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	175376	A. BUILDING _____ B. WING _____	02/21/2019

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

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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§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 81 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to enhance and promote dignity for residents #23, #36, #41, #54, #58, and #66 that required staff assistance to eat their meals.

Findings included:

-On 2/18/19 at 5:04 PM, observation revealed residents #36, #41, #54, and # 58 sat at a table where they could be assisted with eating. At 5:12 PM the residents were served their drinks and staff served residents #36, #46, and #54 their meals. Resident #58 was not served his/her meal and was unable to reach his/her drinks. Direct care staff O assisted resident # 41 with his/her meal. Resident's #36 and #54 sat with food in front of them without staff assistance. At 5:14 PM staff member P assisted resident #54 to eat and residents #36, and #58 sat with food in front of them and no assistance.

At 5:15 PM Resident #23 sat in a broda chair (specialized wheelchair with the ability to tilt and recline), at a table by the window. At 5:17 PM staff member O cleaned the table while resident # 36 continued to eat and resident #58 had not been served food. At 5:18 PM staff member O referred to resident #23 as a "feeder" and stated,

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we are going to move him/her to the "feeder table". At 5:29 PM resident #58 asked staff for a drink of water as he/she was unable to reach his/her drink. At 5:32 PM Resident #23 had not been transferred to the table with residents that needed assistance. Direct care staff G approached resident #23 and stated, "I thought you were going to drink some of your water". Resident #23 stated "I can't". Staff G placed a clothing protector on the resident and walked away, while the resident continued to ask for a drink of water. Resident # 23 sat unassisted from 5:15 PM until 5:50 PM.

During dining observation in the back-dining room on 2/18/19 at 5:01 PM resident #66 sat in his/her broda chair (specialized wheelchair with the ability to tilt and recline),at the table for resident's that required assistance with eating. Resident #66 was served drink and food at 5:04 PM. Resident # 66 sat with his/her meal in front of him/ her from 5:04 PM until 5:50 with no assistance.

During interview on 2/18/19 staff member R stated, we are directed to feed only one resident at a time. The residents must wait until more staff are available to help feed them.

During dining observation on 2/20/19 at 7:34 AM residents #58 and #23 sat at the table with food in front of them. At 7:46 AM resident #23 consumed 25% of his/her warm cereal and ¼ piece of toast. Staff Q encouraged resident #23 to eat more food. At 7:49 AM staff member Q assisted resident #58 to eat breakfast.

During interview on 2/21/19 at 1:33 PM staff M stated, the residents that need assistance to eat are placed at one table in the dining room. Staff

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F 550	Continued From page 3 assist one resident at a time. There was no system that staggered their arrival to a meal. However, staff tried to bring them in first for lunch if they were first for breakfast. During interview on 2/21/19 at 1:39 PM licensed nursing staff G stated the residents that needed assistance in eating should be fed within a few minutes of entering the dining room. A wait time of 15- 45 minutes to be assisted was unacceptable. During interview on 2/21/19 at 1:50 PM administrative staff D stated, staff should not use the words feeder, or feeder table when referring to our residents that need assistance with eating. Residents should not sit at the table with food in front of them. Residents should not be brought to the dining room until a staff member was available to assist them. Residents should not sit for more than a few minutes to be assisted with eating. Review of the facility's assisted dining room policy dated 1/2019 documented, when nursing staff are assisting residents in the assisted dining room, nursing staff will, ensure that residents who are sitting at the same table are served at the same time. All assistance with feeding will be done with the resident's dignity in mind. The facility failed to ensure that residents that require assistance with eating were served and assisted in timely manner in a way to promote dignity and respect.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		

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§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's

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per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 81 residents. The sample included 22 residents of which 3 were reviewed for beneficiary notification. Based on record review and interview the facility failed to issue the CMS (Center for Medicare/Medicaid Services) Advanced Beneficiary Notice of Non-coverage (ABN) form (form used to notify Medicare A participants discharging from Medicare part A services of potential charges) to 2 residents (#82 and #39).

Findings included:

- Resident #82's medical record revealed the resident's Medicare part A episode began on 8/28/18. The last covered day was 9/9/18. He/she remained in the facility for custodial care. The CMS form Notice of Medicare Non-coverage (NOMNC) (form used to notify Medicare A participants of their appeal rights and the last covered date of service) was issued and signed on 9/17/18.

The medical record lacked evidence that the ABN was issued.

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F 582	Continued From page 6 On 02/21/19 at 08:47 AM social services staff X stated the NOMNC was always issued upon discharge from Medicare part A services, but the ABN was only given to new admissions who did not receive Medicare part A services. The facility failed to issue an ABN form which resulted in resident #82 being denied advance notification of potential charges and the opportunity to accept or decline services that may have incurred charges after a Medicare part A episode. - Resident #39's medical record revealed the resident's Medicare part A episode began on 12/6/18. The last covered day was 1/23/19. He/she remained in the facility for custodial care. The NOMNC was issued and signed on 1/17/19. The medical record lacked evidence that the ABN was issued. On 02/21/19 at 08:47 AM services staff X stated the NOMNC was always issued upon discharge from Medicare part A services, but the ABN was only given to new admissions who did not receive Medicare part A services. The facility failed to issue an ABN form which resulted in resident #39 being denied advance notification of potential charges and the opportunity to accept or decline services that may have incurred charges after a Medicare part A episode.	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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§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.
(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

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 81 resident. The sample included 22 residents. Based on record review, observation, and interview the facility failed to develop a comprehensive care plan for hospice (treatment which focuses on non-curative care and comfort for people with terminal diagnoses) services for resident # 20.

Findings included:

- Resident #20's electronic medical record (EMR) documented a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The significant change Minimum Data Set (MDS) dated 4/2/18 recorded the resident had memory problems, disorganized thinking and inattention. It documented the resident required extensive assistance with activities of daily living (ADL) which included bed mobility, toileting, eating, transfers, hygiene and locomotion. The resident received hospice care.

The quarterly MDS dated 12/10/18 documented the resident had memory problems and inattention and continued to require extensive assistance for all ADL. It recorded the resident continued to receive hospice care.

The cognition care area assessment (CAA) dated

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4/2/18 documented the resident continued to be severely cognitively impaired and non-verbal. It documented the resident was placed on hospice services per his/her family's wishes.

The facility-created care plan dated 12/12/18 documented the resident needed to remain comfortable due to the chronic condition of dementia. It directed staff to work with hospice services to meet his/her needs.

The care plan lacked interventions which directed staff on which hospice provider to contact, when to contact and contact information. It further lacked information which directed staff on which equipment, medications, treatments and services were provided by the hospice service.

On 02/21/19 at 07:11 AM the resident laid in bed with his/her eyes open. The resident did not respond to questions.

On 02/21/19 at 09:34 AM administrative nursing staff E stated the facility had a new care plan system. He/she confirmed the care plan did not specifically say which hospice company provided services and what services hospice provided. He/she stated the specifics of the hospice services were in the hospice section of the paper chart.

On 02/21/19 at 01:08 PM direct care staff N stated the staff knew how to care for the residents by verbal report, looking at the care plan and from a book at the nurse's station which contained resident's information. He/she stated he/she was aware that resident #20 received hospice services which included a weekly bath but was uncertain what other services and/or

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equipment were provided by hospice. He/she stated he/she knew which equipment in the room belonged to hospice because it was a different type than used by the facility.

On 02/21/19 at 01:31 PM licensed nursing staff G stated the certified nursing assistants (CNA) received daily reports on how to care for the residents and the information was also available to view on the care plan in the EMR which the CNAs had access to. He/she stated he/she was familiar with resident #30 and aware that the resident received hospice services. Staff G verbalized that he/she thought the specifics regarding what cares, equipment and medication hospice provided were in the hospice agreement in the paper chart stored in the medication room, which had limited access. He/she stated that some of the hospice providers kept a hospice notebook at the nursing station.

On 02/21/19 at 01:47 PM administrative nursing staff D stated staff knew how to care for the resident by daily verbal report, the Kardex (brief summary of resident care needs) and by checking the care plan. He/she stated that hospice documented progress notes in the facility EMR and kept a notebook in the medication room.

The facility policy Care Plans, Comprehensive Person-Centered dated February 2018 directed the comprehensive person-centered care plan would describe the services that were to be furnished to maintain the resident's well-being and identify the professional services that were responsible for each element of the resident's care.

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F 656	Continued From page 11 The facility failed to develop a care plan for resident # 20 which addressed the resident's hospice care including medications, equipment, treatment and services provided to the resident by hospice. The facility failed to develop a care plan which identified the name and contact information of the resident's hospice provider.	F 656		
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 identified a census of 81 resident. The sample included 22 residents. Based on record review, observation, and interview the facility failed to implement interventions developed to maintain safety for resident #31. Findings included: - Resident #31's electronic medical record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), and weakness. The annual minimum data set (MDS) dated 4/16/18 recorded a Brief Interview for Mental Status score of 04 which indicated severe cognitive impairment. The MDS documented the	F 689		

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resident required extensive assistance of one person for bed mobility, transfers, walking with a walker, toileting and hygiene activities. He/she had 2 or more non-injury falls since the prior assessment.

The quarterly MDS dated 12/24/18 documented the resident was severely cognitively impaired with a BIMS score of 3, required extensive assistance of one person for activities of daily living (ADL) which included walking with a walker. The resident had 2 or more non-injury falls since the prior quarterly assessment.

The care area assessment (CAA) for falls dated 4/16/18 recorded the resident forgot to wait for staff assistance. The CAA documented the resident was impulsive and lacked safety awareness and remained on 30-minute safety checks.

The care plan revised on 12/27/18 recorded the resident had the potential to fall, forgot to use his/her assistive device and tried to move around without help. It directed staff to leave the resident's walker beside his/her recliner where he/she could reach it because the resident had fallen trying to reach it. It also directed staff to place the call light where the resident could reach it.

Review of the resident's EMR revealed the resident had a fall on 12/9/18 and 2/16/19 when he/she had ambulated independently without the use of his/her walker.

On 2/19/19 at 10:25 AM the resident sat in his/her recliner with a gait belt around his/her waist. The resident's walker was placed next to the bed and

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F 689	Continued From page 13	F 689		

a bedside table was placed between the resident and his/her walker. The call light was clipped to the bedspread in the middle of the resident's bed.

On 2/20/19 at 09:07 AM the resident sat in his/her recliner with the bedside table in front of him/her. The walker was placed next to the bed on the opposite side of the bedside table and the call light was clipped to the bedspread in the middle of the bed. Upon request, the resident attempted to reach both the call light and the walker from his/her seated position and was unable to reach either.

On 2/21/19 at 01:21 PM direct care staff M stated information on how to care for residents which included inventions for falls were recorded on the resident's Kardex (brief summary of resident care needs) which was kept at the nurse's station. He/she stated the resident was on 30-minute checks due to a history of falls and no other interventions in place.

On 02/21/19 at 01:31 PM licensed nursing staff G stated that interventions which directed staff on how to care for a resident were recorded on the Kardex at the nurse's station and in the resident's care plan. He/she stated resident #31 was at risk for falls, had a history of falls and that staff would ambulate with resident, make sure the resident's call light was within reach and that the resident's walker was placed close to the resident where he/she could reach it.

On 02/21/19 at 01:47 PM administrative nursing staff D stated staff used the care plan and the Kardex as well as daily report to know how to care for the resident. He/she confirmed that resident #31's walker and call light should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	02/21/2019

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F 689	Continued From page 14 placed where the resident could easily reach them without standing or ambulating. The facility policy Falls and Fall Risk Assessment dated January 2019 documented staff would identify and try relevant interventions to prevent falls. The facility failed to implement interventions aimed to prevent falls for resident #31 who was cognitively impaired with a history of falls.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		

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F 880	Continued From page 15	F 880		

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

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

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
The facility identified a census of 81 residents. Based on observation, interview and record review the facility failed to store clean linens/towels in a manner that ensured cleanliness.

Findings included:

- Observations of the clean linen carts used by nursing staff to distribute clean linens and towels to the residents revealed the following:
02/19/19 at 11:21 AM the South back hall linen cart had coffee cup 3/4 full of brown liquid and no lid on the shelf next to clean towels.

02/20/19 at 03:05 PM the South back hall linen cart had a Styrofoam cup with a lid and straw, metal drink tumbler with a lid and straw, 1-liter bottle of Sprite and an open bag of pistachios on the shelf next to clean towels.

02/20/19 at 04:31 PM the South back hall linen cart had a Styrofoam cup with a lid and straw, metal drink tumbler with a lid and straw, 1-liter bottle of Sprite and an open bag of pistachios on the shelf next to clean towels. A set of car keys was observed on the second shelf next to clean gowns.

02/21/19 at 06:53 AM the South back hall linen cart had a coffee mug half full of brown liquid with no lid and a Styrofoam cup with a lid and straw on the shelf next to clean towels.

02/21/19 at 06:56 AM the North back hall linen cart had an open can of energy drink and a

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plastic drink tumbler with a lid on the shelf next to the clean towels.

02/21/19 at 07:42 AM the South back hall linen cart had a coffee cup 1/2 full of brown liquid with no lid, a Styrofoam cup with a lid and straw and a plastic cup with no lid full of yellow liquid and ice next to the clean towels.

On 02/21/19 at 01:08 PM direct care staff N stated the clean linen carts were used to distribute clean linen and towels to the residents. He/she stated he/she had never been told not to store personal items and/or food and drink on the clean linen carts.

On 02/21/19 at 01:21 PM direct care staff M stated there should not be any personal items, food or drinks stored inside the linen carts.

On 02/21/19 at 01:31 PM licensed nursing staff G stated there should not be drinks and personal items stored next to the clean linen/towels.

On 02/21/19 at 01:47 PM administrative nursing staff D confirmed he/she would not expect drinks, food and personal items to be stored next to clean linen and towels on the clean linen carts.

The facility did not provide a policy on the storage and handling of clean linen.

The facility failed to store towels and gowns for resident use in a way that ensured cleanliness and reduced the risk of contamination.