08/19, documented the resident required set-up assistance with eating and supervision; received NAS (no added salt), mechanical soft diet, and consumed 51-75% of most meals. The

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resident's current weight was stable and revealed an increase in BMI (body mass index). She was edentulous (without natural teeth) and chose not to wear her dentures. The resident was without chewing or swallowing concerns. The staff would continue to monitor weights and intake per facility protocol or physician orders.

The "Care Plan" for nutrition, initiated 05/31/17, instructed the staff:
To record food intake at each meal.
Offer appropriate substitutes for uneaten food.
The resident comes out to the table for meals and feeds herself without difficulty.
The resident received a NAS/Mechanical soft diet,
The resident was edentulous.
Monitor for tolerance to present diet and intervene as needed to maintain oral intake at meal time.

Care plan updates for nutrition, dated 06/17/19, instructed the staff:
Offer R2 super cereal (fortified hot cereal/extra calories) at breakfast, as tolerated.
Add Benecal (caloric nutritional supplement) to R2's biscuit and gravy.
Additionally, a care plan update, dated 06/18/19, instructed the staff to weigh the resident weekly.

Review of R2's weight tracking revealed the following weights:
On 02/06/19, weighed 140 lbs.
On 05/02/19, weighed 143 lbs. (weights stable from 02/2019 through 5/2/19).
On 06/02/19, weighed 126 lbs., R2 experienced a weight loss of 17 pounds/11.89% in one month.
On 07/03/19, weighed 129 lbs. R2 experienced a weight gain of three lbs.

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On 07/10/19, weighed 121 lbs. R2 experienced a weight loss of eight pounds/6.2% in eight days.

The physician orders, dated 08/02/19, documented the following orders related to nutrition:
Ice cream shake, by mouth, every day for supplement, at 10:00 AM, with start date of 12/14/18.
Supercereal at breakfast, by mouth, every day for supplement, ordered 06/19/19.
Benecalorie 7.5 kcal/ml (milliliter), oral liquid (caloric nutritional supplement), by mouth every day add to gravy, ordered 06/19/19 and discontinued on 08/02/19.
Ensure plus (lactose-reduced food supplement), 0.05 gram 1.5 kcal/ml, oral liquid by mouth two times a day, ordered 07/10/19.
Diet order- NAS, Mechanical Soft diet, Ensure BID, Benecaloric daily, Supercereal daily, ordered on, 07/29/19.
Benecalorie 7.5 kcal/ml oral liquid (caloric nutritional supplement), by mouth three times every day, ordered 08/02/19.
Mechanical Soft Diet; low spice diet, ordered 08/02/19

Review of the R2's "Medication Administration Records) (MAR), for July 2019 and August 2019, failed to reveal the percentage of Ensure R2 consumed.

Review of the "Dietary Notes" and "Risk Assessments" revealed the documentation included:

On 04/16/19 at 8:46 AM, the quarterly "Nutrition Service Note" and "Nutrition Risk Assessment" were completed and documentation revealed the

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resident would not be referred to the registered dietician.

On 07/08/19 at 03:53 PM, the quarterly "Nutrition Risk Assessment" documentation included R2's diet order as NAS mechanical soft with no fluid restrictions. The resident feeds herself independently and consumes 51-75%. The resident had no swallowing problems with height of 62 inches and a weight of 129 lbs. (pounds). The resident's IBW (ideal body weight) was 110 lbs, with a usual body weight range of 99-121lbs. The resident's BMI (body mass index) of 23.9 and identified the resident had a significant weight loss.

On 07/08/19 at 3:53 PM, the quarterly "Nutrition Service Note" and quarterly "Nutrition Risk Assessment" completed and documentation revealed the resident would not be referred to the registered dietician with, "Will not refer to RD [registered dietitian] review."

Review of Interdisciplinary Team" "Progress Notes" dated 06/02/19 through 08/08/19, revealed the medical record lacked documentation of the resident's significant weight loss on 06/02/19 and 07/10/19, as noted above.

On 08/08/19 at 10:24 AM, Certified Dietary Manager (CDM), CC confirmed the resident's weight loss, physician orders, nutritional notes and assessments. She confirmed R2 should have been referred to the registered dietician for recommendations after the weight loss documented on 06/02/19 and 07/10/19; and the follow-up on the weight loss was not timely to prevent further weight loss. Additionally, CDM CC confirmed the progress notes lacked physician

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notification.

On 08/08/19 at 02:13 PM, Licensed Nurse (LN) J stated he was not aware of the resident's significant weight loss that occurred on 06/02/19 and 07/10/19. He stated the facility protocol for weight loss was the weights were forwarded from the unit/court to the CDM, who then referred it to the Dietician; the dietician sends recommendations to the nurses; the nurses implement the recommendations and send it out for physician's orders for signature. LN J confirmed the progress notes lacked physician notification.

On 08/08/19 at 04:41 PM, LN J called the physician's office and verified the physician's office clinical record lacked notification of the physician being notified by the facility of the acute significant weight loss the resident experienced on 06/02/19 and 07/10/19.

On 08/08/19 at 05:34 PM, Administrative Nurse D, confirmed the above findings; the facility failed to intervene for the resident's identified significant weight loss on 06/02/19 and 07/10/19 in a timely manner to prevent further weight loss. He stated the facility system to address weight loss lacked an immediate address of the significant weight loss in a timely manner and was in need of revision.

On 08/12/19 at 09:48 AM, Administrative Nurse E verified R2 experienced an acute significant weight loss, and the facility did not reassess the resident's nutritional needs. He verified the weight loss for R2 as noted above and confirmed the medical record lacked notification of the physician of R2's weight loss. Administrative Nurse E

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F 580	Continued From page 9 confirmed the physician should have been notified by the nurse, the dietician, or the kitchen manager, when the staff obtained the weight, and not wait for a weight risk meeting to address the concern for a significant weight loss. The lack of the facility to address R2's weight loss represented a system failure to immediately notify the physician and intervene to prevent further weight loss. On 08/12/19 at 11:15 AM, Consultant staff KK confirmed the resident's weight as stable between February and May of 2019; the weight loss on 06/02/19 and 07/10/19 represented a significant weight loss which should have been addressed by staff immediately. consultant staff KK reported the team reviewed the resident at the risk meeting on 06/12/19 and interventions were put in place on 06/13/19. Additionally, Consultant staff KK confirmed the physician had not been notified of the significant weight loss. The facility policy for Significant Weight Loss, dated 01/2019, documentation included, ". . . A nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD [registered dietitian] has requested a nutritional intervention." The facility failed to notify the resident's physician of acute significant weight loss that occurred on 06/02/19 and 07/10/19.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		

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comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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The facility reported a census of 73 residents. Based on observation and interview the facility failed to provide a safe, functional, sanitary, and comfortable environment on four of the five Courts/Units which needed cleaning and/or repairs, for the residents of the facility in these areas.

Findings Included:

- Observations during a tour of the facility, on 08/06/19 at 08:32 AM, revealed the following concerns:

Observations of Court A

A spa whirlpool metal seat with chipped paint on the surface of the seat, which made the seat unsanitizable.

A shower chair with rusty wheel castors.

On 08/06/19 at 08:35 AM, Certified Nursing Assistant (CNA) VV confirmed the above findings.

Observation of Court B

The ceiling to the entrance hallway had two brown stains approximately eight inches in diameter.

The wheelchair (w/c) scales in the spa with torn black pad on the surface, which made the surface unsanitizable.

Two shower chairs with rusty wheel castors.

A spa whirlpool metal seat with chipped paint on

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the surface of the seat, which made the seat unsanitizable.

The Spa seat and back cushions with cracked vinyl, which made the cushion unsanitizable.

The spa whirlpool had a broken covering, on the temperature gauge, on the front of the tub exposing a rusty and corroded temperature gauge.

Lime build-up on the outside edge of the tub rim.

Two bottles of roll on deodorant that lacked resident identification labels.

A bottle of Virex (cleaner) and a bottle of Clorox cleaner stored with the residents' personal hygiene care items.

The dining area's linoleum floor had rips and gouges throughout the dining area.

On 08/06/19 at 09:15 AM, CNA O verified the above findings

On 08/08/19 at 03:26 PM, Maintenance Staff V verified the above findings and the need for cleaning and/or repairs.

The facility lacked a policy on environmental maintenance.

The facility failed to ensure appropriate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment for the residents of Court A and B.

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- Observations during the initial tour of the facility, on 08/05/19 at 08:00 AM, and during the environmental tour with Maintenance Staff V, on 08/08/19 at 02:30 PM, revealed the following areas/items noted to need repair and/or cleaning:

Observations of the D Court revealed:

Two resident rooms had gouges in the resident's drywall, and lacked paint. One of the two rooms had exposed metal trim corners.

A ceiling located in the hallway that had multiple areas of brown discoloration. One ceiling panel had three holes, approximately one inch in diameter, with a black discoloration around the parameter of the holes.

Three dining room ceiling vents dripped water directly onto the floor, creating a puddle approximately four inches in diameter, without a wet floor sign.

A ceiling located in the kitchenette had brown discoloration areas.

A spa room had torn, peeled and loose wall paper border.

A spa room had a cove base area indented, that exposed bare floor underneath the floor finish.

A spa bathing chair lacked numerous chipped areas of paint.

In addition, observation of two of the two elevators revealed both elevators lacked areas of

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wallpaper. One of the two elevators had gouged areas, which exposed raw wood.

Observation of two of the two elevator light fixtures, revealed numerous dead insects.

Observation of the ceiling tiles, on the second-floor breezeway, had brown discolored ceiling panels.

On 08/05/19 at 11:15 AM, Certified Medication Aide (CMA) R, reported the air conditioner vents dripped "a lot."

On 08/05/19 at 02:30 PM, Maintenance Staff V, verified the above concerns.

The facility lacked a policy on environmental maintenance.

The facility failed to ensure appropriate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for these resident areas.

- Observations during the initial tour of the facility, on 08/05/19 at 08:00 AM, and during the environmental tour with Maintenance Staff V on 08/08/19 at 02:30 PM, revealed the following areas/items noted to need repair and/or cleaning:

Observations of the F Court revealed:

A laundry room cabinet door handle was not connected on the bottom to the cabinet door.

A spa room shower area had a container of cleaning supplies, a wash cloth was lying on the

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F 584	Continued From page 15 floor, a vinyl shower curtain placed on a plastic chair, along with a shower curtain rod. A spa room had four ceiling tiles with brown discolored areas on the ceiling panels. A spa bathing chair had a vinyl seat cushion cracked in several places. Observation of two light fixtures located in the kitchenette, revealed a layer of grime and dust. Observation of the cove base area between the kitchenette and the hallway, was loose from the wall. In the common room, four light fixtures lacked light. Four ceiling tiles in the common area had brown discoloration areas. Two wooden columns in the common area, lacked caulking around the columns on all four sides. On 08/08/19 at 02:30 PM, Maintenance Staff V, verified the above concerns. The facility lacked a policy on environmental maintenance. The facility failed to ensure appropriate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for these resident areas on F Court.	F 584		
F 637	Comprehensive Assessment After Signifcant Chg	F 637		

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F 637 SS=D	Continued From page 16 CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility reported a census of 73 residents, with 23 sampled for review. Based on observation, interview and record review the facility failed to complete a significant change "Minimum Data Set" (MDS) assessment for Resident (R)2, after the resident experienced a change in condition in at least two or more areas of ADLs (activities of daily living). Findings included: - Resident (R) 2's, signed "Physician Orders", dated 07/22/19, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral issues, major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), hypertension (high blood pressure), gastro esophageal reflux disorder (backflow of stomach contents to the esophagus),	F 637		

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history of falling, cardiac arrhythmia (irregular heart rate), hyperlipidemia, muscle weakness, communication deficit, and history of UTI (urinary tract infection).

The annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident admitted 03/08/17, from an acute hospital; Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment; required extensive assistance of staff with dressing; limited assistance of staff with bed mobility, transfers, toilet use, and personal hygiene; and supervision with walking and locomotion. The resident's balance during transition and walking was not steady, but the resident was able to stabilize without staff assistance for walking, and only able to stabilize with staff assistance for moving from a seated to standing position, turning around, moving on and off toilet, and with surface to surface transfer.

The quarterly MDS, dated 04/18/19, documentation revealed changes which included a diagnosis of urinary tract infection (UTI), required extensive assistance of staff for bed mobility, transfer, toileting, and personal hygiene.

The quarterly MDS, dated 07/11/19, documentation revealed the resident required extensive assistance of staff with bed mobility, transfers and toilet use; limited assistance of staff personal hygiene; experienced a significant weight loss; and received an antibiotic for four days during the look back period.

The "Care Area Assessment" (CAA) for Nutrition, dated 02/08/19, documented the resident activities of daily living (ADLs) required limited

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assistance for most ADLs and mobility. The resident was able to ambulate independently or with supervision around the court. The resident alert and oriented times one to two with confusion noted.

On 08/07/19 at 02:08 PM, Licensed Nurse (LN) YY,reported the staff completed the MDSs in accordance with the "Resident Assessment Instrument" (RAI) manual and confirmed that should complete a "Significant Change" MDS with two or more changes in ADL status that did not resolve in 14 days. LN YY confirmed the above changes in the resident's ADL status indicated the need to monitor for a Significant Change MDS. LN YY reported she reviewed the 04/18/19 MDS and determined the changes were self limiting, due to a UTI; and she failed to monitor the resident to see if the resident returned to the previous baseline ADL status, within a 14 day period of the identified changes, as required. LN YY verified the 04/18/19 MDS should have been a Significant Change Assessment.

On 08/12/19 at 9:56 AM, Administrative Nurse D confirmed the above findings and agreed the 04/18/19, MDS changes in ADLs should have been addressed as with a Comprehensive Significant Change MDS and would have revealed the need for a significant change in status.

The RAI manual, dated 10/2017, documented " . . . a significant change in status MDS is indicated when it is determined that a significant change (either improvement or decline) in a resident's condition from his or her baseline has occurred as indicated by comparison of the resident's

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F 637	Continued From page 19 current status to the most recent comprehensive assessment and any subsequent quarterly assessments and the resident's condition is not expected to return to baseline within 2 weeks." The facility failed to complete a Significant Change MDS Assessment, when the resident's ADL status changed in two or more areas for the resident.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		

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(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 73 residents. The sample included 23 residents. Based on observation, interview, and record review, the facility failed to develop and/or implement care plan interventions for 2 sampled residents, including Resident (R) 20 related to the use, cleaning and storage of the resident's Continuous Positive Airway Pressure (CPAP) machine; and R20 related to failure to implement planned interventions to prevent repeated falls.

Findings included:

- Review of Resident (R)20's undated "Physician Orders," documentation included diagnoses of congestive heart failure (fluid build-up around the heart), muscle weakness, chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pneumonia, chronic respiratory failure with hypoxia (lack of oxygen in the blood), edema (excessive fluid volume), and morbid obesity

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(severely overweight). Further review of the physician orders, revealed the resident lacked a physician's order for use of the Continuous Positive Airway Pressure (CPAP) and/or the care and services associated with the cleaning or care of the CPAP machine and mask.

R20's Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The resident received oxygen, and respiratory therapy for 125 minutes over the seven day look back period. The MDS coding did not indicate the resident used the CPAP.

The quarterly MDS, dated 04/18/19, documentation lacked any changes in the resident's assessment.

The activities of daily living (ADL) "Care Area Assessment" (CAA), dated 02/02/19, included a diagnoses of congestive heart failure (CHF) and COPD. The resident often required more assistance due to these diagnoses.

The "Care Plan" (CP), dated 05/06/19, documentation included the resident used oxygen as directed, but failed to address the use of the CPAP machine or to instruct the staff of the appropriate care for cleaning and storage.

On 08/05/19 at 09:17 AM, observation revealed the resident's CPAP mask lying face down, directly on the table top, without a barrier in place and a used undated gallon jug of distilled water which sat directly on the floor, next to the resident's oxygen concentrator.

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On 08/05/19 at 09:17 AM, Licensed Nurse (LN) I confirmed the above findings; and stated she did not know who was responsible for cleaning the CPAP machine, most residents had a "Soclean" machine to sanitize the CPAP mask and tubing and she did not know why R20 did not have one. LN I stated the resident started on the CPAP about 2 months ago. Furthermore, the mask should be stored in a bag, and the distilled water should be dated when opened and stored off the floor to prevent cross contamination.

On 08/07/19 at 11:14 AM, observation revealed the CPAP mask lying face down, directly on the table top, without a barrier in place, and a used undated gallon jug of distilled water sat directly on the counter. The resident had her nasal cannula in place and the oxygen concentrator was set at 3 liters of oxygen per minute.

On 08/07/19 at 11:14 AM, Certified Nursing Assistant (CNA) SS, verified the above observation and indicated she did not know who cleaned the CPAP machines. She stated the distilled water was used for the oxygen concentrator's humidifier bottle and should be dated when opened.

Another review of R20's "Physician Orders" now revealed an order to clean the CPAP daily, ordered on 08/7/19. However, the physician orders continued to lack an order for the use and indication for the use of the CPAP.

On 08/12/19 at 8:31 AM, Administrative Nurse D and E agreed the CPAP machine should be cleaned and the mask stored in accordance with facility policy to prevent cross contamination. They confirmed that the distilled water was used

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to fill the humidifier bottle on the concentrator and should have the date written on the bottle when opened and not be stored on the floor. They confirmed that the resident's care plan did not address the cleaning, storage and/or use of the CPAP.

The facility policy for "CPAP/BIPAP Support," dated 04/2018, documentation for cleaning CPAP mask included ". . . clean daily, mask stored ; clean daily by placing in warm soapy water, soak agitate for [five] minutes Rinse with warm water and allow it to air dry between uses every day for maintenance."

The facility failed to develop and implement a care plan to instruct the staff how to provide necessary respiratory care and services related to the cleaning, storage and/or the use of the resident's CPAP machine, to prevent further respiratory infections for the resident.

- Resident (R) 32's current medical diagnoses (located in the resident's electronic health record) included: Dementia (progressive mental disorder characterized by failing memory, confusion), Osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and depression (a sadness, worthlessness and emptiness).

The resident's comprehensive "Minimum Data Set" (MDS), dated 03/07/19, identified the resident scored 0 (severely impaired cognition) on the Brief Interview for Mental Status. The resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.

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The resident's Fall "Care Area Assessment" (CAA), dated 03/07/19, included the resident was at risk for falls and preferred to spend her time sleeping, was incontinent of bowel and bladder, and required extensive assistance for toileting.

The resident's "Nurses Notes" revealed the resident had a falls; on 03/12/19, with intervention to be the last resident up to the table; on 03/18/19, with intervention to please assist with bed pillows for positioning; on 05/24/19, with intervention to place fall mat on the floor; and on 07/26/19, with fall intervention for a bordered defined mattress to the bed.

The resident's "Care Plan), dated 07/30/19, addressed the resident at risk for falls related to declined cognition, history of falls, and the use of psychotropic medication. Interventions prior to 07/26/19 included; a fall matt next to the bed; pillows used for positioning; she needs to be the first to the table for meals and the first one to be removed; PT/OT (Physical Therapy/Occupational Therapy) evaluation and treat; and addition dated 7/26/19 documented to add a bordered mattress to the bed.

During interview, with Administrative Staff E, on 08/08/19 at 2:14 PM, confirmed the planned interventions were not working. Furthermore the bordered mattress was not placed on the resident's bed until 08/07/19, 12 days later.

Administrative Nurse D, on 08/08/19 at 02:28 PM, stated he expected fall interventions to be implemented immediately. The fall intervention on 07/26/19 with the bordered mattress was not implemented until 08/07/19, 12 days after the fall.

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F 656	Continued From page 25 The facility's policy, "Accidents and Incidents-Investigating and Reporting dated 12/17, instructed the Charge Nurse should promptly initiate and document investigation of the accident or incident, any corrective action taken, if the resident sustains a witnesses head trauma, the resident should be observed for neurological abnormalities, Neurological checks are to be initiated and completed for 72 hours and the Nurse Leader Designated should verify timely completion and accuracy in the process of incident investigating and reporting. The facility failed to develop the resident's care plan and failed to implement the intervention of a edged mattress for 12 days, following a fall, leaving the resident implement timely and effective interventions to prevent repeated falls for this resident with multiple falls.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

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An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents, with 23 selected for review. Based on observation, interview and record review, the facility failed to review and revise the Care Plan for three of the 23 sampled residents Resident (R) 15, R2, and R60. Specifically, R15 related to weight loss, R2 for accidents, and R60 for positioning devices.

Findings included:

- Resident (R) 15's, signed "Physician Orders" dated 06/13/19, documented the resident admitted on 02/8/19, with the following diagnoses including; dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The Annual "Minimum Data Set" (MDS), dated 02/14/19, revealed R15 had a BIMS (brief interview for mental status) score of five, indicating severely impaired cognition. R15

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required supervision for eating. The R15 without swallowing or dental issues and weighed 143 pounds.

Review of the Nutrition "Care Area Assessment" (CAA), dated 02/20/19, advised nutrition did not trigger for further investigation.

The Quarterly MDS, dated 05/09/19, revealed the no changes from the Admission MDS dated 02/14/19.

Review of the Nutrition "Care Plan", found in R15's electronic medical record (EMR), reviewed on 05/21/19, advised she would have nutritional needs met, and would not have an unplanned significant weight change over the next review period. Interventions included offer R15 the diet as prescribed, snacks daily, offer a minimum of 480 cc (cubic centimeters) of fluids daily, weigh weekly/monthly, monitor meal intake daily, she received a regular diet, and she may not eat her evening meal during supper time. Please offer her meal later in the evening after everyone had left the dining room if she did not eat during supper.

Review of her EMR "Physician Orders", found under "attachments," advised the physician ordered on 02/10/19, weekly weights. On 02/15/19, the physician ordered a regular diet.

Review of a "Nutrition Risk Assessment" found in R15's EMR under "assessments," dated 2/14/19, advised the she received a regular diet, fed herself, had a good appetite, and her meal intake ranged from 51-75%. She had missing/broken/edentulous, and without difficulty swallowing. R15 weighed 141 pounds, a body

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mass index of (BMI) of 24.1, within normal limits (normal BMI range was 18.5 to 24.5), required 1625 calories per day, 65 Gm (grams) of protein a day, and 1625 cc of fluids a day. She had a good appetite with a regular diet and the regular diet was appropriate and would continue with the diet, monthly weights, and meal intake.

Review of the weights, found in R15's EMR, located under "weight tracking" identified on 07/01/19, R15 weighed 145 pounds. On 07/15/19, R15 weighed 140 pounds. On 07/22/19, R15 weighed 143 pounds. On 07/29/19, R15 weighed 136 pounds. On 08/05/19, R15 weighed137 pounds. R15 with a weight loss of 8 pounds, or 5.52% weight loss.

The meal intake documentation found under POC (point of care) in the EMR, from 07/01/19 through 08/01/19, identified R15's meal intake for breakfast ranged from 76-100%; for lunch 76%; and for dinner the resident with an intake 51-75%.

The "At Risk Review," located in the EMR, found under "assessments" of R15, dated 07/17/19, identified she weighed 140 pounds, on this day, and received a regular diet. Continue to monitor weights and to re-evaluate. R15 eats after everyone else leaves the room.

R15's "Nutritional Assessment" dated 07/29/19, located in the EMR, found under "assessments" advised the physician ordered a regular diet, and fed herself independently. Her meal intake was 51-75%, and food preferences obtained. R15 with broken/missing/edentulous teeth, and without swallowing issues. She weighed 136 pounds, ideal body weight (IBW) was 120 pounds, IBW range was 108-132 pounds, with a BMI of 23.3.

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R15 with a significant weight loss in the last six months.

Review of the "Dietitian/Physician faxed Communication", dated 08/07/19, found in R15's EMR under "Assessment" section documented the physician notified of a significant weight loss of 5.4% in 30 days, and a 11% for 90 days. Recommended offering her Ensure Plus BID (twice a day) and Thrive every day for added calories and protein and continue with a regular diet. The physician agreed with the recommendation.

Observation on 08/06/19 at 12:25 PM, R15 sat at the dining room table with a hamburger, seasoned carrots, mashed potato and gravy, and dessert. At 12:43 PM, she had completed her hamburger, dessert, and was able to feed herself. At 12:57 PM, she stood up from the table and ambulated to her room. R15 did not eat anymore, and staff did not encourage the resident to eat.

On 08/06/19 at 05:25 PM, the meal served included baked ham, baby bakers, broccoli with cheese sauce, corn bread, margarine, and lemon cheesecake bars. At 05:46 PM, she sat in her room was not served dinner. R15 with numerous packages cheese and crackers in her room. When asked if she liked those crackers the she responded those were not her crackers. At 05:52 PM, administrative staff C, took R15 her dinner tray and tried to encourage her to eat the meal, however the she stated it was time for breakfast and she would take coffee and toast. At 05:58 PM, R15 was served toast and coffee.

Interview on 08/06/19 at 03:03 PM, Certifeid nurses aide (CNA) MM stated she feds herself,

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and was not aware of her with weight loss. She does not always come out of her room for meals, however if she does come out of her room, she would usually eat almost all of the meal. If she stayed in her room she would only eat half of her meal. CNA MM stated she would obtain aweight and place it in the computer.

On 08/06/19 at 05:36 PM, CNA RR stated R15 refused to come out for dinner, so CNA RR would ask her again and if she does not come out she would take her a tray. She does this a lot in the evening because her dementia, and did not always eat a lot. R15 offered snacks, and she would eat them.

On 08/06/19 at 06:05 PM, Dietary Cook EE stated she could always count on R15 to eat a hamburger or toast for meals.

On 08/07/19 at 10:42 AM, Certified dietary manager CC (CDM) verified she reviewed the weights and would notify the appropriate staff of any weight loss. She was not aware of R15 with a 5.52% weight loss in 30 days.

On 08/07/19 at 02:06 PM, Licensed Nurse (LN) H stated R15 ate 100% of meals when she was at the table. Once in awhile she would not come out for supper and then she would say it was to late to eat and go to bed. They were able to get her to eat something when that happens. LN H reviewed R15's weights and stated she was not loosing weight, and the her weight fluctuated, just a couple of pounds here and there, and she does not retain fluids. R15 does not recieve supplements she could see. R15 could make her wants and needs known of what she wanted to eat. During the interview, LN H received orders

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from the physician at 2:38 PM, and the physician ordered Ensure and Thrive daily for weight loss.

On 08/07/19 at 04:00 PM, Administrative nurse F verified the facility was not aware of R15 with 5.52% weight loss or 8 pounds in 30 days. She reported the physician was notified of the resident's weight loss, and received an order for a supplement for a significant weight loss.

On 08/08/19 at12:38 PM, Register Dietician (RD) KK reported she was just the consultant and was in the build monthly. CDM CC would send her a weight spread sheet weekly and she monitored the meal intakes. If there was a five pound weight change in a week, then the resident would be discussed during the at risk meeting, on Thursdays at 01:00 PM. Whenever she printed off the weights for the month they may not alway be completed. The facility weights need to be completed by the 7th, and any reweighs completed by the 10th. RD KK noticed the R15 was reweighed at 138 pounds. CDM CC sent the report out this morning and she reviewed the report and sends out the recommendations to the phsyician which she did. CDM KK sends the monthly weights out between the 7th and the 10th of each month.

On 08/08/19 at 03:34 PM, administrative nurse D stated the facility would weigh the residents at least monthly, and as ordered by the physician. He looks at weight with a loss of 5% in 30 days and 10% in six months. The facility meets monthly to review weights in QA (quality assurance meeting). Residents at risk meetins are held weekly, every Thursday, and would review the residents with weight loss, from the report he received from CDM CC. Then Licesed

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Nurse YY sets up the list of residents for the risk meeting and sends it out to everybody. This is when he would review the weights. If R15 was on a monthly weight protocol, then he would hold a monthly meeting, if the resident was a weekly weight, then he would review the weights weekly when the CDM CC brought them to him. The physician would decide which resident should be on weights weekly/monthly and the physician would go by the RD KK's recommendation. Administrative staff D stated he expected to be notified of a resident with any weight loss, and the physician should be notified to obtain nutritional orders if the physician wants. Administrative nurse D stated he would expect to see the care plan updated when a resident had weight loss.

Review of the facility's policy titled, "Significant Weight Loss/Gain", revised on 01/19, advised the facility would provide appropriate nutritional interventions to residents who have a significant weight change is identified as weight loss or gain of 5% in 30 days, or 10% in 180 days. A resident with a weight change of five pounds or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record. A report should be generated identifying all residents with a significant weight change in 30 days, 180 days. At the weekly resident at risk review huddle, the IDT (interdisciplinary team) should discuss residents who triggered for a significant weight loss and who lose more than five pounds since the last weight. The RD should make recommendations for nutritional interventions.

The facility failed to review and revise this resident's care plan who had a 5.52% or 8 pound

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weight loss in 35 days.

- Resident (R) 2's "Physician Orders," dated 07/22/19, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral issues, major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), hypertension (high blood pressure), history of falling, cardiac arrhythmia (irregular heart rate), muscle weakness, communication deficit, history of UTI (urinary tract infection), restless leg syndrome, pain in left ankle, pain in left elbow, abnormalities of gait and mobility.

The Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident admitted 03/08/17, from an acute hospital; BIMS (brief interview for mental status) score of seven indicating severe cognitive impairment; required extensive assistance of staff with dressing; limited assistance of staff with bed mobility, transfers, toilet use, and personal hygiene; and supervision with walking and locomotion. The resident's balance during transition and walking was not steady, but the resident was able to stabilize without staff assistance for walking, and only able to stabilize with staff assistance for moving from a seated to standing position, turning around, moving on and off toilet, surface to surface transfer. The resident without functional limitation of range of motion (ROM) in the upper or lower extremities; and used a walker as an assistive device. The MDS coded the resident as occasionally incontinent of urine and continent of bowel. The resident had two

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non- injury falls and a non injury fall. She received antianxiety and antidepressant medication for seven days of the look back period. The resident received physical therapy services for 290 minutes over five days and did not receive restorative nursing services.

The quarterly MDS, dated 04/18/19, documentation revealed changes which included a diagnosis of urinary tract infection (UTI), required extensive assistance of staff for bed mobility, transfer, toileting, and personal hygiene extensive. The resident used a wheelchair (w/c) in addition to a walker as an assistive device. The resident experienced one fall with minor injury fall during the look back period. Therapy services were documented as ending on 04/04/19. She received restorative nursing program (RNP) for walking, dressing grooming for 6 days of the look back period, and passive range of motion (PROM) for five days of the look back period. The resident received antibiotic, antianxiety and depressant medication for seven days of the look back period.

The quarterly MDS, dated 07/11/19 documentation revealed the resident with a BIMS score of 05 indicating severe cognitive impairment. She required extensive assistance of staff with bed mobility, transfers and toilet use; limited assistance of staff personal hygiene; supervision with walk in room, locomotion off unit did not occur; extensive assistance with toilet use; limited assistance with personal hygiene. The resident experienced two non injury falls; and received RNP for walking and dressing for seven days, and active range of motion (AROM) for six days of the look back period. She received antibiotics for four days of the look back period

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and experienced a significant weight loss.

The Activity of Daily Living (ADL) and Falls respectively "Care Area Assessment' (CAA) ,dated 02/08/19, documented the resident could ambulate independently; had falls since prior assessment; and had a history of falls. The resident was high risk for falls due to unsteady gait at times and medication side effects. She receives an antianxiety, antidepressant and cardiac medications for diagnoses of anxiety, depression and hyper tension. The resident required limited assist x one person for transfers and supervision for mobility. The staff would continue to provide assistance to the resident with needs and monitor for functional decline.

The care plan interventions for ADLS initiated on 12/01/17, included offer toileting prior to going to bed, encourage proper fitting shoes with ambulation, and place walker and wheelchair beside the bed.

The care plan interventions initiated on 11/02/18, included non skid strips placed to floor at bedside.

The care plan, dated 07/18/19, for ADLs, instructed the staff:
The resident needed staff assistance with daily ADL care due to cognitive deficits to provide comfort, cleanliness and safety, dated 03/08/17.
The resident needed supervision/stand by assistance of staff with transfers, dated 03/08/17.
The resident needed supervision and assistance of staff for mobility, dated 03/08/17.
The resident ambulates with a walker as an assistive device, dated 03/08/17.
The resident needed limited assistance of the

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staff with bed mobility, dated 03/08/17.
The resident was occasional incontinent of bladder due to dribbling/stress incontinence, dated 03/08/17.
The resident needed non skid strips in front of my toilet, dated 03/08/17.

The care plan for falls, dated 07/18/19, instructed the staff the resident was at risk for falls related to history of falls, poor impulse control, dementia, poor safety awareness, and cardiac co-morbidities. The care plan interventions initiated on 05/31/17 included offer diversional activities as desired such as TV shows, and wheel of fortune; bed to be placed in the lowest position as indicated; keep area free from obstruction to reduce risk of falls/injury; provide cues and reminders to use assistive devices when noted to be ambulating without them; and physical therapy/occupational therapy (PT/OT) to evaluation and treat if indicated.

The care plan interventions initiated on 11/02/18, included non skid strips placed to floor at bedside.

Additional care plan interventions for falls added in 2019 included: Add bright colored signs to encourage the resident to take the walker when ambulating, on 05/12/19.
Apply bright colored tape to the walker to encourage the resident to use her assistive device, on 08/06/19.
Request PT/OT services for gait balance, and safety training, on 08/07/19.

Review of the "Facility Fall Log, dated 01/2019 through 08/08/19, revealed the resident with falls on; 03/07/19 at 6:25 AM; 04/26/19 at 8:00 AM;

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05/12/19 at 2:00 PM; 08/04/19 at 10:00 PM; and on 08/06/19 at 4:15 PM.

Review of the "Facility Investigative Reports" for the above falls revealed:

On 03/07/19 at 06:25 AM, the resident experienced an unwitnessed fall with injury, in her room. She sustained a laceration above the right eye as a result of the fall. The cause of the fall was listed as accidental. The care plan lacked an immediate intervention, to prevent future falls.

On 04/26/19 at 8:00 AM, the resident experienced an unwitnessed fall, she was found on the floor in her room. Upon examination the charge nurse noted the resident did not want to bare weight on the right leg. The care plan lacked an immediate intervention, to prevent future falls.

On 8/4/19 at 10:00 PM, the resident experienced an unwitnessed fall with the resident complaining of pain of the right knee, elbow, and hip. The charge nurse documented the resident urinated and had a bowel movement when assisted to the bathroom. The resident reported she got out of bed alone to use the bathroom and slid to the floor. The care plan lacked an immediate intervention, to prevent future falls.

On 08/06/19 01:24 PM, observation revealed the resident was in her room; independently walked to the entrance door of her room, without her walker; and another resident advised her to get her walker, as the resident was holding on to the door of her room. The dietary staff provided the resident with her walker in response to the other resident.

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On 08/06/19 at 04:34 PM, the resident was sitting at the table in the dining room, after experiencing a fall at 4:15 PM which was responded to by Certified Nursing Assistant (CNA) WW . The resident was observed to have a discolored left fifth finger, and a dressing in place on the top of her right hand.

On 08/06/19 01:43 PM, CNA UU stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The care plans are updated by the charge nurse when changes in condition occur. When a fall occurs the care plan should be updated with an immediate intervention to prevent further falls.

On 08/06/19 at 3:38 PM, CNA LL stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The care plans are updated by the charge nurse when changes in condition occur. The charge nurse will tell us of changes in the care plan when they occur. CNA LL stated when a fall occurs the care plan should be updated with an immediate intervention to prevent further falls. The charge nurse comes up with an immediate intervention at the time of the fall.

On 08/07/19 at 10:18 AM, CNA VV stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The care plans are updated by the charge nurse when changes in condition occur. When a fall occurs the care plan should be updated with an immediate intervention to prevent further falls.

On 08/07/19 at 12:47 PM, Licensed Nurse (LN) K

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stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The facility staff are very helpful with letting her know what the resident's needs. The care plans are updated by the charge nurse, when changes in condition occur or if the resident has a fall. LN K stated when a fall occurs the care plan should be updated with an immediate intervention to prevent further falls. LN WW stated she did not know what the intervention was for the fall that occurred yesterday.

On 08/08/19 at 2:13 PM, LN J reported the resident was at risk for falls. He stated the charge nurse should initiate the investigation to determine the root cause of the fall and implement an immediate intervention in the care plan. LN J verified the care plan lacked interventions for the falls as noted above..

On 08/08/19 at 03:22 PM, Administrative nurse E verified neuros should have been done following the fall on 08/06/19, due to the fall being an unwitnessed fall.

On 8/08/19 5:34 PM, Administrative Nurse D stated when a resident experienced an unwitnessed fall he expected the charge nurse to take care of the resident; obtain neuro checks; initiated the investigation; do a root cause analysis (RCA) to determine the causative factors of the fall; notify the physician, DON, administrator, and family; update care plans; and forward the information to the clinical team for review the following day. intervention by nurse review in clinicals the next day, go back to the nurse if not appropriate. Administrative nurse D verified the resident left her walker and tried to

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walk and fell, and the charge nurse did not conduct the neuro checks as was expected.

On 08/12/19 at 9:56 AM, Administrative Nurse D, confirmed the facility failed to complete a thorough investigation to determine the cause of the falls; to implement immediate interventions following falls, to prevent future falls; and failed to conduct neuro checks follow the fall on 8/6/19 as, required.

The facility policy for "Accidents and Incidents-Investigation and Reporting", dated 12/2017, documentation included "Accidents or incidents involving residents while in the community shall investigate and complete the appropriate reporting. . . The Charge Nurse should promptly initiate and document investigation of the accident or incident. . . Any corrective action taken . . ." .

The facility failed to review and revise the resident's care plan with immediate interventions following the resident's falls that occured on 03/07/19, 04/26/19, and 08/04/19, for the resident.

- Resident (R) 60's "Physician Order Sheet" dated, 06/09/19, revealed diagnoses included: non-traumatic intracerebral hemorrhage(loss of a large amount of blood in a short period of time), personal history of Transient ischemic attack (TIA)- (episode of cerebrovascular insufficiency), restless and agitation, hemiparesis(muscular weakness of one half of the body) following non-traumatic subarachnoid hemorrhage affecting non-dominant side, and dementia (progressive mental disorder characterized by

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failing memory, confusion) with behavioral disturbances.

The significant change "Minimum Data Set" (MDS), dated 04/11/19, Section C. revealed the resident had a BIMS (brief interview for mental status) score of 99, indicating severely impaired cognition. Section G assessed the resident as needing extensive assist with two staff for bed mobility, transfers, dressing, and toilet use.

The cognitive "Care Area Assessment"(CAA), dated 04/11/19, assessed the resident for cognitive loss/dementia. The resident required limited-extensive assistance for most activities of daily living, transfers, and mobility.

The "Care Plan," dated 10/29/18, instructed staff the resident needed extensive assistance with transfer and one to two person staff support. She also needed extensive assistance with mobility and used a wheelchair. She needed extensive assistance with bed mobility. Staff to anticipate needs as she may be unable to verbalize them. The care plan lacked instructions to the staff related to the need for positioning devices for the resident's proper body alignment.

Per review of "Therapy Notes,"on 10/17/18, R60 was on physical therapy services for gait training and therapeutic activities. On 04/24/19, a wheelchair was delivered from home medical due to being admitted to hospice services. On 08/6/19, orders received for occupational therapy consult for wheelchair positioning.

Observation revealed the following:

On 08/05/19 at 12:31 PM, the resident leaned to

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the right in her wheelchair. The resident's wheelchair lacked positioning devices to prevent her from leaning toward the right side.

On 08/06/19 at 08:20 AM, the resident ate breakfast and leaned to the right without any positioning devices.

On 08/06/19 at 11:51 AM, the resident was in the dining area in the wheelchair and continued to lean to the right without positioning devices.

On 08/06/19 at 12:41 PM, the wheelchair had a high back and the resident had four to five inches on each side of her hips in the seat. The resident leaned to the right, with her right side of body touching the arm rest at her ribs. Her right arm was hanging over the wheelchair arm rest.

On 08/06/19 at 5:30 PM, the resident was in the dining area and leaned to the right while in the wheelchair. There was no pillow present to assist with proper body alignment.

On 08/07/19 at 4:16 PM, the resident transferred with assist of two staff with gait belt into the wheelchair. The wheelchair lacked a cushion or pillow to her right side which touched the arm rest with the right arm leaning over the arm rest.

Interview on 08/08/19 at 10:30 AM, with Certified Nursing Aid (CNA) NN stated, "In the wheelchair, I usually put a pillow on her right side to prop her up."

Interview on 08/12/19 at 1:26 PM, with CNA OO stated, "If she is leaning, we use a pillow to prop her up. She does tend to lean to the right side."

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Interview on 08/12/19 at 2:05 PM, with CNA PP stated, "She likes to lean to the right. We put a pillow to the right side of her. If I had concerns with sizing of the wheelchair, I would let my nurse know."

Interview on 08/12/19 at 12:08 PM, with Licensed Nurse (LN) F stated,"If she is leaning, we should reposition her. She likes to lean to the right. My expectations would be for the aides to keep the pillow in place or let the nurses know of a concern."

Interview on 08/08/19 at 2:17 PM, with therapy staff II revealed, the therapy staff screened the resident according to the MDS schedule and anytime there was a need. The screening on 2/20/19, had no comments. She was then screened again, on 6/24/19, with comments, "Resident is on hospice." The screens deemed no further recommendations.

The facility policy for "Support and Surface Guidelines," dated 01/2018 documented the staff to use a redistributing support surface to promote comfort for bed or chair bound residents.

The facility failed to provide positioning devices for this dependent resident, who required extensive assistance to maintain good body alignment while up in the wheelchair.

Interview on 08/08/19 at 2:30 PM, with Administrative Nurse D, the care plan should be updated with interventions for positioning devices.

The facility policy for "Support and Surface Guidelines," dated 01/2018 documented the staff to use a redistributing support surface to promote

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F 657	Continued From page 44 comfort for bed or chair bound residents. The facility failed to review and revise the dependent resident's care plan to provide positioning devices to maintain good body alignment while up in the wheelchair.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661		

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by:
The facility reported a census of 72 residents with 23 sampled, which included one reviewed for discharge summary. Based on interview and record review, the facility failed to develop a "Discharge Summary" which included a recapitulation of the resident's stay for the one sampled Resident (R) 168, as required.

Findings included:

- Review of Resident (R)168's "Electronic Medical Record" (EMR), revealed he discharged from the facility to home with his family on, 07/14/19.

The "Discharge Summary," found in the EMR form, dated 07/14/19, was not completed upon review, on 08/12/19. The "Discharge Instructions" lacked a recapitulation for R168's stay.

On 08/12/19 at 02:24 PM, Certified Nurses Aide (CNA) VV stated all she did for R168 was to wake him up in the mornings or set-up assistance for bathing.

On 08/12/19 at 12:45 PM, Licensed Nurse (LN) J stated he would fill out a discharge for care, along with the instructions, and give this to R168. LN J was not sure about doing a "Discharge Summary" recapitulation of R168's stay.

On 08/12/19 at 12:59 PM, Administrative nurse D stated the resident discharge was not the usual and unsure why there was not a "Discharge Summary Recapitulation" for R168.

On 08/12/19 at 2:17 PM, LN J stated in this new computer system if there was a "Discharge

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F 661	Continued From page 46 Summary Recapitulation" of R168's stay, then he had not been shown where it was at. The facility policy for "Discharge Summary and Plan" dated 12/07, advised "...The discharge summary would include a recapitulation of the resident's stay at this community..." The facility failed to develop a "Discharge Summary" which included a recapitulation of R168's stay as required.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		

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F 676	Continued From page 47 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents, with 23 selected for sample review. Based on observation, interview, and record review, the facility failed to provide adequate assistance to shave facial hair for one Resident (R) 15, of the four residents reviewed for activities of daily living (ADLs). Findings included: - Resident (R) 15's, signed "Physician Orders," dated 06/13/19, documented the resident admitted on 02/08/19, with diagnoses including; dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission "Minimum Data Set" (MDS), dated 02/14/19, revealed she had a "Brief Interview for Mental Status Score" (BIMS) of five, indicating severely impaired cognition and she required staff assistance for hygiene and bathing.	F 676		

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Review of R15's "Care Area Assessment" (CAA), for "Activities of Daily Living" (ADL's) dated 02/20/19, in the "Electronic Medical Record" (EMR), found under the MDS section V, advised she was alert and oriented to self with confusion. She required supervision to limited staff assistance for most ADL's.

The quarterly MDS, dated 05/09/19, revealed the resident was without any in her ADL's and bathing needs.

The "Care Plan" (CP), for R15's ADL's, dated 05/21/19, identified she required staff supervision and set-up assistance with ADL's. The CP lacked R15's choice for shaving of her chin hairs.

The "Point of Care" (POC), which is the Certified Nurses Aide (CNA) electronic documentation record, for 08/19 on the day shift, identified she received a bath/shower on Saturday (08/03/19) and to have another one on Wednesday (08/07/19). For facial hair, the CNA's documented the staff were trimming R15's facial hair daily.

On 08/05/19 at 03:49 PM, observation revealed she had multiple chin hairs, approximately one inch in length.

On 08/06/19 at 12:00 PM and at 05:00 PM, observations revealed no change in her facial hair length.

On 08/07/19 at 10:00 AM, observation revealed the resident sat on her bed with the continued length of long chin hairs. R15 stated she did not want to have chin hairs feeling of her chin and

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F 676	Continued From page 49 then stated she did not have any chin hairs. At 11:30 AM, she continued to have the same length of chin hair. However, at 1:30 PM, after several staff interviews, the resident's long chin hairs were gone. On 08/07/19 at 11:29 AM, CNA OO stated she gave R15 her shower an hour ago, and she was did not shave her chin whiskers because she did not know she had any chin whiskers. Furthermore, CNA OO stated she was not aware of documenting daily regarding the resident's facial hair. On 08/07/19 at 02:06 PM, Licensed Nurse (LN) H stated she did not really noticed if R15 had any chin hairs before. The CNA's were to offer to shave the men and woman on a daily basis, and was not aware of staff documenting trimming of the facial hair daily for her. On 08/08/19 at 3:34 PM, Administrative nurse D explained that for shaving he expected it to be done per the bathing schedule and per R15's preferences, and expected the preferences to be on the care plan. The CNA's should take off the resident's chin hairs and document on the POC. The facility lacked a policy for ADL's. The facility failed to provide R15 with the necessary assistance to shave her chin hairs as needed for adequate personal hygiene services.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		

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the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents with 23 sampled for review. The sample included four residents reviewed for activities. Based on observation, interview, and record review, the facility failed to provide an ongoing program for activities for one resident Resident (R) 26 of the four sampled residents with an individualized activity program to maintain her physical, mental and psychosocial wellbeing.

Findings included:

- R26, admitted to the facility on 10/02/12, with the following diagnosis including dementia (progressive mental disorder characterized by failing memory.)

The annual "Minimum Data Set" (MDS), dated 05/23/19, revealed the resident had severely impaired cognition. Staff assessment revealed the resident's activity preference included listening to music, doing things with groups of people, and participating in favorite activities. The resident did not leave the unit during the assessment period.

The CAA (Care Area Assessment), dated 05/31/19, documented activities did not trigger.

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The activities care plan, dated 07/22/19, documented the resident likes naps throughout the day. She enjoyed watching the news and a variety of television programs. She enjoyed sitting in the recliner in the living room. She enjoyed country western music. Staff would provide the resident with one to one sensory stimulation, going outside when the weather was nice, parties/social events, on and off her court (unit). Staff would provide the resident a monthly activity calendar, and staff should invite, encourage and assist her to and from activities of her choice.

The "Daily Activity Charting" review, from 06/01/19 to 08/07/19, revealed the resident attended physical activities as a "passive" participation and one to one visits on those documented occurrences with the exception of physical activities for eight of the 69 days, personal care, (nails, pedicure, makeup as examples) on one occasion, and sensory stimulation for one of the 69 days reviewed.

On 08/05/19 at 10:30 AM, the resident slept in a living room recliner, while other residents participated in a group exercise activity in the room.

On 08/05/19 at 01:50 PM, the resident slept in her bed. The activity calendar revealed a bingo activity occurred off the resident's court.

On 08/06/19 at 01:41 PM, the resident slept in her bed, while ball noodle activities occurred off the resident's court.

On 08/07/19 at 09:23 AM, staff propelled the resident to the living room. The resident sat in her

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wheelchair, with her eyes closed. The TV (television) showed a cartoon network.

On 08/07/19 at 11:04 AM, Activity Staff Z, conducted a balloon activity in the living room area. The resident sat in the living room, in a wheelchair. However, activity staff Z failed to attempt to engage the resident in the activity.

On 08/07/19 at 11:27 AM, staff propelled the resident to the dining room while other residents remained in the balloon activity.

On 08/06/19 at 01:50 PM, Certified Nurse's Assistant (CNA) M, reported the resident did not attend activities. Staff did not provide one to one with the resident and had not observed activity staff provide the resident activities. The resident did not participate in socials, parties, or individualized activities.

On 08/07/19 at 09:29 AM, Restorative Staff N, reported the resident did not participate in group exercises.

On 08/07/19 at 10:39 AM, CNA O, reported staff did not attend activities. She did not provide one to one with the resident.

On 08/07/19 at 11:38 AM, "Certified Medication Aide" (CMA) R, reported staff did not involve the resident in activities, other than an occasional activity of nail care.

On 08/07/19 at 11:47 AM, Activity Staff Z, reported he provided activities to the alert residents that enjoyed participation, especially Bingo activities. He reported he did not provide the confused resident with activities.

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F 679	Continued From page 53 On 08/07/19 at 12:27 PM, Activities Staff AA, verified the facility lacked activities for the resident, and she was aware the facility failed to provide the resident with individual activities to enhance the resident's life. She reported she was aware the residents with impaired cognition did not have enough activities, and she was "working" on getting more activities. In the evening, staff should turn on the TV to the "Wheel of Fortune" for all residents. The facility's policy for "Activities", dated 12/2018, documented activities are designed to encourage maximum individual participation and are geared to the individual resident's needs. The facility failed to provide an ongoing program for activities for this confused resident with an individualized activity program to maintain her physical, mental and psychosocial wellbeing.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The 23 residents selected for sample included one reviewed for positioning, mobility. Based on	F 684		

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observation, interview, and record review, the facility failed to provide positioning devices for the one dependent sampled Resident (R) 60 reviewed.

Findings included:

- Resident (R) 60's "Physician Order Sheet" dated, 06/09/19, revealed diagnoses included: non-traumatic intracerebral hemorrhage(loss of a large amount of blood in a short period of time), personal history of Transient ischemic attack (TIA)- (episode of cerebrovascular insufficiency), restless and agitation, hemiparesis(muscular weakness of one half of the body) following non-traumatic subarachnoid hemorrhage affecting non-dominant side, and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances.

The significant change "Minimum Data Set" (MDS), dated 04/11/19, Section C. revealed the resident had a BIMS (brief interview for mental status) score of 99, indicating severely impaired cognition. Section G assessed the resident as needing extensive assist with two staff for bed mobility, transfers, dressing, and toilet use.

The cognitive "Care Area Assessment"(CAA), dated 04/11/19, assessed the resident for cognitive loss/dementia. The resident required limited-extensive assistance for most activities of daily living, transfers, and mobility.

The "Care Plan," dated 10/29/18, instructed staff the resident needed extensive assistance with transfer and one to two person staff support. She also needed extensive assistance with mobility

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and used a wheelchair. She needed extensive assistance with bed mobility. Staff to anticipate needs as she may be unable to verbalize them.

Per review of "Therapy Notes,"on 10/17/18, R60 was on physical therapy services for gait training and therapeutic activities. On 04/24/19, a wheelchair was delivered from home medical due to being admitted to hospice services. On 08/6/19, orders received for occupational therapy consult for wheelchair positioning.

Observation revealed the following:

On 08/05/19 at 12:31 PM, the resident leaned to the right in her wheelchair. The resident's wheelchair lacked positioning devices to prevent her from leaning toward the right side.

On 08/06/19 at 08:20 AM, the resident ate breakfast and leaned to the right without any positioning devices.

On 08/06/19 at 11:51 AM, the resident was in the dining area in the wheelchair and continued to lean to the right without positioning devices.

On 08/06/19 at 12:41 PM, the wheelchair had a high back and the resident had four to five inches on each side of her hips in the seat. The resident leaned to the right, with her right side of body touching the arm rest at her ribs. Her right arm was hanging over the wheelchair arm rest.

On 08/06/19 at 5:30 PM, the resident was in the dining area and leaned to the right while in the wheelchair. There was no pillow present to assist with proper body alignment.

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On 08/07/19 at 4:16 PM, the resident transferred with assist of two staff with gait belt into the wheelchair. The wheelchair lacked a cushion or pillow to her right side which touched the arm rest with the right arm leaning over the arm rest.

Interview on 08/08/19 at 10:30 AM, with Certified Nursing Aid (CNA) NN stated, "In the wheelchair, I usually put a pillow on her right side to prop her up."

Interview on 08/12/19 at 1:26 PM, with CNA OO stated, "If she is leaning, we use a pillow to prop her up. She does tend to lean to the right side."

Interview on 08/12/19 at 2:05 PM, with CNA PP stated, "She likes to lean to the right. We put a pillow to the right side of her. If I had concerns with sizing of the wheelchair, I would let my nurse know."

Interview on 08/12/19 at 12:08 PM, with Licensed Nurse (LN) F stated,"If she is leaning, we should reposition her. She likes to lean to the right. My expectations would be for the aides to keep the pillow in place or let the nurses know of a concern."

Interview on 08/08/19 at 2:17 PM, with therapy staff II revealed, the therapy staff screened the resident according to the MDS schedule and anytime there was a need. The screening on 2/20/19, had no comments. She was then screened again, on 6/24/19, with comments, "Resident is on hospice." The screens deemed no further recommendations.

The facility policy for "Support and Surface Guidelines," dated 01/2018 documented the staff

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F 684	Continued From page 57 to use a redistributing support surface to promote comfort for bed or chair bound residents. The facility failed to provide positioning devices for this dependent resident, who required extensive assistance to maintain good body alignment while up in the wheelchair.	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 72 residents. The sample of 23 included four residents reviewed for accidents. Based upon observation,record review and interview, the facility failed to investigate to determine contributing factors with the cause of falls and implement interventions to prevent repeated falls for three sampled Residents (R) 32, 15, and 2, of the four sampled residents. Findings included: - Resident (R) 32's current medical diagnoses (located in the resident's electronic health record) included: Dementia (progressive mental disorder characterized by failing memory, confusion), Osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased	F 689		

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fracture risk), and depression (a sadness, worthlessness and emptiness).

The resident's comprehensive "Minimum Data Set" (MDS), dated 03/07/19, identified the resident scored 0 (severely impaired cognition) on the Brief Interview for Mental Status. The resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.

The resident's Fall "Care Area Assessment" (CAA), dated 03/07/19, included the resident was at risk for falls and preferred to spend her time sleeping, was incontinent of bowel and bladder, and required extensive assistance for toileting.

The resident's "Nurses Notes" revealed the resident had a falls; on 03/12/19, with intervention to be the last resident up to the table; on 03/18/19, with intervention to please assist with bed pillows for positioning; on 05/24/19, with intervention to place fall mat on the floor; and on 07/26/19, with fall intervention for a bordered defined mattress to the bed.

The resident's "Care Plan), dated 07/30/19, addressed the resident at risk for falls related to declined cognition, history of falls, and the use of psychotropic medication. Interventions prior to 07/26/19 included; a fall matt next to the bed; pillows used for positioning; she needs to be the first to the table for meals and the first one to be removed; PT/OT (Physical Therapy/Occupational Therapy) evaluation and treat; and addition dated 7/26/19 documented to add a bordered mattress to the bed.

During interview, with Administrative Staff E, on

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08/08/19 at 2:14 PM, confirmed the planned interventions were not working. Furthermore the bordered mattress was not placed on the resident's bed until 08/07/19, 12 days later.

Administrative Nurse D, on 08/08/19 at 02:28 PM, stated he expected fall interventions to be implemented immediately. The fall intervention on 07/26/19 with the bordered mattress was not implemented until 08/07/19, 12 days after the fall.

The facility's policy, "Accidents and Incidents-Investigating and Reporting dated 12/17, instructed the Charge Nurse should promptly initiate and document investigation of the accident or incident, any corrective action taken, if the resident sustains a witnesses head trauma, the resident should be observed for neurological abnormalities, Neurological checks are to be initiated and completed for 72 hours and the Nurse Leader Designated should verify timely completion and accuracy in the process of incident investigating and reporting.

The facility failed to implement timely and effective interventions to prevent repeated falls for this resident with multiple falls.

- Resident (R) 2's "Physician Orders," dated 07/22/19, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral issues, major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), hypertension (high blood pressure), history of falling, cardiac arrhythmia (irregular heart rate),

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muscle weakness, communication deficit, history of UTI (urinary tract infection), restless leg syndrome, pain in left ankle, pain in left elbow, abnormalities of gait and mobility.

The Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident admitted 03/08/17, from an acute hospital; BIMS (brief interview for mental status) score of seven indicating severe cognitive impairment; required extensive assistance of staff with dressing; limited assistance of staff with bed mobility, transfers, toilet use, and personal hygiene; and supervision with walking and locomotion. The resident's balance during transition and walking was not steady, but the resident was able to stabilize without staff assistance for walking, and only able to stabilize with staff assistance for moving from a seated to standing position, turning around, moving on and off toilet, surface to surface transfer. The resident without functional limitation of range of motion (ROM) in the upper or lower extremities; and used a walker as an assistive device. The MDS coded the resident as occasionally incontinent of urine and continent of bowel. The resident had two non- injury falls and a non injury fall. She received antianxiety and antidepressant medication for seven days of the look back period. The resident received physical therapy services for 290 minutes over five days and did not receive restorative nursing services.

The quarterly MDS, dated 04/18/19, documentation revealed changes which included a diagnosis of urinary tract infection (UTI), required extensive assistance of staff for bed mobility, transfer, toileting, and personal hygiene extensive. The resident used a wheelchair (w/c)

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in addition to a walker as an assistive device. The resident experienced one fall with minor injury fall during the look back period. Therapy services were documented as ending on 04/04/19. She received restorative nursing program (RNP) for walking, dressing grooming for 6 days of the look back period, and passive range of motion (PROM) for five days of the look back period. The resident received antibiotic, antianxiety and depressant medication for seven days of the look back period.

The quarterly MDS, dated 07/11/19 documentation revealed the resident with a BIMS score of 05 indicating severe cognitive impairment. She required extensive assistance of staff with bed mobility, transfers and toilet use; limited assistance of staff personal hygiene; supervision with walk in room, locomotion off unit did not occur; extensive assistance with toilet use; limited assistance with personal hygiene. The resident experienced two non injury falls; and received RNP for walking and dressing for seven days, and active range of motion (AROM) for six days of the look back period. She received antibiotics for four days of the look back period and experienced a significant weight loss.

The Activity of Daily Living (ADL) and Falls respectively "Care Area Assessment' (CAA) ,dated 02/08/19, documented the resident could ambulate independently; had falls since prior assessment; and had a history of falls. The resident was high risk for falls due to unsteady gait at times and medication side effects. She receives an antianxiety, antidepressant and cardiac medications for diagnoses of anxiety, depression and hyper tension. The resident required limited assist x one person for transfers

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and supervision for mobility. The staff would continue to provide assistance to the resident with needs and monitor for functional decline.

The care plan interventions for ADLS initiated on 12/01/17, included offer toileting prior to going to bed; encourage proper fitting shoes with ambulation; and place walker and wheelchair beside bed.

The care plan interventions initiated on 11/02/18, included non skid strips placed to floor at bedside.

The care plan, dated 07/18/19, for ADLs, instructed the staff:

The resident needed staff assistance with daily ADL care due to cognitive deficits to provide comfort, cleanliness and safety, dated 03/08/17.

The resident needed supervision/stand by assistance of staff with transfers, dated 03/08/17.

The resident needed supervision and assistance of staff for mobility, dated 03/08/17.

The resident ambulates with a walker as an assistive device, dated 03/08/17.

The resident needed limited assistance of the staff with bed mobility, dated 03/08/17.

The resident was occasional incontinent of bladder due to dribbling/stress incontinence, dated 03/08/17.

The resident was continent of bowel, dated 03/08/17..

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The resident needed limited assistance of staff to provide supervision with toileting and peri-care,, dated 03/08/17.

The resident needed non skid strips in front of my toilet, dated 03/08/17.

The resident needed limited assistance of one staff with dressing, dated 03/08/17.

Provide consistent physical environment and daily routine, dated 5/31/17.

Provide task segmentation when having difficulty completing tasks: provide tactile guidance/assist resident to complete tasks if still unable to complete, dated 5/31/17.

Provide cues to promote independence and to ensure safety, 5/31/17.

Introduce yourself to resident and explain what you are going to do, or the activity to be performed in simple I terms; break tasks into one step at a time dated 5/31/17.

Has altered elimination due to occasional incontinence (dribbling) of bladder, dated 5/31/17.

Assess for bowel and bladder program,dated 8/20/18

The care plan for falls, dated 07/18/19, instructed the staff the resident was at risk for falls related to history of falls, poor impulse control, dementia, poor safety awareness, and cardiac co-morbidities. The care plan interventions initiated on 05/31/17 included offer diversional

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activities as desired such as TV shows, and wheel of fortune; bed to be placed in the lowest position as indicated; keep area free from obstruction to reduce risk of falls/injury; provide cues and reminders to use assistive devices when noted to be ambulating without them; and physical therapy/occupational therapy (PT/OT) to evaluation and treat if indicated.

The care plan interventions initiated on 11/02/18, included non skid strips placed to floor at bedside.

Additional care plan interventions for falls added in 2019 included:

Add bright colored signs to encourage the resident to take the walker when ambulating, on 05/12/19.

Apply bright colored tape to the walker to encourage the resident to use her assistive device, on 08/06/19.

Request PT/OT services for gait balance, and safety training, on 08/07/19.

Review of the "Facility Fall Log, dated 01/2019 through 08/08/19, revealed the resident with falls on; 03/07/19 at 6:25 AM; 04/26/19 at 8:00 AM; 05/12/19 at 2:00 PM; 08/04/19 at 10:00 PM; and on 08/06/19 at 4:15 PM.

Review of the "Facility Investigative Reports" for the above falls revealed:

On 03/07/19 at 06:25 AM, the resident experienced an unwitnessed fall with injury, in her room. She sustained a laceration above the right

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eye as a result of the fall. The cause of the fall was listed as accidental. The recorded entry related to medication use was unknown. The investigation lacked a thorough assessment of the cause or contributing factors related to the fall. The care plan lacked an immediate intervention, to prevent future falls.

On 04/26/19 at 8:00 AM, the resident experienced an unwitnessed fall, she was found on the floor in her room. Upon examination the charge nurse noted the resident did not want to bare weight on the right leg. The cause of the fall listed as accidental. The entry related to medication use was not addressed. The investigation lacked a thorough assessment of the cause or contributing factors related to the fall. The care plan lacked an immediate intervention, to prevent future falls.

On 05/12/19 at 2:00 PM, the resident experienced a fall in her bathroom. The report indicated the resident ambulated unassisted without her walker, lost her footing when crossing the transition to the bathroom. The immediate care planned intervention was to address the flooring , and to apply bright colored sign to encourage the resident to take the walker when ambulating.

On 08/04/19 at 10:00 PM, the resident experienced an unwitnessed fall with the resident complaining of pain of the right knee, elbow, and hip. The charge nurse documented the resident urinated and had a bowel movement when assisted to the bathroom. The resident reported she got out of bed alone to use the bathroom and slid to the floor. The investigation lacked a thorough assessment of the cause or contributing

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factors related to the fall. The care plan lacked an immediate intervention, to prevent future falls.

On 08/06/19 at 04:15 PM, the resident experienced an unwitnessed fall with injury, The fall occurred in the resident's room at the bathroom door. The investigation lacked a thorough assessment of the cause or contributing factors related to the fall. The care plan lacked an immediate intervention, to prevent future falls. The resident did not receive neuro checks by the charge nurse after the second neurocheck for the 04:45 PM through the 05:30 PM scheduled checks.

On 08/06/19 at 01:24 PM, observation revealed the resident was in her room; independently walked to the entrance door of her room, without her walker; and another resident advised her to get her walker, as the resident was holding on to the door of her room. The dietary staff provided the resident with her walker in response to the other resident.

On 08/06/19 at 04:34 PM, the resident was sitting at the table in the dining room, after experiencing a fall at 04:15 PM which was responded to by Certified Nursing Aide (CNA) WW. The resident was observed to have a discolored left fifth finger, and a dressing in place on the top of her right hand. The resident participated in a conversation, answering questions appropriately until approximately 05:30 PM.

On 08/06/19 at 01:43 PM, CNA UU stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The care plans are updated by the charge nurse when changes in

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condition occur. When a fall occurs the care plan should be updated with an immediate intervention to prevent further falls. CNA UU stated the resident required a lot of cueing and constant checks by the staff because she gets up without her walker and walks alone. Upon inquiry the CNA stated the resident gets up and down from the table during meals to go to the bathroom and will forget her walker.

On 08/06/19 at 3:38 PM, CNA LL stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The care plans are updated by the charge nurse when changes in condition occur. The charge nurse will tell us of changes in the care plan when they occur. CNA LL stated when a fall occurs the care plan should be updated with an immediate intervention to prevent further us. The procedure for reporting a fall if someone falls or found on the ground included to notify the nurse, who does an assessment, and do not move the resident until the assessment is complete and directed to do so by the nurse. The a charge nurse obtains the vital signs and does the neuro checklists there head or if the fall was unwitnessed; notify the family, physician, Director of Nursing (DON) and the Administrator. If no injury occurred we assist the resident up and take care of the resident. The staff should fill out witness statements to try and determine the cause of the fall. The charge nurse comes up with an immediate intervention at the time of the fall.

On 08/06/19 at 06:04 PM, CNA WW verified the resident fall at 04:15 PM, was not witnessed. She stated the protocol following and unwitnessed fall included to notify the nurse, who will assess the

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resident for injury. The charge nurse will do neurochecks, vital signs, and range of motion, to determine if the resident has an injury. The charge nurse should initiate the investigation and implement an immediate intervention. CNA WW reported she was not aware of the did not know the immediate intervention for the resident's fall that occurred earlier. CNA WW reported existing interventions for the resident at the time of the fall included the resident toilets herself and knows when she needs to go to the bathroom, so staff should watch her closely and make sure she has her walker. The night staff lower the bed at night when the resident is in the bed and the lights are out to make sure if she rolls at night she would not roll far.

On 08/07/19 at 10:18 AM, CNA VV stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The care plans are updated by the charge nurse when changes in condition occur. When a fall occurs the care plan should be updated with an immediate intervention to prevent further falls. She reported the resident required supervision and help with dressing. The resident walked independently; wander around the court, and never sits down in any spot for a few minutes. The resident was steady when she used her walker, but forgets her walker. Interventions to prevent her from falling include make sure she has her walker; the bed not all the way to the floor to help her get out of bed safety; staff should keep a close eye on her. CNA confirmed the protocol for when a resident falls was to make sure the resident was in a safe spot, in a safe spot. notify the nurse who conducts an assessment. The nurse will let us know what the new intervention is supposed to be to prevent

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further fall. An unwitnessed falls and falls that involve head injuries should have neurochecks by the charge nurse every 15 minutes for the first hour following a fall.

On 08/07/19 at 12:47 PM, Licensed Nurse (LN) K stated the care plan and resident guides provided guidance to the staff related to the resident's individual needs and preferences. The facility staff are very helpful with letting her know what the resident's needs. The care plans are updated by the charge nurse, when changes in condition occur or if the resident has a fall. LN K stated when a fall occurs the care plan should be updated with an immediate intervention to prevent further falls. The procedure for reporting a fall if someone falls or found on the ground included to notify the nurse, who does an assessment, and do not move the resident until the assessment is complete and directed to do so by the nurse. The charge nurse obtains the vital signs and does the neuro checks if the fall is unwitnessed or the resident hits their head; notify the family, physician, Director of Nursing (DON) and the Administrator. If no injury occurred, the staff assist the resident up and take care of the resident. The staff should fill out witness statements to try and determine the cause of the fall. The charge nurse comes up with an immediate intervention at the time of the fall and enters it in the computer, which then updates the care plan. The charge nurse initiates the fall investigation and forwards the report to the administration for review at the risk meeting. LN WW stated she did not know what the intervention was for the fall that occurred yesterday.

On 08/08/19 at 2:13 PM, LN J reported the

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resident was at risk for falls fall risk. The interventions to prevent falls included non-skid strips at the bedside; keep her most used items close at hands and in sight; put neon green on the bed side table and the bar on the walker. The charge nurse was responsible for assessing the resident every 15 minutes, for the first hour and every 30 minutes afterwards, if the resident hits their head or has had an unwitnessed fall. LN J stated the charge nurse should initiate the investigation to determine the root cause of the fall and implement an immediate intervention. LN J stated when a resident falls the resident interview is conducted, regardless of the cognition level; start the initial investigation; obtain neuros if indicated; notify the appropriate staff family and physician; and implement a new intervention to prevent further falls. The report will be forwarded to the quality assurance nurse for review at the risk meeting.

On 08/08/19 at 03:22 PM, Administrative nurse E verified neuros should have been done following the fall on 08/06/19, due to the fall being an unwitnessed fall.

On 8/08/19 at 5:34 PM, Administrative Nurse D stated when a resident experienced an unwitnessed fall he expected the charge nurse to take care of the resident; obtain neuro checks; initiated the investigation; do a root cause analysis (RCA) to determine the causative factors of the fall; notify the physician, Director of Nursing (DON), administrator, and family; update care plans; and forward the information to the clinical team for review the following day. intervention by nurse review in clinicals the next day, go back to the nurse if not appropriate. Administrative nurse D verified the resident left her walker and tried to

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walk and fell, and the charge nurse did not conduct the neuro checks as was expected.

On 08/12/19 at 9:56 AM, Administrative Nurse D, confirmed the facility failed to complete a thorough investigation to determine the cause of the falls; to implement immediate interventions following falls, to prevent future falls; and failed to conduct neuro checks following the fall on 08/06/19 as, required.
2's, signed physician
The facility policy for "Accidents and Incidents-Investigation and Reporting", dated 12/2017, documentation included "Accidents or incidents involving residents while in the community shall investigate and complete the appropriate reporting. . . The Charge Nurse should promptly initiate and document investigation of the accident or incident. . . Any corrective action taken . . ." The policy failed to address the analysis of findings and/or the need for neurochecks with an unwitnessed fall.

The facility failed to conduct a thorough investigation, implement immediate interventions, and/or update the care plan following falls on 03/07/19, 04/26/19, 08/04/19, and 08/06/19, to prevent further falls for this dependent cognitively impaired resident.

- Resident (R) 15's, signed physician orders, dated 06/13/19, documented the resident admitted on 02/08/19, with the following diagnoses including; dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction

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characterized by apprehension, uncertainty and irrational fear).

The Admission "Minimum Data Set" (MDS), dated 02/14/19, revealed R15 had a BIMS (brief interview for mental status) score of five, indicating severely impaired cognition. She required supervision for transfers and ambulation. Her balance was not steady moving from seated to standing position, moving on and off the toilet, and surface-to-surface transfer, and without falls.

Review of R15's "Care Area Assessment" (CAA), for falls dated 02/20/19, in the electronic medical record (EMR) found under MDS section V, advised the she was without falls since the admission to the facility and without falls prior to admission. She was at risk for falls related to use of an antidepressant medication, and had a fall risk score of 4, which indicated she was a low risk for falls. Her gait was steady, ambulated independently without the use of a assistive device, and required supervision to limited assistance for most Activities of Daily Living (ADL's), transfers, and mobility.

The quarterly MDS, dated 05/09/19, revealed the following changes only from the admission MDS assessment dated 02/14/19, advised she required a walker for mobility.

The "Care Plan" located in the EMR found under care plan, reviewed on 05/21/19, identified interventions for falls initiated on 02/08/19, for everyone to keep the bed at the appropriate height, and keep personal items within reach. On 06/15/19, an intervention added for floor mat beside bed, and please round on her frequently at night to ensure that she was not falling out of bed.

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The Certified Nurses Aide (CNA) electronic care guide located on the KIOSK (a small, stand-alone device providing information for staff on a computer screen and was often used for entering services provided) advised for safety that she required supervision for bed mobility, transfers, and ambulation. Keep the bed at the appropriate height, please assist with any needs she may have per her request, keep pathways clear and provide adequate lighting, and keep personal items within reach.

The "Hendrick II fall risk model", dated 05/11/19, advised the resident had a score of seven, which identified the resident was high risk for falls. A score of five or greater was high risk for falls.

The "Interdisciplinary Note, (ID) located in the EMR dated 06/15/19 at 05:52 PM, advised R15 observed laying on the floor on her back by the CNA at 05:30 AM. Her feet were toward the head of the bed, her head was toward the foot of the bed and was lying on a blanket. She stated that she laid down on the floor but unsure as to why. Safety measures in place for her at the time of the fall included a low bed, and the call light within reach. Fall interventions in place included a low bed, call light within reach, and non-skid foot wear. The care plan reviewed with interventions updated as indicated.

The safety event (investigation) documentation in the EMR, dated 06/17/19, advised the the safety measures in place at the time of the fall, and fall interventions in place all the same as the nurse's ID note of the fall. The fall prevention interventions in place was an assistive device (walker), call light or personal items within reach,

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and non-slip footwear. The safety event lacked an intervention for this incident. Furthermore, the documentation lacked a root cause analysis and an intervention for this fall.

The second fall per the ID note dated 06/15/19 at 10:37 AM, advised R15 was found on the floor by the CNA at 07:25 AM. She was lying on her back facing the window with her right leg straight out in front of the dresser in her room. Blood was observed to her face and hands. A deep 4 cm (centimeter) laceration (wound to the skin) to the right side of her face and with difficulty in stopping the bleeding. A deep 1 cm laceration noted to her bottom lip. The resident unable to state how the fall occurred, she complained of pain or discomfort to her left hip and ankle and also unable to move said areas effectively. She was shaking and stated she was hurting and cold. The physician was notified at 07:35 AM, and the verbal order to send to the ER (emergency room) for evaluation obtained. At 08:00 AM, EMS (emergency medical services) transported the resident to the ER.

The safety event (investigation) of the fall dated 06/17/19 at 08:34 AM, advised on 06/15/19 at 07:25 AM, she was laying on her back facing the windows. She had a laceration to her right upper lip and lower lip, complained of left ankle and left hip pain. The physician ordered the resident sent to the emergency Room (ER) for evaluation. She had a call light in reach, personal items within reach, and non-slip footwear. The call light was initiated prior to the fall. The investigation lacked an intervention for this fall.

The root cause analysis dated 06/15/19 at 07:25 AM, identified she was unable to state what

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happened, she fell on her back in front of her dresser. The bed was in the correct position, the bottom drawer of the dresser was pulled open, and she wore non-skid socks. At 07:00 AM, neuro checks continued from the previous fall, and intervention most appropriate was the resident sent to the ER.

The care plan lacked an intervention for this fall, and the root cause analysis was incomplete.

The third fall documented in the ID note, dated 06/15/19 at 03:58 PM, advised R15 lowered to the floor in room by the CNA at 03:30 PM. The CNA reported the R15 reached out for her when she entered the room, began to stand and R15 became unsteady. The CNA lowered her to the floor, continued to be unsteady with confusion and she was to ambulate with staff assistance.

The safety event (investigation), dated 06/17/19 at 08:34 AM, advised the same as the above ID note. The fall prevention interventions in place were an assistive device (walker), call light or personal items within reach, and non-slip foot wear.

The care plan lacked an intervention for this fall, and a root cause analysis of the fall was not completed.

Observation, on 08/06/19 at 12:50 PM, identified she ambulated self to her room from the dining room, wore non-skid shoes, and her gait was steady. Her bed was approximately two feet off the floor with a fall mat beside the bed.

On 08/06/19 at 02:35 PM, she rested quietly on her bed. The bed was at approximately two feet

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off the floor, and a fall mat was beside the bed on the floor.

On 08/07/19 at 10:30 AM, she sat on her bed talking to herself. The bed in a height the mattress touches the resident behind the knees, her feet touch the floor, and the fall mat on the floor beside the bed.

On 08/07/19 at 11:50 AM, she ambulated to the dining room. Her gait was steady, non-skid shoes in place, and the resident did not use a walker.

Interview, on 08/16/19 at 03:03 PM, CNA MM stated stated she was pretty sure R15 was a fall risk. She walked independently with her walker. If she took herself to the bathroom then CNA MM would check on her. She does not have her bed in the lowest position because she would get up and take herself to the bathroom. CNA MM would look at the care plan and then during rounds with the off going staff, they would let her know of any changes in R15's care, or of any falls.

On 08/07/19 at 02:06 PM, Licensed Nurse (LN) H stated when R15 fell, it was a day she was not feeling well, and did not eat, which she had never done before. She had two more falls, we did UA's (urine specimen) and labs, and then she went back to normal. When a resident would fall then complete an assessment, start neuro checks if the fall was unwitnessed or they say the hit their head. Complete the safety event, and a root cause analysis. The information collected would advise the cause of the fall. Then LN H would place on intervention on her care plan. LN H reviewed the care plan and stated an intervention was put in place for the first fall of non-skid socks, but this was an intervention used for fall on

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admission. An intervention was not put in the care plan for the second and third fall.

On 08/08/19 at 02:30 PM, Administrative nurse E stated during the morning meeting the working copy of the fall reviewed and does not include the final intervention for the fall put in place. The intervention was to complete frequent rounds on the her, and there was not a definitive time for frequent rounds. The staff thought she had a UTI, but then the physician did not place her on an antibiotic. The staff should have documented in the care plan any interventions. There is not an immediate invention except the frequent rounds and Administrative nurse E was not sure of the date this intervention was initiated because the date the intervention was initiated would not show up. The root cause analysis was not completed for the first and the third fall, and the second falls root cause analysis was not through.

On 08/08/19 at 03:34 PM, Administrative nurse D stated his expectations was the staff assess the residents for injury, provide first aide, assess the situation of why the resident fell, and then expect staff to put an initial intervention in the system and the care plan. Then the IDT teams meet daily in the morning and discuss the fall, and make sure a resident does not happen again. Sometimes the staff are not placing appropriate interventions in place on the care plan for the fall and if the intervention was not appropriate then the intervention would be replaced. In the fall note the immediate intervention should be documented. Administrative nurse D stated he was aware the interventions have not been put on the care plan, and a root cause analysis not completed. There was a system failure and staff did not place an appropriate intervention for the

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F 689	Continued From page 78 falls in the care plan. The facility policy for "Accidents and Incidents, Investigating and Reporting" dated 12/17, identified the charge nurse should promptly initiate and document investigation of the accident or incident. The charge nurse should document any corrective action taken. The "Nurse Leader Designated" should timely completion and accuracy in the process of incident investigating.." The facility failed to initiate and document on the Care Plan, an appropriate intervention following R15's multiple falls to prevent further falls, and to complete a root cause analysis of why she fell timely.	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. §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	F 690		

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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 reported a census of 73 residents, with 23 sampled for review, including one resident reviewed for urinary incontinence. Based on observation, interview, and record review, the facility failed to provide appropriate peri-care, use of personal protective equipment (PPE) and handwashing to prevent cross contamination and urinary tract infections for the one sampled Resident (R) 219. The facility placed the resident on contact isolation, transmission based precautions due to Vancomycin Resistant Enterococcus faecium (VRE) (a highly resistant bacteria to antibiotic treatment), and Escherichia coli (E-coli) (bacterial contaminate usually associated with exposure to feces) to prevent further urinary tract infections for the resident.

Findings included:

- Review of Resident (R) 219's undated "Physician Orders" revealed the resident with

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diagnoses which included urinary tract infection (UTI), and sepsis (infection in the blood).

The Admission "Minimum Data Set" (MDS), dated 08/01/19, documented the resident admitted 07/25/19; with a "Brief interview for Mental Status" (BIMS) score of 15, which indicated cognitively intact; required extensive assistance of staff for transfer, bed mobility, and toilet use; limited assistance for personal hygiene; occasionally incontinent of urine and bowel; and received antibiotics for seven days of the look back period.

The "Care Area Assessment" (CAA) for urinary incontinence/catheter, dated 08/06/19, included the resident admitted with a Foley Catheter (F/C) in place, which staff discontinued on 07/29/19. The resident was occasionally incontinent of urine and used a bedside commode after the F/C was discontinued. The resident wore an adult incontinence brief and received peri-care as needed. She usually knew when she needed to use the bathroom but had trouble retaining urine during transfer to the bed side commode.

The "Care Plan" for urinary incontinence, dated 07/25/19, instructed the staff the resident needed assistance of one to two staff for transfers. The staff should provide assistance with perineal care as needed; remind the resident to wipe front to back; and provide isolation precautions as indicated, due to the urine with Vancomycin resistant Enterococcus faecium (VRE) and Escherichia coli (E-coli) (bacterial contaminate from feces) was present. The resident was to remain on contact isolation for VRE for the duration of antibiotic treatment and physician determination.

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Review of the resident's "Physician Orders" revealed the resident was prescribed Zyvox 600 mg (milligram) tablet, by mouth, two times a day, for a UTI, for seven days, with the start date of 08/05/19. Furthermore, the "Physician Orders" lacked an order for contact isolation.

Review of the resident's urine culture, dated 08/01/19, revealed the resident with a UTI which identified micro-organisms (bacterial contaminates) in the resident's urine as Escherichia coli (E-Coli), with colony count of 40,000 CFU/ml.; and Enterococcus faecium with colony count of 40,000 CFU/ml. Furthermore, the report documented the Enterococcus faecium, as resistant to the antibiotic Vancomycin, and contact precautions were indicated.

On 08/06/19 at 12:17 PM, observation revealed the resident sat on the bedside commode, of Certified Nursing Assistant (CNA) O and Certified Medication Aide (CMA) T entered the resident's room; applied gowns and gloves; and used the sit to stand lift to raise the resident off of the bedside commode to a standing position. CMA T proceeded to provide pericare to the resident following the resident voiding. CMA T cleaned the resident's peri area repeatedly over the same area, with the same wipe and failed to remove her gloves and sanitize her hands between cleaning the anterior and posterior peri area. CMA T pulled the resident's pants up after cleaning the resident; pulled the wheelchair into position for the resident to sit down without changing her gloves or sanitizing her hands after providing peri care. She then proceeded to place the resident's wheelchair (w/c) pedals on the w/c and moved the residents feet to the w/c pedals by

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lifting the resident's legs making direct contact with contaminated gloves. She then rolled the resident out of the room in the common dining area for lunch without offering the resident an opportunity to wash her hands. CNA T did not remove her gloves or wash her hands. The resident was not offered an opportunity to wash her hands before leaving the room.

On 08/06/19 at 12:45 PM, CMA T verified the above findings and reported pericare should be provided following toileting. The staff should clean the resident with one wipe one swipe, cleaning front to back to prevent cross contamination. She stated gloves should be removed and hands sanitized between use and when moving from cleaning one area to another. CMA T reported she should have offered the resident an opportunity to wash her hands after toileting and should not have handled the residents equipment with the gloves used to provide peri care.

On 08/06/19 at 02:51 PM, observation revealed Consultant Staff JJ pushing the resident in the w/c to the room. Consultant Staff JJ reported the resident received therapy and needed to go to the bathroom. Consultant staff JJ and CNA O put on appropriate personal protective equipment (PPE) and proceeded to use a sit to stand lift to transfer the resident to the bedside commode. Consultant staff JJ pulled the resident's brief and pants down with gloved hands and positioned the resident on the commode; and handed the resident the call light with the gloves she had on while pulling the residents pants down. Consultant Staff JJ, removed her gloves and washed her hands before leaving the room.

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On 08/06/19 at 01:07 PM, Licensed Nurse (LN) I, confirmed the resident had a UTI with the infectious organisms of VRE and E-Coli and was on Contact Isolation to prevent the spread of infection to other residents. LPN I stated staff should change gloves and sanitize hands between resident contact; provide peri care front to back with one wipe one swipe; and encourage the resident to wash her hands before leaving the room and entering the dining area.

On 08/06/19 at 03:10 PM, Consultant staff JJ and CNA O confirmed the above findings and agreed gloves should be removed and hands sanitized after direct contact with a resident prior to handling equipment to prevent cross contamination.

On 08/08/19 at 02:13 PM, LN J stated staff should use PPE when giving care to a resident on contact isolation. The staff should remove gloves and sanitize hands between resident care, from one area to another;prior to handling equipment to prevent cross contamination. LN J stated staff should use one wipe for one swipe, front to back,when providing pericare.

On 08/12/19 at 08:31 AM, Administrative Nurse D confirmed the resident's urine culture findings, antibiotic treatment for VRE and E-Coli as noted above. He agreed the failure of the staff to obtain an order for contact isolation; provide appropriate peri care cleaning front to back, with one wipe one swipe; changing gloves and sanitizing hands after direct resident contact and handling the equipment; and failing to encourage the resident to sanitize her hands after toileting was not in keeping with standards of contact isolation to prevent cross contamination and prevent UTIs.

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F 690	Continued From page 84 The facility policy for "Peri Care," dated 12/2017, documentation included "The purpose of this procedure . . . to provide cleanliness and comfort to the resident, to prevent infections and skin irritation. The following equipment a and supplies will be necessary when performing this procedure, disposable wipes, authorized cleaning agent and Personal protective equipment (e.g. gowns, gloves, masks, etc., a needed. . .Wash perineal area, wiping front to back. . . Do not reuse the same disposable wipe to clean the labia. . . Wipe the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same wipe to clean the labia. . . Remove gloves and discard into designated container. Perform hand hygiene." The facility failed to provide appropriate peri-care, use of personal protective equipment (PPE) and handwashing to prevent further cross contamination and urinary tract infections for the Resident on contact isolation for VRE and E-Coli of the urine who was on contact isolation.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		

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desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents. The sample of 23 residents included 4 reviewed for nutrition. Based on observation, interview, and record review, the staff failed to develop and implement timely interventions to prevent weight loss for two Residents (R) 2 and R15, and one R#9 for weight gain, of the 4 residents sampled for nutrition. Specifically R2, from 05/02/19 through 06/02/19, lost 17 pounds/11.89% in 1 month, (the 05/02/19, weight of 143 pounds, and the 06/02/19 weight of 126 pounds) and from 07/03/19 through 07/10/19, R2 lost eight pounds/6.2% in 8 days, (the 07/03/19 weight of 129 pounds, and the 07/10/19 weight of 121 pounds).

Findings included:

The facility reported a census of 72 residents. The sample of 23 residents included 4 reviewed for nutrition. Based on observation, interview, and record review, the staff failed to develop and implement timely interventions to prevent weight loss for two Residents (R) 2 and R15, and one R#9 for weight gain, of the 4 residents sampled for nutrition. Specifically R2, from 05/02/19

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through 06/02/19, lost 17 pounds/11.89% in 1 month, (the 05/02/19, weight of 143 pounds, and the 06/02/19 weight of 126 pounds) and from 07/03/19 through 07/10/19, R2 lost eight pounds/6.2% in 8 days, (the 07/03/19 weight of 129 pounds, and the 07/10/19 weight of 121 pounds).

Findings included:

- Resident (R) 2's signed "Physician Orders" dated 07/22/19, included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral issues, major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), hypertension (high blood pressure), gastro esophageal reflux disorder (backflow of stomach contents to the esophagus), history of falling, cardiac arrhythmia (irregular heart rate), hyperlipidemia, muscle weakness, communication deficit, and history of UTI (urinary tract infection).

The Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident admitted 03/08/17, from an acute hospital with a BIMS (brief interview for mental status) score of seven indicating severe cognitive impairment. The resident lacked exhibited depression mood indicators or behaviors. The resident required the staff to set-up meals and provide supervision with eating. The resident had no functional limitation in range of motion ROM in the upper or lower extremities. R2's height of 62 inches and weight of 139 pounds (lbs.), did not indicate a weight gain or loss. R2 received a therapeutic mechanical altered diet. The resident had no

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natural teeth or tooth fragments. The resident received anti-anxiety and antidepressant medication for seven days of the look back period.

The Quarterly MDS, dated 07/11/19, documented changes included BIMS score of five, indicating severe cognitive impairment. The resident had a depression indicator score of one related to feeling down, depressed or hopeless for two-six days of the look back period. The resident's weight of 129 documented the resident experienced a significant weight loss and was not on a physician prescribed weight loss regimen. The resident received antibiotics for four days of the look back period.

The Nutrition "Care Area Assessment" dated 02/08/19, documented the resident required set-up assistance with eating and supervision; received NAS (no added salt), mechanical soft diet, and consumed 51-75% of most meals. The resident's current weight was stable and revealed an increase in BMI (body mass index). She was edentulous (without natural teeth) and chose not to wear her dentures. The resident was without chewing or swallowing concerns. The staff would continue to monitor weights and intake per facility protocol or physician orders.

The "Care Plan" for nutrition, initiated 05/31/17, instructed the staff:

To record food intake at each meal.

Offer appropriate substitutes for uneaten food.

The resident comes out to the table for meals and feeds herself without difficulty.

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The resident received a NAS/Mechanical soft diet,

The resident was edentulous.

Monitor for tolerance to present diet and intervene as needed to maintain oral intake at meal time.

Care plan updates for nutrition, dated 06/17/19, instructed the staff:

Offer R2 super cereal (fortified hot cereal/extra calories) at breakfast, as tolerated.

Add Benecal (caloric nutritional supplement) to R2's biscuit and gravy.

Additionally, a care plan update, dated 06/18/19, instructed the staff to weigh the resident weekly.

Review of R2's weight tracking revealed the following weights:

On 02/06/19, weighed 140 lbs.

On 05/02/19, weighed 143 lbs. (weights stable from 02/2019 through 5/2/19).

On 06/02/19, weighed 126 lbs., R2 experienced a weight loss of 17 pounds/11.89% in one month.

On 07/03/19, weighed 129 lbs. R2 experienced a weight gain of three lbs.

On 07/10/19, weighed 121 lbs. R2 experienced a weight loss of eight pounds/6.2% in eight days.

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The physician orders, dated 08/02/19, documented the following orders related to nutrition:

Ice cream shake, by mouth, every day for supplement, at 10:00 AM, with start date of 12/14/18.

Supercereal at breakfast, by mouth, every day for supplement, ordered 06/19/19.

Benecalorie 7.5 kcal/ml (milliliter), oral liquid (caloric nutritional supplement), by mouth every day add to gravy, ordered 06/19/19 and discontinued on 08/02/19.

Ensure plus (lactose-reduced food supplement), 0.05 gram 1.5 kcal/ml, oral liquid by mouth two times a day, ordered 07/10/19.

Diet order- NAS, Mechanical Soft diet, Ensure BID, Benecaloric daily, Supercereal daily, ordered on, 07/29/19.

Benecalorie 7.5 kcal/ml oral liquid (caloric nutritional supplement), by mouth three times every day, ordered 08/02/19.

Mechanical Soft Diet; low spice diet, ordered 08/02/19

Review of the R2's "Medication Administration Records) (MAR), for July 2019 and August 2019, failed to reveal the percentage of Ensure R2 consumed.

Review of the "Dietary Notes" and "Risk Assessments" revealed the documentation included:

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F 692	Continued From page 90 On 04/16/19 at 8:46 AM, the quarterly "Nutrition Service Note" and "Nutrition Risk Assessment" were completed and documentation revealed the resident would not be referred to the registered dietician. On 07/08/19 at 03:53 PM, the quarterly "Nutrition Risk Assessment" documentation included R2's diet order as NAS mechanical soft with no fluid restrictions. The resident feeds herself independently and consumes 51-75%. The resident had no swallowing problems with height of 62 inches and a weight of 129 lbs. (pounds). The resident's IBW (ideal body weight) was 110 lbs, with a usual body weight range of 99-121lbs. The resident's BMI (body mass index) of 23.9 and identified the resident had a significant weight loss. On 07/08/19 at 3:53 PM, the quarterly "Nutrition Service Note" and quarterly "Nutrition Risk Assessment" completed and documentation revealed the resident would not be referred to the registered dietician with, "Will not refer to RD [registered dietitian] review." Review of Interdisciplinary Team" "Progress Notes" dated 06/02/19 through 08/08/19, revealed the medical record lacked documentation of the resident's significant weight loss on 06/02/19 and 07/10/19, as noted above. On 08/06/19 at 06:01 PM, the resident fed herself 75%-100% of the meal, which consisted of ham, corn bread, broccoli cheese, potatoes, chopped meat, grape juice, and 1 bite of the lemon bar. She got up from the table and left the dining room independently.	F 692		

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On 08/07/19 at 08:45 AM, R2 fed herself breakfast, which consisted of cream of wheat, (super cereal, 100%), banana slices (couple of bites), 1/2 glass of orange juice, water glass. The staff did not serve the resident the biscuits and gravy, and the resident explained she had what she wanted.

On 08/08/19 at 04:59 PM, Certified Nursing Assistant (CNA) TT and Licensed Nurse (LN) J weighed the resident. R2's weight was 126 pounds. Both LN J and CNA TT verified the procedure for obtaining weights was accurate and that the resident did not appear to have lost weight in the last 3 months

On 08/06/19 at 04:34 PM, the resident stated she liked sweets, but did not like greasy foods. She explained she did not like to eat a lot because she did not want to stretch her stomach. She reported her weight as "around 100 lbs." most of her life. Additionally, R2 reported the facility gave her snacks when she wanted them.

On 08/06/19 at 01:43 PM, CNA UU reported the individual needs and preferences of the residents communicated through the resident care guide/care plan. The MDS coordinator updated the resident care guides to reflect new interventions when changes in the resident's condition occur. Staff UU stated she was made aware of R2's weight loss, felt the weight loss was due to confusion, but did not see a difference in her weight over the past few months. She reported the interventions for the resident's weight loss included the staff provided the resident with ensure, as supplement; weigh R2 weekly; encourage her to eat more; and provide

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her with a lot of cueing and redirection when the resident gets up from the table. Staff UU stated the dietary staff document the meal intake, and the CMA (Certified Medication Aides) document in the MARs when they provide supplements to the resident but did not document percentage taken by the resident.

On 08/06/19 at 04:56 PM, Dietary Aide (DA) FF reported the resident received a regular, mechanical soft diet, with ground meat. She stated R2's intake varied, some days really good, some days she ate 1/2 of her meal and she averaged a meal intake around 50-75%. Staff FF stated the resident usually eats from all the food groups and did not require assistive devices. The resident liked biscuits and gravy at breakfast and drank plenty of fluid. The staff also offered the resident snacks throughout the day. The resident could get snacks, at all of the time.

On 08/07/19 at 10:45 AM, CNA (Certified Nursing Assistant) VV explained the individual needs and preferences of the residents were communicated through the resident care guide/care plan, and the nurse notified the CNAs of changes in the care plan. She reported R2 sometimes only picked at the food, and some days she eats it all. Staff VV stated the resident liked sweets, staff tried to get her to eat ice cream, and offered alternative when she leaves food on her plate. Staff VV reported the resident usually eats 85-100%, breakfast was her favorite meal, and she liked supercereal. The staff obtain monthly weights at a minimum and then weekly weight for residents identified to have a weight loss concern. She stated she was not aware of the resident's weight loss.

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On 08/07/19 at 12:47 PM, LN (Licensed Nurse) K reported the residents' needs and preferences were in the care plan. LN K was not aware of the resident's weight loss. The medication aides give the supplements. On review of the resident's medication record staff K verified the weight loss and orders as noted above.

On 08/08/19 at 10:24 AM, CDM, (Certified Dietary Manager) CC confirmed the weight loss, physician orders, nutritional notes and assessments. She confirmed R2 should have been referred to the registered dietician for recommendations after the weight loss on 06/02/19 and 07/10/19; and the follow-up on the weight loss was not timely to prevent further weight loss. Additionally, CDM CC confirmed the care plan was not updated to reflect changes in the interventions to address weight loss and nutritional status for increase of Benecal to three times a day on 08/02/19 and diet order changed to Mechanical soft, no spice.

On 08/08/19 at 2:13 PM, LN (Licensed Nurse) J stated he was not aware of the resident's significant weight loss that occurred on 06/02/19 and 07/10/19. The weight loss related to dementia, the resident wondered away from meals more frequently, and takes herself to the bathroom. The staff goes to her room and walk her back to the table. LN J verified the resident received supplements of ensure and benecal. The resident usually ate 78-80% of breakfasts and 50% of lunch. LN J described the resident as more anxious in the evenings over the last 6 weeks and with a decrease in her attention span. Staff J stated a significant weight loss should be reported to the nurse immediately, and an intervention should be implemented at the time of

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the notification. LN J was not aware of the weight loss that occurred on 06/02/19 or 07/10/19. He stated the facility protocol for weight loss was the weights were forwarded from the court/unit to the CDM, who then referred to the Dietician. The dietician sends recommendations to the nurses. The nurses implement the recommendations and send out the orders for signature. Staff J confirmed the weight loss triggered 07/29/19 and the RD (Registered Dietician) addressed the weight loss in the note of 08/07/19.

On 08/08/19 at 04:41 PM, LN J called the physician's office and verified the clinical record lacked documentation of the physician being notified by the facility of the acute weight loss noted on 06/02/19 and 07/10/19.

On 8/08/19 at 5:34 PM, Administrative Nurse D, confirmed the above findings; the facility failed to intervene for the resident's identified significant weight loss on 6/2/19 and 7/10/19 in a timely manner to prevent further weight loss. He stated the facility system to address weight loss lacked an immediate address of significant weight loss in a timely manner and was in need of revision

On 8/12/19 at 9:48 AM, Administrative Nurse E verified R2 experienced a significant weight loss and the facility did not reassess the resident nutritional needs. He verified the weight loss for R2 as noted above and confirmed the medical record lacked notification of the physician of R2's weight loss. Staff E confirmed the physician should have been notified by the nurse, dietician, or kitchen manager, when the staff obtained the resident's weight, and not wait for a weight risk meeting to address a concern for a significant weight loss. The lack of the facility to address

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R2's weight loss represent a system failure to immediately notify the physician and intervene to prevent further weight loss. She verified the lack of reassessment before adding a supplement. Review of the resident's labs drawn on 06/12/19, revealed the protein and albumin levels as with in normal limits. Staff notified the RD of the weight loss on 06/13/19, 11 days after identification of the weight loss. The medical record lacked the % of the supplement consumed by the resident.

On 08/12/19 at 11:15 AM, Consultant staff KK confirmed the resident's weight as stable between February and May of 2019. The weight loss on 06/02/19 and 07/10/19 represented a significant weight loss which should have been addressed by staff immediately. Staff KK reported the staff reviewed the resident's weights at the risk meeting on 06/12/19 and interventions were put in place on 06/13/19. Additionally, staff KK confirmed the physician had not been notified of the significant weight loss.

The facility policy for Significant Weight Loss, dated 01/2019, documentation included ". . . appropriate interventions shall be provided to residents who have a significant weight change. A significant weight change is identified as a weight loss or gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. A report should be generated from the electronic medical record (EMR) system identifying all residents with a significant weight loss in 30 days, 90 days, and/or 180 days. The RD [Registered Dietician] should make recommendations for nutritional interventions based on the information obtained from the weekly Resident at Risk Review huddle meetings. The RD recommendations should be reviewed and initiated by nursing associates. A

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nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD has requested a nutritional intervention." The policy lacked direction for the immediate address and physician notification of a significant weight loss to prevent further weight loss.

The facility failed to implement timely interventions to prevent further weight loss for this cognitively impaired resident with significant weight loss from 05/02/19 through 06/02/19, lost 17 pounds/11.89% in 30 days/one month, and from 07/03/19 through 07/10/19, lost eight pounds/6.2% in 8 days for the resident.

- Observation, on 08/06/19 at 12:25 PM, revealed Resident (R) 9 sat at the dining room table and looked at a plate of meat loaf, mashed potato's and gravy, carrots, hot roll with margarine, and peach crumble. At 12:28 PM, certified nurses aide (CNA) MM encouraged R9 to eat. She continued to sit and stare at her food. At 12:31 PM, CNA QQ encouraged R9 to eat and she started feeding herself slowly. At 12:35 PM, CNA QQ left the table to assist another R to eat, and R9 continued to feed herself. She ate approximately half of her mashed potato's and gravy, and then started to feed herself the dessertt. At 12:45 PM, she completed eating. R9 ate 1/2 of her potato's and gravy, her deserrt, and drank her fluids.

Observation, on 08/06/19 at 05:31 PM, revealed the meal served was baked ham, baby bakers, broccoli with cheese sauce, corn bread with margarine, and lemon cheesecake bars. The spouse was beside R9 and had set-up the plate

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and was verbally encouraged her to feed herself. At 05:50 PM, she had fed herself all the potato's, and broccoli with cheese sauce, corn bread, and almost all of her ham. At 05:56 PM, she finished her meal, and ate 100%.

Interview, on 08/05/19 at 8:30 AM, with R9's spouse stated she gained alot of weight and told the staff to stop the ensure and the ice cream. The spouse did not want her to gain a lot of weight.

On 08/06/19 at 03:03 PM, CNA MM stated the care plans would inform her of R9's care. She was a two person assistance with a mechanical lift and staff propelled the wheelchair for her. Usually in the morning R9's spouse would feed her. At noon today R9 did not want to eat, with her dementia. CNA MM was not sure if the resident did not like the food or what but usually really ate good.

On 08/07/19 at 10:00 AM, certified dietary manager (CDM) CC stated she was not sure if R9 was on a supplement now. R9 had been eating well, expecially breakfast and supper.

On 08/07/19 at 02:59 PM, CNA OO stated R9 fed herself, and might require some cueing from the staff, but she eats very well. The staff would get her weight and document it in the KIOSK (electronic medical record) under the weight tracking, but the staff were unable to see the last previous weight put in the record, so the staff could not tell if she gained or lost weight.

On 08/07/19 at 02:06 PM, licensed nurse (LN) H stated she remembed the order for the supplements but not when it was obtained. R9

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ate well 51-75% of her meals. But after a while the spouse asked for the supplements to be stopped because R9 had gained to much weight. R9 was not sick, just the increase in the calories which caused her to gain weight. She was not sick medically during the time frame. The CNA's would obtain the weight and then they would put it in the computer. LN H stated she was not informed of any weight changes by the aides.

On 08/07/19 at 04:00 PM, administrative nurse E stated that the facility certified dietary manager was responsible over the residents' weights.

On 08/08/19 at 12:14 PM, Registered Dietician (RD) KK stated the weight loss was from a previous stay, so she advised the physician to increase R9's Ensure and add ice cream at supper. She was unaware the R9's spouse did not want her to gain a lot of weight. She reviewed the weights every month, and did not notice a significant weight gain in the last 6 months. On her Febraury 2019, spread sheet she identfied in 90 days a 10.6% weight gain and 30 days 9.95% weight gain. She would usually request R9 to be reweighed by the staff and it looked like she did not and she should have made the resident a weekly weght. Her expectation was the facility staff and herself should have identified the resident's weight gain sooner.

On 08/08/19 at 04:16 PM, administravie nurse D stated his expectation with the resident's weight gain should have been identified in February 2019, and possibly stopped the supplement and revised the care plan. Administrative nurse D would have thought CDM CC and the RD KK would have notified him and they could have stopped the supplement. He had never had this

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happen before.

Review of the facility's policy titled, "Significant Weight Loss/Gain", revised on 01/19, instructed that the facility would provide appropriate nutritional interventions to residents who have a significant weight change is identified as weight loss or gain of 5% in 30 days, or 10% in 180 days. A resident with a weight change of five pounds or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record. A report should be generated identifying all resident's with a significant weight change in 30 days, 180 days. At the weekly resident at risk review huddle, the IDT (interdiciplinary team) should discuss residents who triggered for a significant weight loss and who lose more than 5 pounds since the last weight. The RD should make recommendations for nutritional interventions.

The facility failed to monitor and identify timely the interventions to address R9's significant weight gain from 01/06/19 to 02/06/19, when she weighed 160 pounds, a weight gain of 15 pounds or 10.42 % in 35 days. From 02/06/19 through 03/06/19, R9 weighed 172 pounds, a weight gain of 12 pounds or a 7.5% weight gain in 38 days, or an overal weight gain of 30 pounds, or 18.86 % of weight in 58 days.

- Resident (R) 15's, signed "Physician Orders" dated 06/13/19, documented the resident admitted on 02/8/19, with the following diagnoses including; dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, major depressive disorder

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(major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The Annual "Minimum Data Set" (MDS), dated 02/14/19, revealed R15 had a BIMS (brief interview for mental status) score of five, indicating severely impaired cognition. R15 required supervision for eating. The R15 without swallowing or dental issues and weighed 143 pounds.

Review of the Nutrition "Care Area Assessment" (CAA), dated 02/20/19, advised nutrition did not trigger for further investigation.

The Quarterly MDS, dated 05/09/19, revealed the no changes from the Admission MDS dated 02/14/19.

Review of the Nutrition "Care Plan", found in R15's electronic medical record (EMR), reviewed on 05/21/19, advised she would have nutritional needs met, and would not have an unplanned significant weight change over the next review period. Interventions included offer R15 the diet as prescribed, snacks daily, offer a minimum of 480 cc (cubic centimeters) of fluids daily, weigh weekly/monthly, monitor meal intake daily, she received a regular diet, and she may not eat her evening meal during supper time. Please offer her meal later in the evening after everyone had left the dining room if she did not eat during supper.

Review of her EMR "Physician Orders", found under "attachments," advised the physician ordered on 02/10/19, weekly weights. On 02/15/19, the physician ordered a regular diet.

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Review of a "Nutrition Risk Assessment" found in R15's EMR under "assessments," dated 2/14/19, advised the she received a regular diet, fed herself, had a good appetite, and her meal intake ranged from 51-75%. She had missing/broken/edentulous, and without difficulty swallowing. R15 weighed 141 pounds, a body mass index of (BMI) of 24.1, within normal limits (normal BMI range was 18.5 to 24.5), required 1625 calories per day, 65 Gm (grams) of protein a day, and 1625 cc of fluids a day. She had a good appetite with a regular diet and the regular diet was appropriate and would continue with the diet, monthly weights, and meal intake.

Review of the weights, found in R15's EMR, located under "weight tracking" identified on 07/01/19, R15 weighed 145 pounds. On 07/15/19, R15 weighed 140 pounds. On 07/22/19, R15 weighed 143 pounds. On 07/29/19, R15 weighed 136 pounds. On 08/05/19, R15 weighed137 pounds. R15 with a weight loss of 8 pounds, or 5.52% weight loss.

The meal intake documentation found under POC (point of care) in the EMR, from 07/01/19 through 08/01/19, identified R15's meal intake for breakfast ranged from 76-100%; for lunch 76%; and for dinner the resident with an intake 51-75%.

The "At Risk Review," located in the EMR, found under "assessments" of R15, dated 07/17/19, identified she weighed 140 pounds, on this day, and received a regular diet. Continue to monitor weights and to re-evaluate. R15 eats after everyone else leaves the room.

R15's "Nutritional Assessment" dated 07/29/19,

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located in the EMR, found under "assessments" advised the physician ordered a regular diet, and fed herself independently. Her meal intake was 51-75%, and food preferences obtained. R15 with broken/missing/edentulous teeth, and without swallowing issues. She weighed 136 pounds, ideal body weight (IBW) was 120 pounds, IBW range was 108-132 pounds, with a BMI of 23.3. R15 with a significant weight loss in the last six months.

Review of R15's dietary meal card on 08/06/19, identified the resident was to receive a regular diet and a beverage.

Review of the "Dietitian/Physician faxed Communication", dated 08/07/19, found in R15's EMR under "Assessment" section documented the physician notified of a significant weight loss of 5.4% in 30 days, and a 11% for 90 days. Recommended offering her Ensure Plus BID (twice a day) and Thrive every day for added calories and protein and continue with a regular diet. The physician agreed with the recommendation.

Observation on 08/06/19 at 12:25 PM, R15 sat at the dining room table with a hamburger, seasoned carrots, mashed potato and gravy, and dessert. At 12:43 PM, she had completed her hamburger, dessert, and was able to feed herself. At 12:57 PM, she stood up from the table and ambulated to her room. R15 did not eat anymore, and staff did not encourage the resident to eat.

On 08/06/19 at 05:25 PM, the meal served included baked ham, baby bakers, broccoli with cheese sauce, corn bread, margarine, and lemon cheesecake bars. At 05:46 PM, she sat in her

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room was not served dinner. R15 with numerous packages cheese and crackers in her room. When asked if she liked those crackers the she responded those were not her crackers. At 05:52 PM, administrative staff C, took R15 her dinner tray and tried to encourage her to eat the meal, however the she stated it was time for breakfast and she would take coffee and toast. At 05:58 PM, R15 was served toast and coffee.

Interview on 08/06/19 at 03:03 PM, Certifeid nurses aide (CNA) MM stated she feds herself, and was not aware of her with weight loss. She does not always come out of her room for meals, however if she does come out of her room, she would usually eat almost all of the meal. If she stayed in her room she would only eat half of her meal. CNA MM stated she would obtain aweight and place it in the computer.

On 08/06/19 at 05:36 PM, CNA RR stated R15 refused to come out for dinner, so CNA RR would ask her again and if she does not come out she would take her a tray. She does this a lot in the evening because her dementia, and did not always eat a lot. R15 offered snacks, and she would eat them.

On 08/06/19 at 06:05 PM, Dietary Cook EE stated she could always count on R15 to eat a hamburger or toast for meals.

On 08/07/19 at 10:42 AM, Certified dietary manager CC (CDM) verified she reviewed the weights and would notify the appropriate staff of any weight loss. She was not aware of R15 with a 5.52% weight loss in 30 days.

On 08/07/19 at 02:06 PM, Licensed Nurse (LN) H

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stated R15 ate 100% of meals when she was at the table. Once in awhile she would not come out for supper and then she would say it was to late to eat and go to bed. They were able to get her to eat something when that happens. LN H reviewed R15's weights and stated she was not loosing weight, and the her weight fluctuated, just a couple of pounds here and there, and she does not retain fluids. R15 does not recieve supplements she could see. R15 could make her wants and needs known of what she wanted to eat. During the interview, LN H received orders from the physician at 2:38 PM, and the physician ordered Ensure and Thrive daily for weight loss.

On 08/07/19 at 04:00 PM, Administrative nurse F verified the facility was not aware of R15 with 5.52% weight loss or 8 pounds in 30 days. She reported the physician was notified of the resident's weight loss, and received an order for a supplement for a significant weight loss.

On 08/08/19 at12:38 PM, Register Dietician (RD) KK reported she was just the consultant and was in the build monthly. CDM CC would send her a weight spread sheet weekly and she monitored the meal intakes. If there was a five pound weight change in a week, then the resident would be discussed during the at risk meeting, on Thursdays at 01:00 PM. Whenever she printed off the weights for the month they may not alway be completed. The facility weights need to be completed by the 7th, and any reweighs completed by the 10th. RD KK noticed the R15 was reweighed at 138 pounds. CDM CC sent the report out this morning and she reviewed the report and sends out the recommendations to the phsyician which she did. CDM KK sends the monthly weights out between the 7th and the 10th

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of each month.

On 08/08/19 at 03:34 PM, administrative nurse D stated the facility would weigh the residents at least monthly, and as ordered by the physician. He looks at weight with a loss of 5% in 30 days and 10% in six months. The facility meets monthly to review weights in QA (quality assurance meeting). Residents at risk meetins are held weekly, every Thursday, and would review the residents with weight loss, from the report he received from CDM CC. Then Licesed Nurse YY sets up the list of residents for the risk meeting and sends it out to everybody. This is when he would review the weights. If R15 was on a monthly weight protocol, then he would hold a monthly meeting, if the resident was a weekly weight, then he would review the weights weekly when the CDM CC brought them to him. The physician would decide which resident should be on weights weekly/monthly and the physician would go by the RD KK's recommendation. Administrative staff D stated he expected to be notified of a resident with any weight loss, and the physician should be notified to obtain nutritional orders if the physician wants.

Review of the facility's policy titled, "Significant Weight Loss/Gain", revised on 01/19, advised the facility would provide appropriate nutritional interventions to residents who have a significant weight change is identified as weight loss or gain of 5% in 30 days, or 10% in 180 days. A resident with a weight change of five pounds or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record. A report should be generated identifying all residents with a significant weight change in 30 days, 180 days. At

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F 692	Continued From page 106 the weekly resident at risk review huddle, the IDT (interdisciplinary team) should discuss residents who triggered for a significant weight loss and who lose more than five pounds since the last weight. The RD should make recommendations for nutritional interventions. The facility failed to monitor and implement timely effective interventions to address this R15's who had a 5.52% weight loss in 35 days, with a loss of 8 pounds from 07/01/19 (145 pounds) through 08/05/19 (137 pounds).	F 692		
F 695 SS=E	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 73 residents. The sample included 23 residents with one Resident (R)20 selected for review of respiratory care. Based on observation, interview, and record review the facility failed to provide necessary respiratory care and services related to the use of R20's Continuous Positive Airway Pressure (CPAP) machine; and labeling with storage of distilled water used for the concentrator's humidifier bottle. Furthermore, the facility identified 23 of the 73 residents required oxygen therapy. Based on	F 695		

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observation and interview the facility failed to store oxygen E- tanks/oxygen concentrators in a clean and sanitary manner, to prevent further respiratory infections for these 23 residents.

Findings include:

- Review of Resident (R)20's undated "Physician Orders," documentation included diagnoses of congestive heart failure (fluid build-up around the heart), muscle weakness, chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pneumonia, chronic respiratory failure with hypoxia (lack of oxygen in the blood), edema (excessive fluid volume), and morbid obesity (severely overweight). Further review of the physician orders, revealed the resident lacked a physician's order for use of the Continuous Positive Airway Pressure (CPAP) and/or the care and services associated with the cleaning or care of the CPAP machine and mask.

R20's Annual "Minimum Data Set" (MDS), dated 01/24/19, documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The resident received oxygen, and respiratory therapy for 125 minutes over the seven day look back period. The MDS coding did not indicate the resident used the CPAP.

The quarterly MDS, dated 04/18/19, documentation lacked any changes in the resident's assessment.

The activities of daily living (ADL) "Care Area Assessment" (CAA), dated 02/02/19, included a

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diagnoses of congestive heart failure (CHF) and COPD. The resident often required more assistance due to these diagnoses.

The "Care Plan" (CP), dated 05/06/19, documentation included the resident used oxygen as directed, but failed to address the use of the CPAP machine or to instruct the staff of the appropriate care for cleaning and storage.

On 08/05/19 at 09:17 AM, observation revealed the resident's CPAP mask lying face down, directly on the table top, without a barrier in place and a used undated gallon jug of distilled water which sat directly on the floor, next to the resident's oxygen concentrator.

On 08/05/19 at 09:17 AM, Licensed Nurse (LN) I confirmed the above findings; and stated she did not know who was responsible for cleaning the CPAP machine, most residents had a "Soclean" machine to sanitize the CPAP mask and tubing and she did not know why R20 did not have one. LN I stated the resident started on the CPAP about 2 months ago. Furthermore, the mask should be stored in a bag, and the distilled water should be dated when opened and stored off the floor to prevent cross contamination.

On 08/07/19 at 11:14 AM, observation revealed the CPAP mask lying face down, directly on the table top, without a barrier in place, and a used undated gallon jug of distilled water sat directly on the counter. The resident had her nasal cannula in place and the oxygen concentrator was set at 3 liters of oxygen per minute.

On 08/07/19 at 11:14 AM, Certified Nursing Assistant (CNA) SS, verified the above

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observation and indicated she did not know who cleaned the CPAP machines. She stated the distilled water was used for the oxygen concentrator's humidifier bottle and should be dated when opened.

Another review of R20's "Physician Orders" now revealed an order to clean the CPAP daily, ordered on 08/7/19. However, the physician orders continued to lack an order for the use and indication for the use of the CPAP.

On 08/12/19 at 8:31 AM, Administrative Nurse D and E agreed the CPAP machine should be cleaned and the mask stored in accordance with facility policy to prevent cross contamination. They confirmed that the distilled water was used to fill the humidifier bottle on the concentrator and should have the date written on the bottle when opened and not be stored on the floor.

The facility policy for "CPAP/BIPAP Support," dated 04/2018, documentation for cleaning CPAP mask included ". . . clean daily, mask stored ; clean daily by placing in warm soapy water, soak agitate for [five] minutes Rinse with warm water and allow it to air dry between uses every day for maintenance."

The facility failed to provide necessary respiratory care and services related to the cleaning and storage of the resident's CPAP machine and distilled water to prevent further respiratory infections for the resident.

- The tour of the laundry room with Laundry Staff U, on 08/07/19 at 11:23 AM, revealed the facility stored their oxygen tanks, and oxygen

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F 695	Continued From page 110 concentrators in the laundry room, where the staff sorted the dirty laundry, and directly beside the soiled linen barrels. An interview with Administrative staff D, on 08/07/19 at 7:35 AM, stated, the oxygen tanks were taken from the laundry room storage area, directly to the residents' room and there was a possibility of splash contamination in the current storage area. The staff identified 23 residents had oxygen usage orders. An interview with Administrative Staff E, on 08/12/19 at 8:47 AM, confirmed the oxygen tanks were being stored in the soiled laundry area, creating a possible infection control issue. Review of the facility's policy titled,"Infection Prevention and Control Program," dated 05/2018, revealed the following information," The objectives of our infection control policies and practices are to maintain a safe, sanitary, and comfortable environment for personal,residents,visitors, and the general public." The facility failed to store the 23 residents' oxygen tanks/concentrators, in a sanitary area to prevent respiratory infections for the 23 residents of the facility.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		

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F 732	Continued From page 111 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility had a census of 73 residents. Based on interview and record review, the facility failed to post the daily nursing staffing sheets, to include the actual hours worked for the Certified Nurses Aides (CNA).	F 732		

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F 732	Continued From page 112 Findings included: - Review of the facility's "Daily Staff Posting Sheets," from 05/01/19 through 08/08/19, revealed the facility failed to provide the actual hours worked by the Certified Nurses Aides (CNA's). On 08/12/19 at 08:40 AM, Administrative Nurse D stated the CNA's would work seven and a half hours after taking a 30 minute lunch and If the CNA's did not receive lunch then the CNA's would have an eight hour day. On 08/12/19 at 11:15 AM, Administrative staff B stated she filled in the "Daily Nursing Staffing Sheet," a week at a time. She would then sometimes go back and change the actual hours worked if a CNA called in or else wait and change the actual hours worked at the end of the week. Furthermore, she had been using eight hours for the CNA's instead of the seven and a half hours. postings for a week at a time. On 08/12/19 at 11:20 AM, Administrative Nurse D verified the "Daily Nursing Staffing Sheets" lacked the correct actual hours worked for the CNA's. The facility failed to post daily staffing information, including the actual hours staff worked, as required, for the residents and visitors of the facility.	F 732		
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	F 755		

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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.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents with 23 sampled for review. The sample included six residents reviewed for medications. Based on observation, interview, and record review, the facility failed to ensure staff administered medications to one Resident (R) 170, of the six residents sampled, as ordered by the physician.

Findings included:

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- Resident (R) 170's signed "Physician Order Sheet," documented the resident admitted to the facility on 08/01/19, with diagnosis including diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Physician's Order" directed the staff to administer Januvia (medication to control blood glucose), 100 milligrams, daily, for diabetes, ordered 08/02/19.

Review of the "Medication Administration Record" (MAR), from 08/01/19 to 08/06/19, revealed the following:

On 08/02/19 at 1:17 PM, documented the staff did not administer the resident's Januvia, because staff were "waiting on pharmacy to send the med" [medication],"not here to give."

On 08/03/19 at 08:34 AM, documented the staff failed to administer the resident's Januvia, related to the medication "not here."

Review of "Interdisciplinary Team" (IDT) notes, from 08/01/19 to 08/07/19, revealed the resident admitted from home on 08/01/19. On 08/03/19, the resident admitted to the hospital related to chest pain, and she returned to the facility on 08/04/19.

On 08/06/19 at 12:35 PM, Certified Medication Aid (CMA) R administered medications to the resident. The medication card of Januvia was full.

On 08/05/19 at 09:06 AM, the resident reported when she admitted to the facility, she did not get

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all her medications because there was a "mix up" in the medications.

On 08/06/19 at 09:22 AM, Licensed Nurse (LN) G, reported staff should call the pharmacy when medications were not available to be administered.

On 08/06/19 at 12:35 PM, CMA R, reported staff were unable to administer the resident's Januvia until 08/06/19, because the medication was unavailable at the facility. CMA's should notify the charge nurse when medications were unavailable at the facility.

On 08/07/19 at 11:57 AM, LN H, reported when a resident admits to the facility, staff should check the resident's medications. If a medication was unavailable at the facility, staff should notify the pharmacy. LN H verified staff failed to administer the resident's medication, because the medication was unavailable to administer at the facility.

On 08/08/19 at 10:00 AM, Administrative Nurse D, reported if a medication was unavailable, staff should check the emergency medication kit. If the medication was not in the emergency medication kit, then staff should notify the pharmacy.

On 08/08/19 at 02:33 PM, Consulting Pharmacist GG and Consultant Pharmacist HH, reported staff should notify the pharmacy when medication was unavailable to administer.

The facility's policy for "Medication Orders and Receipt Record", dated 12/2017, documented medications should be ordered in advance, based on the pharmacy's required lead time.

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F 755	Continued From page 116 The facility failed to ensure the staff administered the resident's medication as ordered by the physician.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		

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maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 72 residents, with five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to act timely upon recommendations of the consultant pharmacist for one Resident (R) 17, of the five sampled residents.

Findings included:

- Resident (R) 17's, "Physician Order Sheet," dated 07/20/19, of R 17, documented the resident admitted to the facility on 04/15/19, with the following diagnoses including gastro esophageal reflux (backflow of stomach contents to the esophagus) and arteriosclerotic heart disease (a thickening and hardening of the walls of the coronary arteries).

The "Physician's Orders" revealed the following orders:

Pantoprazole (medication used to treat certain stomach disorders), 20 milligrams, daily, for Gastro Esophageal Reflux, ordered on 05/16/19.

Plavix (medication used to that treat blood clots and help prevent blood clot formation in the veins and arteries), 75 milligrams, daily, as an anticoagulant, ordered 04/16/19.

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Review of the pharmacist "Consultation Report,"with a recommendation date of 04/17/19, documented the resident received Plavix and Nexium (medication used to treat certain stomach disorders). Co-administration of these two medications could result in a significant reduction in the Clipidogrel's active level and antiplatelet activity. The pharmacist recommended to consider discontinuing the Esomeprazole, and start Pantoprazole 20 milligrams daily, as an alternative.

The physician accepted the recommendation on 05/16/19, a total of 30 days later.

On 08/07/19 at 03:49 PM, Administrative nurse D, reported he was aware the facility had an "ongoing struggle" to get the pharmacy recommendations acted upon, in a timely manner.

On 08/08/19 at 02:33 PM, Consultant Pharmacist GG, reported when the facility had not obtained a response to the consultation report, the facility should re-issue the report to the physician, for follow-up.

The facility's policy for "Medication Regimen Reviews,"dated 12/2016, documented the consultant pharmacist would document their findings and recommendations on the monthly drug/medication regimen review report. However, the policy lacked guidance for the follow-up of the recommendations written by the pharmacist.

The facility failed to timely act upon recommendations made by the consultant pharmacist, for the resident's medications to ensure no adverse consequences.

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F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The sample of 23 residents, included five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to clarify further physician instructions on one Resident (R) 17, of the five sampled residents. Staff administered the insulin to the resident when the blood glucose readings elevated outside of the physician's ordered parameters on 41 of 272 opportunities, to ensure no unnecessary medication usage. Findings included:	F 757		

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- Resident (R) 17's "Physician Order Sheet", dated 07/20/19, documented the resident admitted to the facility on 04/15/19, with the following diagnosis including diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Physician's Orders" included:

Lantus (insulin medication used to treat diabetes), 15 units, at bedtime, ordered on 04/15/19.

Obtain blood glucose checks before meals and at bedtime. Staff should notify the physician if results were less than 60, or greater than 250, ordered on 04/16/19.

Novolog (insulin medication used to treat diabetes), seven units, three times a day, for diabetes, ordered 07/10/19.

Review of the "Electronic Medication Administration Record," (eMAR) from 06/01/19 to 08/07/19, revealed the following blood glucose readings.

From 06/01/19 to 6/30/19, at the 11:30 AM blood glucose testing, staff obtained the resident's blood glucose, with the resident's blood glucose elevated over 250 on nine of the 30 occasions. Staff documentation included the staff administered the insulin with each of these elevated glucose levels without clarification from the physician.

From 06/01/19 to 06/30/19, at the 04:30 PM blood glucose testing, staff obtained the resident's blood glucose, with the resident's blood

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glucose elevated over 250 on eight of the 30 occasions. Staff documentation included the staff administered the insulin with each of these elevated glucose levels without clarification from the physician.

From 06/01/19 to 06/30/19, at the 08:00 PM blood glucose testing, staff obtained the resident's blood glucose, with the resident's blood glucose elevated over 250 on 12 of the 30 occasions. Staff documentation included the staff administered the insulin with each of these elevated glucose levels without clarification from the physician.

From 07/01/19 to 07/31/19, at the 04:30 PM blood glucose testing, staff obtained the resident's blood glucose, with the resident's blood glucose elevated over 250 on six of the 31 occasions. Staff documentation included the staff administered the insulin with each of these elevated glucose levels without clarification from the physician.

From 07/01/19 to 07/31/19, at the 08:00 PM blood glucose testing, staff obtained the resident's blood glucose, with the resident's blood glucose elevated over 250 on six of the 31 occasions. Staff documentation included the staff administered the insulin with each of these elevated glucose levels without clarification from the physician.

On 08/06/19 at 03:08 PM, Certified Medication Aide (CMA) Q, reported she frequently obtained the resident's blood glucose. If the blood glucose reading was high, she would notify her charge nurse.

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F 757	Continued From page 122 On 08/07/19 at 03:04 PM, Licensed Nurse (LN) K, reported CMA's obtained the resident's blood glucose readings. She verified the resident had elevated blood glucose readings, and staff should notify the physician when the resident's blood glucose was out of the physician's ordered parameters. On 08/07/19 at 03:49 PM, Administrative Nurse D, verified staff failed to notify the physician for the resident's blood glucose levels over 250. Staff should notify the physician when the resident's blood glucose readings were out of the physician's ordered parameters. The facility's policy for "Medication and Treatment Orders," dated 12/17, lacked guidance for out of parameter blood glucose readings. The facility failed to clarify further physician instructions on this resident with multiple blood glucose readings outside of the physician's ordered parameters, to ensure no unnecessary medication usage.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		

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Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 73 residents. Based on observation, interview and record review, the facility failed to provide appropriate storage of medications on one (B) of the 5 Courts/Units, with eight cards of expired medications, for the residents of the Court/Unit.

Findings included:

- On 08/06/19 at 08:43 AM, inspection of the Court B medication cart, with Certified Medication Aide (CMA) UU, revealed 8 expired medication cards as follows:

A medication card for Tylenol 650 mg, (milligram) tablets, with 29 tablets, which expired on 10/15/17.

A medication card for Ibuprofen 600 mg, with 29 tablets, which expired 03/05/19.

A medication card for Loperamide 2 mg, with 27 tablets, which expired 04/21/18.

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F 761	Continued From page 124 A medication card for Hyoscyamine 0.125 mg, with 12 tablets, which expired 03/08/18. A medication card for Furosimide 20 mg, with 21 tablets , which expired 10/07/17. A medication card for Ondansetron 4 mg, with 17 tablets, which expired 08/02/19. A medication card for Promethazine 25 mg, with 26 tablets, which expired 06/08/18. A medication card for Benzonatate 100 mg, with 21 tablets, which expired 03/02/18. On 08/06/19 at 08:47 AM, CMA UU, verified the above findings. On 8/06/19 at 11:43 AM, Administrative Nurse D, stated the staff should check medication storage for expired medications the first of each month. Staff D confirmed the findings above. On 8/06/19 at 12:03 PM, Administrative Nurse E, confirmed the medications were expired as noted above. Administrative Nurse E stated the medication expiration dates should be checked by staff at least monthly. The facility did not have a policy to address monitoring medication storage for expired drugs. The facility failed to provide appropriate storage of medications related to eight different cards of medications for residents of the B Court/Unit.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 125 §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: The facility reported a census of 72 residents. Based on observation and interview, the facility failed to store, prepare, and serve food under sanitary conditions, for two of the five kitchenettes, and the main kitchen, for the residents of the facility. Findings included: - Observations during the initial tour of F Court kitchenette, on 08/05/19 at 11:42 AM, and during the environmental tour with Maintenance Staff V, on 08/08/19 at 2:30 PM, revealed the following area/items of concern: Two cabinet drawers contained food particles in the bottom of the drawer and along the front on	F 812		

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the inside.

The five base cabinets contained food particles in the bottom of the cabinets, along with a grime build-up.

The faucet on the sink was loose and continuously dripping water.

The threshold of the kitchenette doorway had a layer of dirt and grime build-up.

On 08/08/19 at 02:30 PM, Maintenance Staff V, verified the faucet sink was loose and dripping water, and the cabinets with dirt and grime build-up.

The facility's policy for "Food Preparation Area Safety and Sanitation," dated 07/2018, documented walls and ceilings should be washable.

The facility failed to store, distribute, and serve food under sanitary conditions for the residents of the F Court Kitchenette for the residents that resided there.

- Observations during the initial tour of the main kitchen, on 08/05/19 at 08:04 AM, with Certified Dietary Manager CC, and on 08/07/19, at 04:13 PM, revealed the following areas/items of concern:

Four containers of Sweet Chilitops, had a build-up of dust particles.

Eleven spice containers, had a layer of white powder on the lids.

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F 812	Continued From page 127 The dry storage room contained metal racks which contained a layer of grime on the bottom shelves. During a revisit to the main kitchen on 08/07/19 at 4:13 PM, observation revealed in the dishwasher area, condensation from an overhead vent, which dripped onto a rack of dishes drying. Furthermore, a large brown discoloration noted around the overhead vent. The prep area revealed the pipes to the sprinkler with red discoloration. A drawer by the double sink had a layer of grease and grime inside the lip of 3 drawers. On 08/07/19 at 04:13 PM, Dietary Manger ZZ verified the areas, spices, containers, and the drawers required cleaning. On 08/08/19 at 8:45 AM, Maintenance Staff V verified the the sprinkler and the vent required maintenance. The facility's policy for "Food Preparation Area Safety and Sanitation," dated 07/2018, documented walls and ceilings should be washable. The facility failed to store, distribute, and serve food under sanitary conditions for the residents of the facility from this main kitchen. - Observations during the tour of the D court kitchenette, on 08/06/19 at 08:17 AM, and during the environmental tour with Maintenance Staff V,	F 812		

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F 812	Continued From page 128 on 08/08/19 at 02:30 PM, revealed the following area/items of concern: A plastic bag of biscuits, in the refrigerator, expired on 07/28/19. One half of a cake, identified as "Carrot Cake," in the refrigerator, dated "use by" 08/4/19. An undated container of watermelon, in the refrigerator. A cabinet drawer that contained food particles in the bottom of the drawer. In addition, food particles were in the bottom of the silverware storage container. Two cabinet doors had a heavy build-up of brown grime, on the outside. Seven wooden cabinet fronts lacked a protective finish. A microwave had a build-up of dust across the top of the appliance. On 08/06/19 at 08:30 AM, Dietary Staff BB, verified the concerns. Staff should label and date foods. Foods should be discarded after the expiration or the "use by" date. She verified the cabinets lacked finish, and the build-up of grime on the cabinet doors. Staff should clean on a weekly schedule. The drawers should be cleaned out immediately if food spills into the drawer. On 08/08/19 at 02:30 PM, Maintenance Staff V, verified the cabinet doors with a build-up of grime and lack of a protective coating.	F 812		

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F 812	Continued From page 129 The facility's policy for "Food Preparation Area Safety and Sanitation," dated 07/2018, documented walls and ceilings should be washable. In addition, the facility's policy for food purchasing and storage, dated 07/2018, documented food should be dated with the current date, and be used or discarded per "State Food Code Regulations." The facility failed to store, prepare, distribute, and serve food under sanitary conditions for the residents of the D Court kitchenette.	F 812		
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: The facility reported a census of 72 residents. Based on observation and interview, the facility failed to maintain mechanical equipment related to the facility kitchen's stove in a safe operating condition for the residents of the facility. Findings included: - Observation during a revisit to the main kitchen on 08/07/19 at 04:13 PM, with Certified Dietary Manager CC, revealed the following area/item of concern: The oven door was held in the "Closed" position, by the use of a piece of card board folded in half, approximately four inches by six inches in size. On 08/07/19 at 05:03 PM, Certified Dietary	F 908		

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F 908	Continued From page 130 Manager CC stated the card board was being used to hold the oven door closed. The part for the oven would be here tomorrow, and the oven was not being used. On 08/08/19 at 08:45 AM, Maintenance Staff V stated he completes monthly checks on the kitchen. The broken spring for the oven door found yesterday, after questioning of the kitchen staff, and now he ordered the part today. The oven was not currently being used. The facility lacked a policy for maintenance of essential equipment in the kitchen. The facility failed to ensure mechanical equipment of the stove in the kitchen was in safe operating condition for the residents of the facility.	F 908		