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	085027	A. BUILDING _____ B. WING _____	C 08/22/2019

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E 000	Initial Comments An unannounced annual survey was conducted at this facility from August 18, 2019 through August 22, 2019. The facility census the first day of the survey was 110. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 18, 2019 through August 22, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 110. The survey sample totaled fifty-one (51). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/23/2019

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

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NP - Nurse Practitioner;
PA - Physician Assistant;
SW - Social Worker;
CP - Consultant Pharmacist;
DSS - Director of Social Services;
DR - Director of Recreation;
PNP - Psychiatric Nurse Practitioner;
AA - Activities Aide;
PT - Physical Therapist;

ADL's - Activities of Daily Living, such as bathing and dressing;
Antidepressant - medication for depression;
Antihistamine - medication used to treat common allergy symptoms, such as sneezing, watery eyes, hives, and a runny nose;
Ativan - medication for anxiety;
Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Zyprexa);
Anxiety - feeling worried, nervous or restless;
Auditory hallucinations - a form of hallucination that involves perceiving sounds without an auditory stimulus;
Bed mobility - how a resident moves to and from a lying position, turns side to side, and positions body while in bed;
BID - Twice a day;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15:
13-15: Cognitively intact
8-12: Moderately impaired
0-7: Severe impairment;
Contracture - joint with fixed resistance to passive stretch of a muscle and cannot be straightened;
Cognition - mental process, thinking, memory;
Delusion - false belief that is thought to be true;
Dementia - brain disorder with memory loss, poor

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judgement, personality changes and confusion;
Dialysis - cleansing of the blood by artificial means when kidneys have failed;
eTAR - Electronic Treatment Administration Record [TAR] (in the computer);
eMAR - Electronic Medication Administration Record [MAR] (in the computer);
EMR - Electronic Medical Record;
ER - emergency room;
etc (et cetera) - and so forth;
e.g.- for example;
Geri sleeve - a sleeve worn on the arms to protect from injury;
Hallucination - something that seems real, but does not really exist;
Hospice - service that provides care to residents who are terminally ill;
HS - at bedtime;
Hydrocortisone - medication to treat itching and other skin conditions;
Hydroxyzine - medication for anxiety and an antihistamine;
i.e.- that is;
Kardex - information needed to provide specific resident care;
Lbs - pounds;
Locomotion - ability to move between places;
LTC - Long Term Care Unit;
Major depressive disorder with psychotic feature - major depressive episode with features of psychosis, such as hallucinations and/or delusions;
MAR - medication administration record;
MDS - Minimum Data Set (standardized assessment used in nursing homes);
Med Pass - high protein, high calorie nutritional supplement;
Medication Regimen Review (MRR) - monthly review of resident's medications and laboratory

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tests by a pharmacist to see if anything unusual exists;
mg (milligrams) - metric unit of weight;
mobility - ability to move;
OOB - out of bed;
Pain Scale - rating pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain;
Paranoid delusion - irrational thoughts and beliefs that become fixed that nothing (including contrary evidence) can convince a person that what they think or feel is not true;
Parkinson's Disease - a long-term degenerative disorder of the central nervous system that mainly affects the motor system;
Physician Order Sheet (POS) - monthly report of active physician orders;
PO - physician's Order;
POA - Power of Attorney;
Point of Care - name of electronic charting system;
Pressure ulcer - a sore area of skin that develops when blood supply to it is cut off due to pressure;
Psychiatric - relating to mental disorders;
Psychoactive - any medicine capable of affecting the mind, emotions and behavior;
Psychosis - a severe mental disorder in which thoughts and emotions are so impaired that contact is lost with external reality;
Psychotic - suffering from psychosis;
Psychotropic - affecting mental activity, behavior or perception;
PRN - as needed;
pre - before;
post - after;
Rehab- rehabilitation;
Restless Leg Syndrome (RLS) - unpleasant feeling in legs with strong urge to move them;
Schizoaffective disorder - condition in which a

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F 000	Continued From page 4 person experiences a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms, such as mania or depression; Schizophrenia - mental disorder with false beliefs of being harmed; sx - symptom; TID - three times a day; Tab - tablet; Vital signs - clinical measurements (i.e., pulse rate, temperature, respiration rate, blood pressure); X - Time or by; Xanax - medication for anxiety; > - greater than; % - percent.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §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	F 582		10/4/19

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F 582	Continued From page 5 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 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: Based on record review and interview, it was determined that for two (R37 and R57) out of two residents reviewed for Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN), the facility failed to provide the appropriate notice when a resident was moved from the transitional	F 582	F Tag 582 1. The facility administration provided a skilled nursing facility Advance Beneficiary Notice to residents (R37) and (R57). 2. Current residents have the potential to be affected. An audit will be conducted to	

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F 582	Continued From page 6 care unit to the long term care unit. Findings include: 1. Clinical record review for R37 revealed the following: 3/5/19 - R37 was admitted to the facility. 3/23/19 - R37 was discharged from Medicare A and remained in the same facility. 8/20/19 - Evidence of the required SNF ABN was not provided on the completed SNF Beneficiary Protection Notification Review form. 2. Clinical record review for R57 revealed the following: 4/16/19 - R57 was admitted to the facility. 4/26/19 - R57 was discharged from Medicare A and remained in the same facility. 8/20/19 - Evidence of the required SNF ABN was not provided on the completed SNF Beneficiary Protection Notification Review form. 8/21/19 at 12:03 PM - During an interview, E24 (Business office) confirmed that R37 and R57 were not given SNF ABNs upon discharge from Medicare A. E24 explained that the facility just started using the SNF ABN form. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 582	determine if any other residents should have received an ABN. The business office and CRC will review all patients moving from transitional care to long term care in order to assure ABN information was received. 3. An RCA was completed. As a result, it was determined that education will be given to the business office and CRC□s on the policy for ABNs. Upon education the business office and CRC would be responsible for the corrective action. 4. The business office will complete a weekly audit on the 10%of the residents for ABN. If after 4 weeks 100% compliance is achieved the audit will move to a monthly review for two more months. The results of the audits will be presented at the monthly QUAPI committee meetings for review and recommendations.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		10/4/19

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F 641	Continued From page 7 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R97, R42 and R60) out of 30 residents sampled for investigations the facility failed to ensure accuracy of MDS assessments. Findings include: 1. Review of R97's clinical record revealed: July 2019 and August 2019 - Review of R97's MAR indicated the resident received a prescribed anti-psychotic. 8/1/19 - A quarterly MDS assessment completed for R97 in the area of Medications indicated anti-psychotics were not given to the resident. During an interview on 8/21/19 at 2:41 PM, E22 (RN/MDS coordinator) confirmed that R93's 8/1/19 MDS assessment contained an error related to receiving anti-psychotics. 2. Review of R42's clinical record revealed: 2/14/19 - A Weights and Vitals Summary revealed that R42's weight was 187.2 lbs. 3/15/19 - A Weights and Vitals Summary revealed that R42's weight was 198.5 lbs. The resident had a weight gain of 6.04% in one month. 3/15/19 - R42's quarterly MDS assessment revealed a weight of 199 lbs and there was no or unknown weight gain of 5% or more in the last	F 641	F641 □ 1. R97 still resides in the facility and has had an updated MDS done to reflect accurate and current assessment. 2. All residents that are currently in the facility have the potential to be effected by this deficiency. An audit will be performed by CRC/designee on all current residents MDS to review for accurate coding for taking an anti-psychotic medication. Any errors noted during the audit will have an updated MDS sent. 3. The root cause has been completed. The Manager-Clinical Reimbursement will in-service the CRC□s on accurate coding in these areas. 4. CRC□s/designee will audit 100% of MDS for accurate coding for anti-psychotic x 2 weeks and then 50% weekly x 1 month and 25 % monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal. 1. R42 still resides in the facility and has had an updated MDS done to reflect accurate and current assessment. 2. All residents that are currently in the facility have the potential to be effected by this deficiency. An audit will be performed by registered dietician/designee on all current residents MDS to review for	

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F 641	Continued From page 8 month. 3. Review of R60's clinical record revealed: 6/23/19 - A quarterly MDS assessment revealed that R60 had one fall with no injury, one fall with injury (except major) and one fall with major injury. 8/18/19 at 1:54 PM - During an interview, when asked about his/her recent fall, R60 responded, "I never fell." 8/20/19 at 10:36 AM - The investigative report on R60's fall (referred to on the 6/23/19 MDS assessment) was requested. 8/20/19 11:39 AM - During an interview, E2 (DON) confirmed that the fall information entered on R60's 6/23/19 quarterly MDS was incorrect. E2 stated that hasn't fallen since August (11 months ago). These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 641	accurate coding for weight loss or weight gain. Any errors noted during the audit will have an updated MDS sent. 3. The root cause has been completed. The Manager-Clinical Reimbursement will in-service the registered dietician on accurate coding in these areas. 4. Registered Dietician/designee will audit 100% of MDS for accurate coding for weights x 2 weeks and then 50% weekly x 1 month and 25 % monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		10/4/19

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F 644	Continued From page 9 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R7) out of one resident reviewed for Pre-admission Screening and Resident Review (PASRR) the facility failed to refer a resident with a newly evident serious mental disorder to the State agency. Findings include: 3/22/12 - PASRR Level 1 analysis revealed that R7 had a diagnosis of a mental illness and included details on depression and anxiety. 11/10/18 and 2/9/19 - Two quarterly MDS assessments revealed that R7's active diagnoses included anxiety disorder, schizophrenia and major depressive disorder. 3/28/19 - A practitioner progress note revealed that R7 was a patient "with multiple psychiatric diagnoses on record including: Schizoaffective Disorder..." 5/10/19 - An annual MDS, revealed that R7's active diagnoses included anxiety disorder, schizophrenia and major depressive disorder. 6/27/19 - A practitioner progress note revealed	F 644	F- 644 1. A new PASSAR was completed for resident R7 2. Current residents have the potential to be affected. The facility will audit all residents change of condition related to a newly evident serious mental disorder. 3. An RCA was compete. It was determined that the social worker and CRC will be educated on the policy concerning PSSAR screens. The social worker will be responsible for the connective activity. 4. The Social Worker will complete weekly audits of 10% of the resident□s population to determine compliance. If 100% compliance is achieved by week 4 then the audit will then move to once a month review for the next two months. Results of the monthly audits will be presented at the monthly QAPI committee meetings for review and recommendations.	

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F 644	Continued From page 10 that R7 "has a [history] of schizoaffective disorder." 8/20/19 - There was no evidence that a PASRR screening or evaluation for R7 was completed related to the additional diagnosis of schizophrenia/schizoaffective disorder. 8/21/19 at 9:33 AM - E1 (NHA) confirmed that R7's "most recent PASRR" was from 3/22/12. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 644		
F 656 SS=E	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	F 656		10/4/19

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F 656	Continued From page 11 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R31, R43, R62, R67, R85, and R91) out of 30 sampled residents for investigations, the facility failed to develop and implement a care plan to reflect accurate intervention. Findings include: 1. Cross refer F756, example 2 Cross refer F758, example 1 Review of R43's clinical records revealed the following: 4/29/16 - R43 was admitted to the facility from the hospital. 1/20/19 - The Psychiatric Nurse Practitioner (PNP) progress note, documented "...follow-up	F 656	F656 □ 1. R43 still resides in this facility. The care plans have been reviewed and revised to reflect current status and preferences of these residents. 2. All residents requiring care planning for auditory hallucination and/or hearing voices will have their care plans reviewed, updated to reflect current status and up to date interventions. 3. The root cause analysis was completed. The Unit managers/designee will be in serviced by the NPE for accurate and complete care planning as per 482.21(b) Develop/Implementing Comprehensive Care plan. 4. Unit Managers/designee will audit the	

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F 656	Continued From page 12 delusions...Admits to hearing voices and staff reports (he/she) wears (his/her) headphones. Symptoms currently controlled." 5/10/19 - The PNP progress note documented, "...Staff reports pt. (patient) wears headset to block out voices..." 6/7/19 - The PNP progress note documented, "...Hallucinations/delusions controlled with current regimen." 7/5/19 - The PNP progress note documented, "...Paranoid delusions controlled with Zyprexa (anti-psychotic). Nursing reports no concerns." There was a lack of evidence of a care plan for R43 hearing voices or having auditory hallucinations. 8/21/19 9:51 AM - An interview with E3 (ADON) confirmed the lack of a comprehensive care plan for auditory hallucinations. After this interview, the surveyor was provided a newly developed care plan for R43's auditory hallucinations and delusions. 2. Review of R67's clinical records revealed the following: 5/15/18 - R67 was admitted to the facility. 10/10/18 - An order was started for compression stockings for both lower extremities (legs) when out of bed. 5/11/19 - An order was started for Lasix daily (medication to help remove excess fluid) for a diagnosis of edema (swelling or fluid retention).	F 656	care plans for auditory hallucinations and/or hearing voices 50% x 2 weeks for 100% compliance then 25% x 1 month and then 25% monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal. 1. R67 still resides in this facility. The care plans have been reviewed and revised to reflect current status and preferences of these residents. 2. All residents requiring care planning for edema will have their care plans reviewed, updated to reflect current status and up to date interventions. 3. The root cause analysis was completed. The Unit managers/designee will be in serviced by the NPE for accurate and complete care planning as per 482.21(b) Develop/Implementing Comprehensive Care plan. 4. Unit Managers/designee will audit the care plans for edema 50% x 2 weeks for 100% compliance then 25% x 1 month and then 25% monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal. 1. R85 still resides in this facility. The care plans have been reviewed and revised to reflect current status and a measurable goal of these residents. 2. All residents requiring care planning for constipation will have their care plans	

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F 656	Continued From page 13 There was lack of evidence of a care plan for edema. 8/22/19 4:00 PM - An interview with E2 (DON) confirmed the lack of a comprehensive care plan for edema. During this interview, E2 was asked what the system was to ensure care plans were developed and implemented. E2 stated that any licensed nursing staff can develop and implement a care plan. 3. Review of R85's clinical record revealed the following: 7/19/19 - R85 was admitted to the facility after hospitalization. 7/25/19 - A care plan problem was developed for constipation with the goal that R85 will not develop GI (gastrointestinal) complications. This goal is not measurable. 8/22/19 at 8:28 AM - During an interview, E6 (RN, UM) confirmed the finding. 4. Review of R91's clinical records revealed the following: A care plan, last reviewed on 2/18/19 with an intervention initiated on 7/30/14, documented that a geri sleeve (to protect the arms from friction and such) was to be applied to the right arm in the morning and taken off in the evening or as needed. 8/18/19 10:00 AM - An observation was made of R91 with bruises to the left forearm and right	F 656	reviewed, updated to reflect a measurable goal. 3. The root cause analysis was completed. The Unit managers/designee will be in serviced by the NPE for accurate and complete care planning as per 482.21(b) Develop/Implementing Comprehensive Care plan. 4. Unit Managers/designee will audit the care plans for constipation with a measurable goal 50% x 2 weeks for 100% compliance then 25% x 1 month and then 25% monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal. 1. R91 still resides in this facility. The care plans have been reviewed and revised to reflect that the geri sleeves are to be worn on both arms. 2. All residents requiring care planning for geri-sleeves will have their care plans reviewed, updated to reflect current status and up to date interventions. 3. The root cause analysis was completed. The Unit managers/designee will be in serviced by the NPE for accurate and complete care planning as per 482.21(b) Develop/Implementing Comprehensive Care plan. 4. Unit Managers/designee will audit the care plans for geri-sleeves 50% x 2 weeks for 100% compliance then 25% x 1 month and then 25% monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make	

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F 656	Continued From page 14 wrist. R91 was also wearing a sling to the right arm. 8/20/19 10:30 AM - During an interview, E25 (CNA) revealed that R91 wears the sling to protect the right arm. E25 further revealed that R91 did not have any geri sleeves. 8/21/19 9:18 AM - An observation was made of R91 wearing geri sleeves on the right and left arms. 8/21/19 2:33 PM - During an interview, E17 revealed that R91's geri sleeves were ordered on 8/20/19. The care plan incorrectly documented the use of geri sleeves to just the right arm instead of geri sleeves (the right and left arm as ordered. 5. Review of R31's clinical record revealed the following: 7/26/19 - R31's care plan revealed that R31 is at risk for falls and interventions include the following: Provide verbal cues for safety and sequencing when needed; Place call light within reach while in bed or close proximity to bed; Maintain a clutter-free environment in the resident's room and consistent furniture arrangement; When resident is in bed, place all necessary items within reach; 8/18/19 11:30 AM - An observation was made of a fall mat on the floor, next to R31's bed.	F 656	recommendations to achieve the goal. 1. R31 still resides in the facility and the care plan has been reviewed and updated to reflect all current fall interventions. 2. All residents requiring care planning for falls will have their care plans reviewed, updated to reflect current status and all up to date interventions. 3. The root cause analysis was completed. The Unit managers/designee will be in serviced by the NPE for accurate and complete care planning as per 482.21(b) Develop/Implementing Comprehensive Care plan. 4. Unit Managers/designee will audit the care plans for fall intervention accuracy 50% x 2 weeks for 100% compliance then 25% x 1 month and then 25% monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal. 1. R62 still resides in the facility and has had the care plan updated to reflect behaviors listed in R62□s diagnoses which included unspecified dementia with behavioral disturbance, moderate major depressive disorder and delusional disorder. 2. All residents requiring care planning for unspecified dementia with behavioral disturbances, any with a moderate major depressive disorder and delusional disorder diagnosis will have their care plans reviewed, updated to reflect current status and all up to date interventions.	

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F 656	Continued From page 15 8/18/19 at approximately 2:20 PM - An interview with E9 (RN) confirmed that R31's bed is put in a low position at night and his/her door is opened in order to monitor him/her since he/she fell before. The facility failed to develop a care plan for R31 for falls that included fall mats, low bed, and to keep the door open at night. 6. Review of 62's clinical record revealed the following: 4/17/19 - A progress note confirmed that while at the hospital, R62 "was found confused and with auditory hallucinations." 4/24/19 - Care plans were developed as follows: Resident/patient has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Short/long term memory loss; and Resident has impaired communication as evidenced by dementia. 7/6/19 - A quarterly MDS assessment revealed the following health conditions: Dementia, depression, and a psychotic disorder. The facility failed to develop a care plan that specifically addressed behaviors listed in R62's diagnoses, which include unspecified dementia with behavioral disturbance; recurrent, moderate major depressive disorder; and delusional disorders. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 656	3. The root cause analysis was completed. The Unit managers/designee will be in serviced by the NPE for accurate and complete care planning as per 482.21(b) Develop/Implementing Comprehensive Care plan. 4. Unit Managers/designee will audit the care plans for unspecified dementia with behavioral disturbances, any with a moderate major depressive disorder and delusional disorder diagnosis 50% x 2 weeks for 100% compliance then 25% x 1 month and then 25% monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	
F 657	Care Plan Timing and Revision	F 657		10/4/19

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F 657 SS=E	Continued From page 16 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined 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: Based on record review and interview, it was determined that for nine (R1, R17, R30, R35, R43, R61, R62, R67, and R91) out of 30 residents sampled for investigations, the facility failed to ensure that care plans were developed by the IDT (Interdisciplinary Team). Findings include:	F 657	F657 1. R1, R30, R35, R43, R61, R62, R67, and R91 all still reside in the facility. R17 no longer resides in facility. All of these residents had their current care plan reviewed by the complete IDT team to ensure person center care plan are in place and noted in those residents□	

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F 657	Continued From page 17 The facility's policy and procedure titled Person-Centered Care Plan, with a revision date of 7/1/19, indicated the following: - The IDT, in conjunction with the patient and/or resident representative, as appropriate, will develop individualized care plan for each of the residents. - The care plan will be reviewed and revised by the IDT team after each assessment. - The IDT members included the attending physician, a RN with responsibility for the patient, a nurse aide with responsibility for the patient, food and nutrition services staff, to the extent practicable, the participation of the patient and the resident representative(s). Purpose of the policy included: - To promote positive communication between patient, resident representative, and team to obtain the patient's and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcomes. 1. Cross refer F690 Review of R17's clinical record revealed the following: 5/31/19 - A quarterly MDS assessment was completed. 6/12/19 - A progress note documented that a care plan meeting meeting was held. There was lack of evidence that R17's attending physician, CNA responsible for R17, and staff of the Nutrition/Dietary Department attended. 2. Review of R30's clinical record revealed the following: 3/3/19 - A quarterly MDS assessment was	F 657	charts. 2. All other residents have the potential for not having their care plan reviewed by the complete IDT team. Residents that still reside in this facility will have their care plan reviewed by the whole IDT team from Aug 23, 2019 going forward. Any necessary updates to the care plan will be completed including a note about the collaborations with the physician/NP about the resident□s care plan. 3. The NPE will educate the whole IDT on the care plan meeting process to include that the whole IDT be at the care plan meeting. The IDT team consist of the RN responsible for the patient, a nurse aide responsible for the patient, food and nutrition services staff, and to the extent practicable the participation of the patient and resident representative. The physician/NP will be collaborated with by the Social Worker/designee prior to the care plan meetings about any concerns and will be noted in the resident□s chart and discussed with the IDT team during the care plan meeting. If there are any concerns from the care plan meeting that needs to be brought to physician/NP for further discussion than a discussion can be held with the physician/NP and documented in the patient□s chart. 4. Audits will be done by the social worker / designee to ensure all parts of the IDT team attends and/collaborated with to review the patients care plan for 100% of the care plans x 2 weeks until 100% compliant and then 50 % weekly x 2 weeks and then 25% monthly x 3 months. The CNE/designee will report results of	

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F 657	Continued From page 18 completed. 3/21/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that R30's attending physician, the CNA responsible for R30, and staff of the Nutrition/Dietary Department attended. 6/2/19 - A quarterly MDS assessment was completed. 6/13/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that R30's attending physician, CNA responsible for R30, and staff of the Nutrition/Dietary Department attended. 3. Review of R35's clinical record revealed the following: 3/9/19 - A significant change MDS assessment was completed. 4/2/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that the CNA and the RN responsible for R35, as well as the staff of the Nutrition/Dietary Department attended. 6/8/19 - A quarterly MDS assessment was completed. 6/20/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that the CNA and the RN responsible for R35, as well as the staff of the Nutrition/Dietary Department attended. 4. Review of R43's clinical record revealed the	F 657	the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 657	Continued From page 19 following: 3/16/19 - A quarterly MDS assessment was completed. 4/4/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that R43's attending physician, CNA responsible for R43, and staff of the Nutrition/Dietary Department was invited and/or attended. 6/15/19 - A quarterly MDS assessment was completed. 6/27/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that R43's attending physician, CNA responsible for R43, and staff of the Nutrition/Dietary Department attended. 5. Review of R67's clinical record revealed the following: 4/12/19 - An annual MDS assessment was completed. 4/25/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that the CNA and the RN responsible for R35, as well as the staff of the Nutrition/Dietary Department attended. 7/6/19 - A quarterly MDS assessment was completed. 7/18/19 - A progress note documented that a care plan meeting was held. There was lack of evidence that the CNA and the RN responsible	F 657		

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F 657	Continued From page 20 for R35, as well as the staff of the Nutrition/Dietary Department attended. 6. Review of R1's clinical record revealed the following: 2/7/19 - A quarterly MDS assesment was completed. 2/22/19 - A care plan meeting attendance log revealed a lack of evidence of the attendance of a nurse aide, and a member of the food and nutrition services staff. 7. Review of R61's clinical record revealed the following: 6/27/19 - A quarterly MDS assessment was completed. 7/11/19 - A progress note revealed that neither a doctor, a food/nutrition services staff member nor a nurse's aide participated in R61's quarterly care plan meeting. 8. Review of R91's clinical record revealed the following: 4/27/19 - An annual MDS assessment was completed. 5/9/19 (late entry) - A progress note revealed that neither a doctor, a food/nutrition services staff member nor a nurse's aide participated in R61's quarterly care plan meeting. 7/22/19 - A quarterly MDS assessment was completed.	F 657		

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F 657	Continued From page 21 8/1/19 - A progress note revealed that neither a doctor, a food/nutrition services staff member nor a nurse's aide participated in R61's quarterly care plan meeting. 9. Review of R62's clinical record revealed the following: 7/6/19 - A quarterly MDS assessment was completed. 7/19/19 - A progress note by E4 (Social Service Director) revealed that neither a doctor, a food/nutrition services staff member nor a nurse's aide participated in R62's care plan meeting. 8/20/19 1:10 PM - During an interview, E8 (DSS) confirmed that the attending physician, the CNA assigned to the resident and Nutrition Dietary staff did not routinely attend the IDT meetings. E8 provided a copy of the above policy titled Person-Centered Care Plan, which stated that the IDT members included the attending physician, the RN responsible for the patient, CNA with responsibility of the patient, Social Service, Food and Nutrition. 8/22/19 8:45 AM - During an interview, E10 (Social Worker) confirmed that all attendees at the care plan meetings are documented in the care plan meeting notes and/or conference forms. There is no other documentation where any additional participants would be listed. 8/22/19 9:55 - During an interview, E8 (DSS) it was reported that "for our short term residents it's usually nursing, rehab, the resident and family. For our long term it is usually activities, nursing, the resident and family" that attend care	F 657		

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F 657	Continued From page 22 plan meetings. When asked if CNAs, MD or dietary staff regularly attend care plan meetings E8 stated, "the CNA in some cases, but as a rule, no." 8/22/19 at 9:00 AM - During an interview, E31 (CNA) and E32 (CNA) revealed that they had not participated in any care plan meetings. 8/22/19 at 9:11 AM - During an interview, E33 (CNA) revealed that he/she had not participated in any care plan meetings. 8/22/19 at 9:16 AM - During an interview, E13 (CNA) revealed that he/she had never attended or been asked to participate in a care plan meeting. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 657		
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)	F 676		10/4/19

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F 676	Continued From page 23 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, §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: Based on interview, observation and record review, it was determined that for one (R60) out of one resident reviewed for dental the facility failed to provide care and services for oral care. Findings include: Review of R60's clinical records revealed: 12/31/18 - The latest revision of R60's ADL care plan revealed that R60 "requires assistance for ADL care in ... personal hygiene...related to impaired mobility due [to] visual impairment/legally blind, chronic diseases compromising functional ability."	F 676	F676 1. R60□s has had her care plan reviewed on personal hygiene and it was updated to reflect her current status. She was provided a toothbrush, toothpaste and oral rinse. Her POC was updated to reflect the actual assistance she currently needs to perform oral care. 2. All residents have the potential to be affected by the deficiency. Each resident was checked to ensure they had the necessary items for oral hygiene and that the care plans reflect accurately the level of assistance each resident need for ADL Care.	

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F 676	Continued From page 24 6/23/19 - A quarterly MDS revealed that R60 received supervision with personal hygiene. 8/1/19 - 8/19/19 - The Document Survey Report for the task of "Mouth care-cleaning teeth/dentures/mouth" with a frequency of "every morning and hs (bedtime)" revealed that out of 19 days, the resident provided his/her own care 30 times, refused care two times, and the result was not available six times. 8/18/19 at 1:56 PM - During an interview, R60 said that he/she did not brush his/her teeth. An observation, made at the same time, of R60's toiletries revealed that there was not a toothbrush stored with R60's toiletries. 8/21/19 11:12 AM - During an interview, E25 (CNA) stated that R60 did not need help with any morning care, except emptying of the commode. At the same time, during an interview, R60 stated that R60 did not have a toothbrush and confirmed that he/she had not been performing any self-oral care. E25 immediately obtained oral care products to give to R60. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 676	3. The root cause was completed. The NPE will educate nurses and CNA about monitoring the amount of assistance that a resident needs with personal hygiene and reporting to Unit Manager. Unit manager will update care plans and POC with the changes in the level of assistance needed. 4. The Units nurses/designee will audit supplies in resident□s room and ensure resident are receiving the correct level of care for oral hygiene. This audit will review 25 % of residents on each station weekly x 4 weeks for accuracy and then 25% of the residents monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		10/4/19

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F 677	Continued From page 25 Based on observation, interviews and record review, it was determined that the facility failed to provide the ADL care necessary to maintain grooming and personal hygiene to a dependent resident for one (R97) out of one resident reviewed for ADL's. Findings include: Review of R97's clinical record revealed the following: 1/30/18 (last updated 6/4/19) - A care plan for "requires assistance/is dependent for ADL care" was created for R97. 8/1/19 - A quarterly MDS assessment completed for R97 indicated in the functional status section that R97 required extensive assistance of two people for personal hygiene. Random observations of R97 revealed the following: 8/17/19 at 11:37 AM - R97 was observed in the hallway in a wheelchair with unkempt facial hair. 8/18/19 at 3:38 PM - R97 was observed in bed alert, fully dressed, with unkempt facial hair. 8/20/19 at 10:46 AM - R97 was observed in the hall with 50% of facial hair clean shaven and 50% unkempt facial hair, with hair remaining on the jowls, neck, upper lip, and sporadic places on both sides of the face. Review of the undated "Nurse Aide Information Sheet" indicated that R97 was totally dependant for personal hygiene. During an interview on 8/20/19 at 1:56 PM with	F 677	F677 1. R97□s has been groomed and personal hygiene completed daily since Aug 23, 2019. 2. All dependent residents have the potential to be affected by this deficiency. All dependent residents were checked and personal hygiene (combed hair and shaven facial hair) have been provided to those residents. 3. The root cause was completed. CNA was educated on what is complete personal hygiene by the NPE. CNA□s and nurses will be educated by the NPE on what is complete personal hygiene on dependent residents and to report any refusals of care to the charge nurse for their respected unit. 4. The unit nurses/designee will do daily rounds on residents on their hallways to ensure complete personal hygiene (shaven and hair combed) is offered to all dependent residents. If any refuse than it should be reported to the unit nurse for documentation purposes. An Audit will be completed for each hallway daily x 1 week and then 50% of the dependent residents weekly for 4 weeks then 25% of the residents that are dependent in care x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 677	Continued From page 26 E23 (CNA), it was confirmed that E23 did not offer to groom R97s unkempt facial hair and R97 did not refuse care. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 677		
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 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: Based on observation, clinical record review, and interview, it was determined that for one (R30) out of three sampled residents reviewed for activities the facility failed to ensure that the resident received an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Findings include: The following was reviewed in R30's clinical record: 6/20/16 - R30 was admitted to the facility from the hospital.	F 679	F-679 1. Resident #30 was reassessed for their important preferences and interest. This was done by interviewing the resident□s son in order clarify resident□s needs and desires due to the residents communication limitations. The care plan was edited to include a person-centered goal that reflects the resident□s current status and appropriate interventions that include the support needed to engagement in important preferences. 2. Other residents have the potential to be affected. An audit of recreation care plans for all residents having a BIM score	10/4/19

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F 679	Continued From page 27 12/5/17 (Initial creation date of 6/29/16) - A care plan for activities included a goal that R30 will self-direct involvement in meaningful activities and that staff will anticipate R30's needs when necessary and through yes/no questions and R30's reactions/interactions. The target date for this goal was 8/30/19. Interventions included offering the following activities of interest: - listening to music and prefer R&B, oldies from the 50s/60s, and gospel as indicated by my reactions/interactions. - doing things with groups of people. Recreation staff will invite/escort to scheduled group activities of assessed interest, such as entertainment, socials, special events, outdoors, arts/crafts, fitness, TV/movies, sensory groups, music, some games, culinary. - watching/listening to TV. - participating in religious services or practices: Recreation staff will invite/escort to in-facility spiritual programs, and provide spiritual resources, as available and requested, through (his/her) reactions/interactions with staff. 3/3/19 - A quarterly MDS assessment documented that R30 had both short and long term memory problems, does not speak, able to sometimes understand others and was rarely/never understood by others. 5/30/19 - A Recreation Comprehensive Assessment documented that R30's current activities of interests, that were somewhat important to R30 included: - listening to music, likes blues, religious, and 50's and 60's music through a CD player and/or live music.	F 679	of 8 or below will be performed. 3. An RCA was completed to identify potential issues. It was determined that education will be provided to the recreation staff to ensure that resources are in reach and necessary devices are on and useable by the resident who is dependent. 4. An audit of 105 of participation records will be completed each month for the next 3 months by the director of recreation services. The results of these audits will be reported at the monthly QAPI committee meetings for evaluation and recommendations as needed.	

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F 679	Continued From page 28 - to be around animals, such as pets, and was interested in pet visits by cats and dogs. - group activity including entertainment, TV/movies, physical games/exercises, arts/crafts, spiritual activities, some outdoor activities, and cooking. - being by herself/himself looking out the window, lying down/resting, people watching in his/her bedroom and/or in a common space such as in the hallway. - watching or listening to TV and liked classic and comedy movies. - going outside to get fresh air when the weather was sunny, warm, cloudy/overcast to sit and bird watching. - attending and/or watching religious services. 6/1/19 through 8/21/19 - Review of the Activities Participation Record (which documented the activities offered/refused) revealed that R30 was offered and/or participated daily in one or more activities such as, watching TV, relaxing/looking out window/resting/thinking, socializing/socials/talking on phone/visits/sending cards. There was no evidence that the resident was invited to go outside of the facility and/or activities involving dogs and cats. 8/18/19 - There were multiple observations during the day at 8:30 AM, 10:30 AM, and 12:50 PM that revealed R30 was in bed with no meaningful activity. 8/19/19 9:51 AM to 11:00 AM - R30 was observed sitting up in a wheelchair in his/her room, with eyes closed with no meaningful activity. 8/20/19 10:01 AM - R30 was observed lying in bed with eyes closed with no meaningful activity.	F 679		

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F 679	Continued From page 29 8/21/19 1:35 PM - R30 was observed sitting up in a wheelchair in his/her room with no meaningful activity. 8/22/19 8:30 AM - An interview with E15 (DR) confirmed that the facility failed to have evidence that they offered R30 her/his activities of interest including going outside and pet activities from 6/1/19 through 8/21/19. E15 stated that currently, they are unable to offer activities with pets, as they have not been able to locate an organization to provide such activities. No explanation was provided as to why outdoor activity was not offered/provided. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		10/4/19

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F 686	Continued From page 30 Based on observation, record review, interview and review of other documentation, as indicated, it was determined that for one (R30) out of four sampled residents for pressure ulcer investigation, the facility failed to ensure that a resident without a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice. For R30, a totally dependent resident, the facility failed to ensure that the resident was turned side to side to prevent skin breakdown. Findings include: Review of R30's clinical record revealed the following: 6/20/16 - R30 was admitted to the facility. 6/2/19 - The most recent quarterly MDS assessment stated that R30 was totally dependent with two person physical assistance for bed mobility, severely impaired for daily decision making, and did not have a pressure ulcer. 6/12/19 - The care plan for being at risk for skin breakdown as evidenced by impaired mobility, fragile skin and incontinence included interventions to apply barrier cream with each cleansing, ensure and assist resident as needed to turn and reposition (T & R), check skin every 2 hours and float heels while in bed. 8/1/19 through 8/17/19 - The CNA Activities of Living Flow Record (The CNA Care Plan) revealed that for bed mobility, R30 was totally dependent with two person physical assist every day of the month on all shifts. August 2019 CNA Tasks in EMR system	F 686	F686 1. Resident R30 still resides in the facility. Resident remains totally dependent for bed mobility and at risk for skin breakdown. Skin assessment was completed and resident□s skin remains intact. 2. All dependent residents are at risk for skin breakdown. Nursing rounds will be conducted by the charge nurse/designee to determine current residents that require assistance/dependence with turning, reposition and off-loading heels is occurring per their respected plan of care. 3. The root cause was completed and the CNA□s were in serviced on turning and repositioning. The surveyor was given a copy of the Inservice. The NPE or designee will educate CNA□s and licensed nurses on pressure ulcer prevention including the importance of turning, repositioning and off-loading heels. 4. Charge nurses or designee will complete random rounds/observation of 25% of residents who are assisted or dependent for turning, repositioning and off-loading heels during various shifts. This audit will be conducted daily on 25 % of the residents each shift x 7 days than 25% weekly x 4 weeks for compliance and then monthly 10 % x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 686	Continued From page 31 documented: - Ensure and assist resident as needed to T & R and check skin every 2 hours. - Float heels off bed. - Pressure relieving device in chair and bed. The following observations were made of R30 sitting up in bed, with the overbed table containing breakfast items in front of R30. - 8/18/19 8:30 AM. - 8/18/19 10:30 AM. - 8/18/19 12:50 PM. 8/18/19 12:52 AM - During an interview, E12 (CNA) revealed that he/she had switched the resident assignment with another CNA (E13), thus, R30 was assigned to E13 during the 7:00 AM to 3:00 PM shift. E12 proceeded to speak with E13, in the presence of the surveyor and E13 stated that he/she was not assigned to R30, thus, had not provided care during the shift. E12 confirmed that he/she failed to discuss the change in the resident assignment with his/her supervisor, E14 (RN), and stated that the supervisor would make any changes and not the frontline CNA. E12 confirmed that R30 was not turned, repositioned, and had skin checked every two hours as care planned. 8/18/19 12:55 AM - During an interview E14 (RN) confirmed that he/she was not informed of the request for a CNA change in resident assignment and confirmed that E12 (CNA) was assigned to R30 during the 7:00 AM to 3:00 PM shift. E14 immediately intervened to ensure R30 was provided the necessary care and services. 8/18/19 1:10 PM - Progress Notes documented	F 686		

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F 686	Continued From page 32 that R30's skin was assessed with no skin impairment. 8/19/19 11:15 AM - An interview with E2 (DON) confirmed that the facility was unable to provide evidence that R30 was turned and repositioned from approximately 8:30 AM to 12:50 PM on 8/18/19. The facility failed to ensure R30 was turned and repositioned and had his/her skin checked every 2 hours per the care plan. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		10/4/19

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F 688	Continued From page 33 by: Based on interview, record review and review of other facility documentation, it was determined that for one (R61) out one resident reviewed for range of motion the facility failed to carry out the range of motion program according to the plan of care instructions. Findings include: A facility document (not dated) entitled "Range of Motion" describes "Range of motion exercises are a vital part of keeping patients' muscles strong and healthy. Nursing staff can help patients maintain their normal range of motion by performing or assisting with range of motion exercises. Range of motion exercises are best done by completing at least three movements per joint at least twice a day or more often if ordered. When a joint is moved through its normal range of motion, it is moved without pain. If a patient complains of any pain, the exercises should stop and the nurse should be notified. Support the patient's body part with one hand while you move it with the other. Move slowly through each exercise. Patients should be encouraged to participate fully or partially in range of motion exercises, whenever possible." 5/8/19 - A care plan was initiated for R61 for "Restorative Range of Motion Patient demonstrates loss of range of motion due to cognitive loss/dementia." The goal is to prevent further contractures and maintain skin integrity for 90 days. The interventions included, "For passive range of motion, move joint slowly and gently never forcing past resistance. Avoid fast movements or stretching. Support above and below the joint. Explain each step prior to doing it."	F 688	F688 1. R61 still resides in the center. She is now receiving Passive Range of Motion with documentation in the POC of PCC. 2. All residents on a ROM program have to the potential to be affected. All residents on Range of motion program will be reviewed for accuracy and ensure staff are aware that the resident needs to have ROM performed as per care plan. 3. The root cause was completed. The NPE / designee will educate the nurses and CAN□s on how and when to perform ROM on their residents. 4. Unit nurses or designee will complete random rounds/observation of 25 % of residents who are on the ROM program to ensure the CNA□s are performing the required ROM for that resident. This audit will be conducted daily on 25% of the residents x 7 days than 25% weekly x 4 weeks for compliance and then monthly 10 % x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 688	Continued From page 34 8/18/19 9:11 AM - During an interview, R61 revealed that "I did have therapy and it was stopped". It was further revealed that R61 did not receive any range of motion by any staff member. R61 stated, "I do some exercises on my own." 8/19/19 1:30 PM and 8/20/19 10:40 AM - During interviews, R61 revealed that R61 did not have range of motion on either day. 8/1/19 through 8/19/19 - The facility document entitled Plan of Care (POC) identifies a task for CNAs to perform "Passive ROM to all extremities 3 times daily for a total of 10 minutes each time." It was documented as completed and tolerated fair each day. 8/20/19 9:37 AM - During an interview E4 (Director of Rehabilitation) revealed that R61 was discharged from therapy because R61 had reached his/her therapy goals. E4 made recommendations that R61 should receive range of motion and R61 was also given an exercise packet so R61 could do exercises on his/her own. 8/21/19 9:00 AM - During an interview, R61 revealed that two CNA's came to do range of motion today and said that they were not previously aware that R61 was supposed to get the range of motion exercises. 8/21/19 2:40 PM - During an interview, E25 (CNA) revealed that he/she thought that the range of motion was repositioning, dressing, and bathing. 8/22/19 9:00 AM - During an interview, E31 (CNA) revealed that range of motion was completed as a separate task.	F 688		

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F 688	Continued From page 35 8/22/19 10:30 AM - During an interview, E2 (DON) and E3 (ADON) confirmed that range of motion is an intentional exercise that is performed on a resident and it is not a part of the residents daily bathing, dressing, toileting, or repositioning. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 688		
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 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	F 690		10/4/19

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F 690	Continued From page 36 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: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined for one (R17) out of one sampled resident for urinary incontinence (UI) investigation, the facility failed to ensure that R17 received appropriate care and services to restore as much normal bladder function as possible. Findings include: The facility's policy and procedure titled "Continence Management", with a revision date of 3/1/18, stated, "A urinary incontinence assessment and/or bowel incontinence assessment and the Three Day Continence Management Diary will be completed if the patient is incontinent upon admission or re-admission and with a change in condition or change in continence status." "Practice Standards 1. Identify patient's continence status and need for management by reviewing the nursing assessment... 5. Develop a plan of care based on information from assessment and Diaries. 6. Implement revisions to the care plan as needed..." Cross refer F657, example 1	F 690	F690 Urinary incontinence 1. R17 no longer resides at Silver Lake. 2. All residents on a toileting plan have the potential to be effect. All resident on a toileting plan will have their bladder program reviewed by the Unit Manager to ensure resident maintains as much normal bladder function as possible and update the care plan as indicated. 3. The root cause analysis was completed. The NPE will educate the Unit Managers, ADON will be in-service on the urinary incontinence program and revising the care plans. Audits will be completed to ensure policy is followed. 4. CNE/Designee will complete random audits of residents on a toileting program to ensure when/if a revision to program is needed. 25 % of the residents on a toileting plan will be audit weekly x 4 weeks and then 10% monthly x 3 months to ensure compliance. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 690	Continued From page 37 2/26/19 - R17 was admitted to the facility from the hospital with diagnoses including Parkinson's Disease. 2/26/19 - The Admission Nursing Assessment documented that R17 had episodes of UI. 2/28/19 - A UI Assessment determined that R17's UI was not transient/reversible or unable to be reversed such as with medication and that R17's UI was persistent. The outcome of the assessment was to initiate a 3 day continence dairy. 3/5/19 - A Progress Note, Nursing Intervention documented the type of UI was Mixed and a toileting plan was initiated. 3/6/19 - A care plan for UI with a potential for improved control or management of urinary elimination was initiated. The goal was revised on 4/1/19 to include that R17 would demonstrate improved urinary elimination control as evidenced by experiencing less than two episodes of urinary incontinence per day with a target date of 9/11/19. Interventions initiated on 3/6/19 included: - Encourage resident to use toilet upon awakening, after meals, nightly and PRN. - Provide access to the bathroom. - Provide positive reinforcement for success. - Provide privacy and comfort. - Respond promptly to the resident's request to use toilet. 3/6/19 through 3/12/19 - The "Documentation Survey Report" for bladder continence (from CNA documentation in the electronic record) showed that R17 had experienced UI mostly during the	F 690		

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F 690	Continued From page 38 evening and night shifts. 3/8/19 through 3/12/19 - The Three Day-Continence Management Diary (Voiding diary) revealed three UI episodes; two on night shift and one on day shift. 3/12/19 - The 14 day MDS assessment indicated that R17 had a BIMS score of 12 (moderate cognitive impairment) and required extensive assistance of one staff member for bed mobility , transfers, and hygiene. In addition, R17 was frequently incontinent of urine with seven or more episodes of incontinence and was on a toileting plan. There was lack of evidence, that the facility reassessed the interventions to improve R17's UI. 3/20/19 through 3/26/19 - The "Documentation Survey Report" for bladder continence documented that R17 had experienced UI again during the evening and night shifts. 3/26/19 - An admission MDS assessment indicated that R17's BIMS score was 10 (moderate cognitive impairment). For bed mobility, transfers, toileting, and hygiene, R17's level of assistance by staff remained unchanged as extensive assistance of one staff. In addition, R17 continued with frequent UI and was on a toileting plan. There was lack of evidence that the facility identified the need to reassess R17's care plan interventions to improve R17's UI. 5/25/19 through 5/31/19 - The "Documentation Survey Report" for bladder continence	F 690		

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F 690	Continued From page 39 documented that R17 experienced UI daily, during the night shifts and occasional UI both during the day and evening shifts. 5/31/19 - A quarterly MDS assessment continued to document that R17 was moderately impaired for daily decision making with a BIMS score of 11, and required extensive assistance of one staff for bed mobility, transfers, and hygiene. R17 now required extensive assistance of two staff members for toileting and he/she continued to be frequently incontinent of urine and was on a toileting plan. Again, there was a lack of evidence that the facility identified the need to reassess the care plan interventions to improve R17's UI. 6/1/19 - R17 relocated to from Unit 1 to Unit 2. 8/1/19 through 8/19/19 - The "Documentation Survey Report" for bladder continence documented the following UI per shift: - Day shift: 10 out of 21 episodes. - Evening shift: 16 out of 20 episodes. - Night shift: 18 out of 18 episodes. 8/18/19 1:27 PM - During an interview, R17 revealed that he/she was aware of when he/she needed to urinate, but sometimes, when R17 activated the call bell for toileting assistance, it took a long time and he/she was not able to wait, thus, leading to an UI episode for which R17 wears an adult brief. 8/20/19 8:30 AM - An observation was made of R17 in bed with lights off in the room; there was no odor of incontinence noted.	F 690		

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F 690	Continued From page 40 8/20/19 3:01 PM - During an interview, E11 (CNA) revealed that R17 was encouraged to toilet upon awakening and after meals. E11 stated that R17 was aware of when he/she needs to be toileted and E11 provided assistance to the toilet. R17 wore adult briefs in case he/she cannot be toileted fast enough and E11 stated there have been occasions in which R17 would have UI episodes, such as when he/she was involved in out of room activities and was not able to get to the bathroom fast enough. 8/21/19 11:38 AM - During an interview, E6 (RN, UM Station 2) confirmed there were no reassessments of the toileting plan initiated on 3/6/19 before R17 transferred to Station 1 on 6/1/19. E6 stated that he/she was not aware of the CNA UI data and was uncertain as to who was responsible to review such data. When asked by the surveyor, "Who would review and revise the care plan?", E6 replied, "Any nurse". 8/21/19 11:45 AM - During an interview, E2 (DON) confirmed the lack of reassessments of the care plan interventions to improve, control or management of urinary elimination since the care plan interventions were implemented on 3/6/19. The facility failed to ensure that R17, a resident with UI was provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible as evidenced by a lack of evidence of reassessment of the toileting plan since the initial development of the care plan for UI on 3/6/19. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 690		

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F 692 SS=D	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 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: Based on observation, interview and review of facility documentation, it was determined that for one (R63), out of one resident reviewed for dialysis, the facility failed to ensure R63 received the correct therapeutic diet. R63 had a diagnosis of end stage renal disease (ESRD) and received dialysis. R63 received a 2 gram sodium diet instead of a renal (kidney) diet. Findings include: Review of R63's clinical record revealed the following: 6/28/19 - R63's care plan for nutritional risk was created and included interventions to provide a	F 692	F692 1. R63 still resides in the facility and is currently receiving a liberalized renal dysphagia advanced chopped meat diet as per physician orders. 2. All resident have the potential to be affected by not receiving the appropriate diet as per physician orders. A charge nurse/designee will review all physician diet orders with a print out from the kitchen□s diet order to ensure that the residents are receiving the appropriate diet as per physician orders. 3. The root cause was completed. The	10/4/19

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F 692	Continued From page 42 liberalized renal, dysphagia (difficulty swallowing) advanced, chopped meats diet, as ordered. There were no revisions of this care plan. 7/8/19 - A nutritional assessment documented R63 was receiving a liberalized renal diet. 7/8/19 3:52 PM - A nutritional progress note documented that "a nutrition assessment was completed today... diet appropriate to R63's diagnosis, intake is excellent, nutritional needs met, no changes." 8/15/19 - 8/17/19 - R63 was admitted to the hospital. Dietary instructions within the hospital discharge summary recommended a "renal diet". 8/17/19- The physician's orders and interim plan of care sheet, documented that R63 was to receive a 2 gram sodium diet. 8/20/19 8:18 AM - A dining observation was made of R63 with a dietary slip on the meal tray that indicated that the resident was on a "2 gram sodium dysphagia diet." 8/20/19 8:56 AM - During an interview, E35 (RD) stated, "R63 is on a liberalized renal dysphagia advanced (diet) with chopped meats." E35 was shown the dietary slip that accompanied R63's breakfast that day, then asked if this was an appropriate change. E35 stated, "I haven't seen R63 since the return [from the hospital], but I would still recommend the renal diet." 8/20/19 9:05 AM - E35 (RD) stated, "I am going to go to the kitchen to have them resume the renal diet."	F 692	NPE will educate the nurses that admission orders for diets need to be followed with dietary notified of the new/changed diet. Dietary will ensure all new orders are put into the computer for delivery to the patient. 4. Unit Managers/designee will complete post admission audit of all new admission dietary orders to ensure it was transcribed correctly & dietary will audit that all new orders are put into effect by the next meal. These audits will be 100% of admissions x 4 weeks and then 25 % of admission monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 692	Continued From page 43 These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of policies and procedures, it was determined that for one (R85) out of five residents sampled for medication review, the facility failed to assess the pain location and intensity before and/or after PRN pain medication using the same pain scale. Findings include: 2002 - The pain management standards that were approved by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. A facility policy entitled Pain Management, (effective 1/1/04), reviewed 1/23/18 and revised 3/1/18, documented, "pain management that is consistent with professional standards of practice, the comprehensive person-centered	F 697	F 697 1. R 85 still resides in the facility and is currently still receiving prn pain medications. His chart was reviewed for prn pain medication documentation since August 10th for accurate documentation for pain location and intensity before and/or after PRN pain medication using the pain scale and documentation on the front of the MAR for accuracy. Those nurses not completing the documentation as per policy will be educated. 2. All residents receiving PRN pain medication have the potential to be affected by not having the correct documentation of the pre/post pain scale and location of the pain, documentation on the front page of the MAR when PRN was given. A charge nurse/designee will audit MAR□s for prn pain medication to ensure pre/post pain scale and location are documented on those residents receiving PRN pain medications. 3. The root cause analysis has been	10/4/19

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F 697	Continued From page 44 care plan, and the patient's goals and preferences is provided to patients who require such services. If PRN medications are given, document on the back of the MAR or on the PRN Pain Medication Flow Sheet. " Review of R85's clinical record revealed: July - August 2019 - Review of MAR's and nursing notes revealed that R85 received seven doses of PRN pain medication: - 6 out of 7 administrations failed to identify R85's pain location and/or pain intensity before and/or after the PRN medication (July 22, 26 and 31; August 6, 8 and 10.) - 1 out of the 7 PRN pain medications was not documented on the front of the MAR, which increases the likelihood of administering a repeat dose too soon (August 8). 8/21/19 (2:09 PM) - During an interview, E9 (RN) confirmed that the location and pain score should be documented before and after PRN pain medication. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 697	completed. The NPE will be in servicing the nursing staff on accurate documentation as it pertains to pre/post medication documentation, location of pain and documenting on the front of the MAR about prn medications. The charge nurses will be checking each other for completion of PRN medication documentation. The implementation of electronic medication administration will begin in a few months. This system will alert if any documentation is not completed for a resident. 4. Unit nurses or designee will complete random audits of residents that receive PRN pain medications to ensure compliance with documentation. The audits will be of 100% of each hallways resident that receive PRN pain medication daily x 7 days for 100% compliance and then 25 % of residents will be audited weekly x 3 months to ensure compliance with the documentation. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		10/4/19

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F 698	Continued From page 45 by: Based on record review and interview, it was determined that for one (R63) out of one resident sampled for dialysis the facility failed to ensure consistent communication with the dialysis center. In addition, the facility failed to ensure pre/post dialysis weights were completed. Findings include: The facility policy on dialysis, last updated 10/1/18, in the subsection entitled Shared Communication between the facility and the dialysis center, indicated that : - "The care of the patient receiving dialysis must reflect ongoing communication, coordination, a collaboration between the facility and dialysis staff." - "The communication process should include nutritional/fluid management include documentation of weights..." Review of R63's clinical record revealed: 6/19/19 - R63 was admitted to the facility with multiple diagnoses including end stage renal (kidney) disease, dependence on renal dialysis, personal history of mental and behavioral disorders, and unspecified dementia with behavioral disturbance. 6/20/19 - A care plan was created for R63's impaired renal function and risk for complications related to hemodialysis. Interventions included to request pre and post weights from the dialysis center. 6/26/19 - An admission MDS assessment documented R63 as receiving special treatments, specifically, dialysis.	F 698	F698 1. R63 still resides in the facility. He still goes three times a week for dialysis. The DON has spoken and gone to the resident□s dialysis center and explain the importance of communication between the two centers for continue care for this resident. The resident has been asked to please try and bring back the communication book from dialysis. The staff for any dialysis residents has been in serviced on taking vital signs before departure and putting any concerns about the resident in communication book/calling the dialysis center about concerns and documenting the conversation. Upon his return the center will review communication book for weights pre/post dialysis and any problems at dialysis. If the communication book is not returned the nurse staff is to call for the information and then chart it in the resident□s record. 2. All other dialysis patients could be affected by this deficient practice of not sharing information between the facility and dialysis center. The unit manager/designee will audit when residents return that there is documented communication between the two centers especially as it pertains to pre/post weights. 3. The root cause analysis was completed. The NPE will educate the nursing staff about the policy on communication between dialysis and the facility. She will also add that if the communication book is missing to call and	

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F 698	Continued From page 46 June 2019 - August 2019 - Review of R63's clinical record revealed two dialysis communication records dated 6/21/19 and 6/28/19. There were no other dialysis communication records in R63's chart. Review of R63's weights from June 2019 through August 2019 revealed post dialysis weights on 7/16/19, 7/22/19 and 7/31/19. There was no evidence of pre dialysis weights, and no weights were obtained, pre or post dialysis, for the month of August 2019. 8/20/19 9:35 AM - During an interview, E43 (LPN) revealed that R63's dialysis communication records were "usually in a green binder [at the nurses station]. If not, the resident has it ." E43 attempted to retrieve the binder from R63, however, the binder was unable to be located. 8/20/19 1:45 PM - During an interview, E43 (LPN) confirmed there were no dialysis communications in the resident record available except the two dated 6/21/19 and 6/28/19. 8/21/19 9:43 AM - During an interview, E2 (DON) confirmed the facility did not have R63's dialysis communication records. E2 stated that R63 "keeps losing the book so we don't have them." 8/21/19 2:29 PM - An observation was made of E2 (DON) placing a call to the dialysis center to request copies of prior dialysis communication records for the surveyor to review. No copies of the dialysis communication records were ever provided to the surveyor. 8/21/19 4:13 PM - During an interview, E2 (DON)	F 698	document the conversation and the pre/post weights. 4. The unit manager/designee will complete random audits on dialysis residents to ensure that the communication book is correctly utilized or that there is documentation in the chart of resident□s pre/post dialysis weights. These audits will be of all dialysis residents 100% for 2 weeks for compliance and then 25% of the residents monthly x 3 months for compliance. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 698	Continued From page 47 explained that in the absence of a copy of the dialysis communication record upon return of R63 from dialysis, facility staff "should call [the dialysis center], take vital signs, and assess the resident." R63's clinical record lacked evidence that facility staff made previous calls to the dialysis center upon R63's return from dialysis. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		10/4/19

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F 725	Continued From page 48 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation, it was determined, that for six residents who wished to remain anonymous (A1, A2, A3, A4, A5, and A6) the facility failed to provide sufficient nursing staff on a 24 hour basis to meet resident care needs. Findings include: 1. Resident Council Meeting minutes were reviewed from January 2019 through July 2019 and revealed the following staffing related concerns: 2/19/19 - "Station 1 resident stated it's taking too long to have call light answered on 11:00 PM -7:00 PM." 3/22/19 - "Station 1 aides taking too long to pass out food once it is on the floor. Station 1 both halls, Station 2 front hall, aides coming in and asking what the issue is, turning off the (call) light and saying 'I'll be back', and then either never coming back or taking awhile to return. Station 1 both halls, Station 2 front hall, 11:00 PM to 7:00 AM aides continue to take too long to answer call lights. Station 1 in particular back hall." 5/31/19 - "Station 2... concern with aides not able to take patients back from the dining room to the floor timely." 7/18/19 - "Front hall 11:00 PM - 7:00 AM not answering lights timely." 2. During initial pool interviews, in response to	F 725	F-725 1. The facility administration has followed up on anonymous complaints expressed during the survey with individuals along with resident council. The topics that were discussed during the follow up included call bell response times, dining room transportation and overall care needs response. All of these topics were discussed at the resident council meeting. 2. Current residents have the potential to be affected. The facility held a resident council meeting to follow up to the residents□ concerns. In addition to the monthly resident council meetings. Bi-weekly audits will be done with residents on each station to determine compliance. These audits will be done for 3 consecutive months. 3. An RCA was completed. As a result of the RCA it was determined that education was needed for all staff. The center scheduling manager will staff the facility to meet the resident care needs either at or above the state required levels. Administration will attend all monthly resident council meetings as well as participate in audits. 4. Center staff will complete bi-weekly audit of 10% of the resident population. The audit will continue for 3 consecutive months. The results of the audits and resident council minutes will be presented	

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F 725	Continued From page 49 being asked whether residents receive the care and assistance they need without having to wait a long time, the following anonymous responses were received: 8/18/19 at 8:45 AM - A1 stated, "Can't find help throughout the day they are short staffed sometimes they don't answer at all." 8/18/19 at 9:14 AM - A2 stated, "I have waited up to an hour when ringing the call bell", it was further revealed that A3 "had an accident (episode of incontinence) and I did not like that. I am continent." 8/18/19 at 10:32 AM - A3 stated, "3:00 PM to 11:00 PM shift is bad and 11:00 PM to 7:00 AM is worse. One aide for whole floor I have to wait a half hour to an hour at night time, they use to have three (aides) and now they have one." 8/18/19 at 10:54 AM - A4 stated, "It takes at least a half an hour to answer my bell and sometimes they ask what I need and it takes another 20 minutes to come back to me." 8/18/19 at 1:27 PM - a family member for A5 stated, "Call bell response times are too long and [A5] must urinate in a brief; [A5 resident knows when it is time to urinate]." During a resident council meeting on 8/20/19 at 1:45 PM for the question "do you get the help you need," A6 revealed that when he/she was dependent for care and needed help to go to the bathroom "sometimes I was incontinent before they got to me, but I am independent now so I don't have the problem anymore."	F 725	at the monthly QAPI committee meetings for review and recommendations.	

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F 725	Continued From page 50 These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 725		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for one (R31) out of five sampled residents for review of dementia care, the facility failed to ensure that R31 received appropriate care and services to maintain his/her highest practicable mental and psychosocial well-being. Findings include: 12/4/18 - R31's care plan revealed, "Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: anxiety/fear caused by a diagnosis of anxiety. Interventions include the following: Encourage resident/patient to seek staff support for distressed mood; Refocus resident/patient to something positive; Encourage resident/patient participation in activity preferences; Approach the resident/patient in a calm, unhurried manner; reassure as needed; Allow time for expression of feelings; Provide empathy, encouragement, and reassurance." 3/3/19 - A quarterly MDS assessment confirmed	F 744	F744 1. R31 still resides in the facility. Her care plan will be reviewed to ensure resident receives the appropriate treatment and services to attain or maintain his or her highest practicable physical mental and psychosocial well-being. E29 will be in serviced on anxiety and appropriate treatment and how to care for residents with anxiety. 2. All other residents with diagnosis of anxiety/dementia have the potential to be affected. An Inservice about anxiety and appropriate treatment of dementia residents will be conducted by the NPE to ensure appropriate care and services to our residents so they maintain highest practicable mental and psychosocial well-being. 3. The root cause analysis was completed. This employee as well as the nursing staff will be in serviced about anxiety and appropriate treatment of dementia residents. The NPE will educate the nursing staff in techniques to	10/4/19

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F 744	Continued From page 51 that R31 had a BIMS of 12. 6/2/19 - The most recent quarterly MDS assessment confirmed that R31 had diagnoses that included dementia, anxiety and depression. 8/21/19 10:55 AM - An observation was made of R31 in the hallway asking for help and repeating, "Oh, God. I'm scared." This writer attempted to find staff to assist R31. This writer asked an (unidentified) aide in R31's room if he/she could assist, but he/she informed this writer that he/she was from a hospice company and was there to care for R31's roommate. He/she did, however, rub R31's back and try to calm him/her. R31 stated, "Everyone knows I am a bad patient." R31 pointed out his/her aide, who was coming down the hall. When this writer attempted to ask E29 (CNA) for assistance, he/she tersely stated, "No! False accusations!" and continued walking down the hall away from R31. This writer continued to stand with R31. E29 passed down the hall once more without stopping. E34 (Beauty Shop Assistant) stopped and asked R31 if he/she wanted his/her hair done, but R31 declined. E34 attempted to cajole R31 into coming with him/her, reminding him/her that he/she enjoys having his/her hair done, but R31 continued to refuse. 8/21/19 11:10 AM - E4 (Social Services Director) stopped at R31's doorway and stated to R31, "I saw your son. Did you want to get your hair done?" E4 put his/her arm around R31, while speaking to him/her, in an effort to give R31 comfort. 8/21/19 12:06 PM - An interview with E30 (LPN), who is familiar with R31, confirmed that redirection is very important in dealing with R31	F 744	calm anxious resident and redirecting dementia patients with anxiety to help the resident maintain highest practicable mental and psychosocial wellbeing. 4. The unit manager/designee will complete random audits on how staff interact with residents with anxiety and ensure the care plan is followed. This audit will review 25 % of each hallway□s residents with anxiety/dementia diagnosis daily x 1 week to ensure 100% compliance, then 25 % weekly x 1 month and then 25 % monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal.	

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F 744	Continued From page 52 because of his/her anxiety. 8/22/19 11:35 AM - The above findings were reviewed with E2 (DON). These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 744		
F 756 SS=F	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	F 756		10/4/19

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F 756	Continued From page 53 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and 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: Based on record review, interview and review of policies and procedures, it was determined that the facility's medication regimen review policy did not include the time frames for the different steps in the process. In addition, for three (R43, R97 and R62) out of five residents sampled for medication regimen review (MRR), the facility failed to conduct a medication regimen review, failed to conduct in a reasonable timeframe, or failed to identify an irregularity. Findings include: 1. Review of the facility policy entitled Medication Regimen Review (effective 11/28/16) revealed the lack of time frames: - for when the pharmacist will address copies of residents' MRRs to the Director of Nursing and/or the Attending Physician and to the Medical Director. - for when facility staff should ensure that the attending physician, Medical Director, and Director of Nursing are provided with copies of the MRRs. 2. Cross refer F656, example 1 Cross refer F758, example 1 Review of R43's clinical record revealed the	F 756	1. R 43 still resides in this facility. The residents Behavior Monitoring and Intervention Form has been corrected for monitoring the behaviors for auditory hallucination R97 still resides in this facility. The resident did have the recommendation from the pharmacist finally returned from the MD 6 weeks later no bad outcomes noted with the delay. R62 still resides in the facility. The Consultant pharmacist has reviewed the residents chart each month since July for discrepancies. The consultant pharmacist will go back and complete a review for the July 2019 month to ensure no discrepancies have been note. 2. All residents have the potential to be affected. All of august MRR's were reviewed to ensure all residents were seen and received a MRR done by the consultant pharmacist. 3. Consultant Pharmacist will be retrained on the appropriate use of Omnicare's consulting software to assure all residents receive a thorough MRR. Review of Medication Regimen Review did lack the time frames for addressing	

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F 756	Continued From page 54 following: 4/29/16 - R43 was admitted to the facility from the hospital. 1/30/19 through 5/10/19 - The following Psychiatric Nurse Practitioner (PNP) Progress Notes, by E20 revealed: - 1/30/19: Diagnosis of major depressive disorder with psychotic feature. "...Follow-up for delusions... Admits to hearing voices and staff reports [R43] wears his/her headphones... symptoms currently controlled." - 4/11/19: "... psychotic sx (symptoms) controlled with current dose of Zyprexa." - 5/10/19: "...Staff reports pt. (patient) wears headset to block out voices.." 6/1/19 through 6/30/19 - Review of the Behavior Monitoring and Interventions Form (BMIF) revealed that the targeted behavior for the use of anti-psychotic medication, Zyprexa was documented as "Verbal, directed towards others. ...V5 Other:_____" The facility failed to define the targeted behavior for monitoring. Despite the lack of targeted behavior(s), for the entire month, every shift for the 30 days period of time, the facility documented that R43 did not have the behavior. 6/7/19 - A PNP Progress Note, by E20 documented "...Hallucinations/delusions controlled with current regimen..." 7/5/19 - A PNP Progress Note by E20 documented .: "...Paranoid delusions controlled with Zyprexa. Nursing reports no concerns."	F 756	MRR's and when the attending physician should give a response. In coordination with the facility's Director of Nursing and the Medical Director, the Timeliness of Medication Regimen Review timeline will be that from the completion of the Consultant pharmacist review – three days to get it to the Director of Nursing/designee. The Director of Nursing/designee will review the completed MRR and send the attending physician the recommendation from pharmacy within 72 hours. The MRR will be audited by the Director of Nursing/designee to ensure a response or denial are back from the physician within 21 days. If a MRR is urgent that the consultant pharmacist is to bring it to the Director of Nursing or Assistant Director of nursing immediately so that the item can be address immediately by the attending physician/NP or the medical director. This will ensure that all recommendations turnaround time should be from beginning to end 30 days. 4. In coordination with the facility's Director of Nursing and the Medical Director, the Timeliness of Medication Regimen Review timeline will be completed and implemented by the Consultant pharmacist to assure all irregularities are addressed within 30 day time line if not urgent. If urgent than the consultant pharmacist is to bring it to the Director of Nursing or Assistant Director of nursing right away so that the item can be address. An audit will be performed by the Assistant Director of Nursing/designee to ensure that all residents have a monthly	

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F 756	Continued From page 55 7/8/19 - The MRR was conducted by the facility's Consultant Pharmacist (CP), E19 and no irregularity was identified, including the lack of adequate monitoring for target behaviors for the use of Zyprexa. 3. Review of the MRRs for R97 revealed that the pharmacist made a recommendation to the physician on 1/28/19. E21 (MD), the physician documented review of the recommendation on 3/13/19, a month and several weeks after the pharmacist recommendation. During an interview on 8/21/19 at 2:29 PM with E2 (DON), it was reported that "physicians usually visit residents every 30 days." 4. 8/19/19 - A review of R62's EMR lacked evidence of a pharmacist review of his/her drug regimen for the month of July 2019. 8/20/19 at 9:04 AM - An interview with E2 (DON) confirmed that no pharmacist review of R62's drug regimen occurred in the month of July 2019. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 756	medication regimen review completed and monitor the timely return of the requested done by the Consultant Pharmacist. This audit will be 100% for the first month and then 50 % x 3 months to ensure review and follow through with recommendations. 1. R 43 still resides in this facility. The residents Behavior Monitoring and Intervention Form has been corrected for monitoring the behaviors for auditory hallucination. 2. All resident with auditory hallucination have the potential to be affected by this deficiency. All residents with auditory hallucination will have their Behavior Monitoring and Intervention form reviewed for accuracy and completeness. The Consultant pharmacist will be reminded to review Behavior Monitoring and intervention form as part of the monthly review. 3. The consultant pharmacist will be retrained on the appropriate use of Omnicare's consulting software to assure all residents receive a through monthly review of medications and behaviors. 4. In coordination with the facility's Director of Nursing and the Medical Director, the Timeliness of Medication Regimen Review timeline will be completed and implemented by the Consultant pharmacist to assure all irregularities are addressed within 30 day time line if not urgent. If urgent than the consultant pharmacist is to bring it to the Director of Nursing or Assistant Director of nursing right away so that the item can be	

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F 756	Continued From page 56	F 756	address. An audit will be performed by the Assistant Director of Nursing/designee to ensure that all residents have a monthly medication regimen review completed and monitor the timely return of the requested done by the Consultant Pharmacist. This audit will be 100% for the first month and then 50 % x 3 months to ensure review and follow through with recommendations. 1. R97 still resides in this facility. The resident did have the recommendation from the pharmacist finally returned from the MD 6 weeks later. 2. All residents with physician E21 have the potential to be affected by this deficiency. The Assistant Director of Nursing/designee will now follow up closely all monthly MRR reviewed by the Consultant pharmacist to ensure a timely response from E21. The medical director and Omnicare have agreed that 30 days is long enough to get a response from a MD about the MRR. If it is an urgent matter during the review the consultant's pharmacist is to immediately get the charge nurse, ADON or DON to get an immediate response from the resident's physician. If the physician is not available than the medical director. 3. The consultant pharmacist will be retrained on the appropriate use of Omnicare's consulting software to assure all residents receive a through monthly review of medications and behaviors. 4. In coordination with the facility's Director of Nursing and the Medical Director, the Timeliness of Medication	

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F 756	Continued From page 57	F 756	Regimen Review timeline will be completed and implemented by the Consultant pharmacist to assure all irregularities are addressed within 30 day time line if not urgent. If urgent than the consultant pharmacist is to bring it to the Director of Nursing or Assistant Director of nursing right away so that the item can be address. An audit will be performed by the Assistant Director of Nursing/designee to ensure that all residents have a monthly medication regimen review completed and monitor the timely return of the requested done by the Consultant Pharmacist. This audit will be 100% for the first month and then 50 % x 3 months to ensure review and follow through with recommendations. 1. R62 still resides in the facility. The Consultant pharmacist has reviewed the residents chart each month since July for discrepancies. The consultant pharmacist will go back and complete a review for the July 2019 month to ensure no discrepancies have been note. 2. All resident have the potential to be affected by this deficient practice. August and September's MRR will be reviewed to ensure there is a MRR for each resident during the time the Consultant was in to review charts. 3. The consultant pharmacist will be retrained on the appropriate use of Omnicare's consulting software to assure all residents receive a through monthly review of medications and behaviors. The	

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F 756	Continued From page 58	F 756	consultant will print out a daily census on each visit to ensure that each resident received a MRR during the month. The Assistant Director of Nursing/ or designee will review each months MRR report to ensure that no resident get missed during the Consultants visit to the facility. 4. In coordination with the facility's Director of Nursing and the Medical Director, the Timeliness of Medication Regimen Review timeline will be completed and implemented by the Consultant pharmacist to assure all irregularities are addressed within 30 day time line if not urgent. If urgent than the consultant pharmacist is to bring it to the Director of Nursing or Assistant Director of nursing right away so that the item can be address. An audit will be performed by the Assistant Director of Nursing/designee to ensure that all residents have a monthly medication regimen review completed and monitor the timely return of the requested done by the Consultant Pharmacist. This audit will be 100% for the first month and then 50 % x 3 months to ensure review and follow through with recommendations.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		10/4/19

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F 758	Continued From page 59 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the clinical record and facility documentation, as indicated, it was determined that for two (R43 and R85) out of six sampled residents for psychotropic medication investigations, the facility failed to ensure that the clinical record accurately reflected the appropriate targeted behavior(s) for the use of anti-psychotic medication. Findings include: 1. Cross refer F656, example 1 Cross refer F756, example 2 The following was reviewed in R43's clinical record: 4/29/16 - R43 was admitted to the facility from the hospital. 1/30/19 through 5/10/19 - The following Psychiatric Nurse Practitioner (PNP) Progress Notes, by E20 (PNP) revealed: - 1/30/19: "Diagnosis of major depressive disorder with psychotic feature...Follow-up for delusions... Admits to hearing voices and staff reports (R43) wears her/his headphones... symptoms currently controlled." - 4/11/19: "... psychotic sx (symptoms) controlled with current dose of Zyprexa." - 5/10/19: "...Staff reports pt. wears headset to block out voices..Reviewed 5/19 - No issues with adequate monitoring". 6/1/19 through 6/30/19 - Review of the Behavior Monitoring and Interventions Form (BMIF) revealed that the targeted behavior for the use of	F 758	F758 1. R 43 still resides in the facility. Behavior monitoring sheet for the anti-psychotic is corrected and in use for this resident. R85 still resides in the facility. The behavior monitoring sheet for anti-psychotic is correct and in use for this resident. 2. All active resident who receive anti-psychotic medication will be reviewed for appropriate medical diagnosis. Those residents that are receiving anti-psychotic medication will be reviewed to ensure behavior monitoring sheet is in place and filled out correctly to match resident□s behaviors that need to be monitored. 3. Root cause was completed, the NPE/designee will Inservice nursing staff on behavior monitoring for anti-psychotic uses and to ensure the appropriate indications for psychotropic medication is in place when carrying out physician orders. 4. Unit manager/designee will do daily audits on all new admissions/readmission and new order to ensure that the any orders for antipsychotic medications have appropriate indication for use and that a behavior monitoring sheet is put into place. These audits will review 100 % of the orders for 100% compliance is achieved, followed by 50 % audit of the orders then 50 % of the monthly for the next 3 months for compliance. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make	

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F 758	Continued From page 61 anti-psychotic medication, Zyprexa was "Verbal, directed towards others. V5 Other:_____" The facility failed to define the targeted behavior on this monitoring form. Despite the lack of targeted behaviors for the entire month, every shift for the 30 days period of time, the facility documented that R43 did not have the behavior. 6/7/19 - A PNP Progress Note, by E20 documented "...Hallucinations/delusions controlled with current regimen..." 7/1/19 through 7/31/19 - Review of the subsequent month's BMIF revealed that the targeted behavior for the use of anti-psychotic medication, Zyprexa was "Verbal, directed towards others. V5 Other:_____" Again, the facility failed to define the targeted behavior on this monitoring form. Despite the lack of the targeted behavior, for the entire month, every shift for the 31 day period of time, the facility documented that R43 did not have the behavior. 7/5/19 - A PNP Progress Note by E20 documented .: "...Paranoid delusions controlled with Zyprexa. Nursing reports no concerns." 8/1/19 through 8/19/19 - Review of the BMIF revealed that the facility failed to identify and monitor the targeted behavior for the use of anti-psychotic medication, Zyprexa. 8/19/19 4:10 PM - During an interview, E44 (LPN) revealed he/she was uncertain of the targeted behavior(s) for which R43 was prescribed Zyprexa. 8/19/19 4:20 PM - During an interview, E7 (RN, UM Station 1) confirmed that the facility failed to	F 758	recommendations to achieve the goal	

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F 758	Continued From page 62 identify the targeted behavior on the 6/19 and 7/19 Behavior Intervention Monitoring Form, thus, failed to have evidence of adequate monitoring of the targeted behavior for which Zyprexa was being prescribed. It is unclear what behaviors were being monitored by the licensed staff as it was not defined. Additionally, E7 confirmed that the facility failed to have evidence of the targeted behavior for the use of Zyprexa from 8/1/19 through 8/19/19, 8/20/19 5:30 PM - During an interview, E3 (ADON) revealed that R43 has auditory hallucinations, as evidenced by R43 hearing things and this would be a targeted behavior for R43 for the use of Zyprexa. 8/21/19 7:55 AM - During an interview, E17 (RN Supervisor) revealed that R43 has auditory hallucinations as evidenced by hearing things not real and that the headphones connected to the TV or CD/radio player helps with this targeted behavior. 2. Review of R85's clinical record revealed: 7/19/19 - R85's admission physicians' orders included: - Risperdal (an antipsychotic medication) for mood. - Cymbalta (an antidepressant) for depression. - Aricept for dementia. Mood was not an appropriate diagnosis for Risperdal. 7/22/19 - Physician orders included to change the diagnosis for Risperdal to dementia with delusions.	F 758		

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F 758	Continued From page 63 8/6/19 8:10 PM - A nursing note summarized that R85 did not have any physical or verbal behaviors nor did R85 display rejection of care. 8/7/19 - A care plan was initiated for the use of psychotropic drugs with the goal to "have the smallest most effective dose without side effects." Interventions included to complete behavior monitoring flow sheet; to monitor for side effects and consult physician and/or pharmacist as needed; psychiatric evaluation as ordered; and provide informed consent to resident... 8/16/19 - A care plan was developed for verbal behaviors related to a "history of verbal outbursts directed toward others of abusive language, pattern of challenging / confrontational verbal behavior." The goal was R85 "will not have more than ___ episodes of (type in behavior i.e., verbal aggression) and was not individualized. Interventions included to monitor for pain; evaluate the nature and circumstances (i.e., triggers) of the verbal behavior; evaluate need for psychiatric / behavioral health consultation; provide consistent, trusted caregiver and structured daily routine; and acknowledge R85's progress toward goals. July - August 2019 - Review of behavior monitoring found: - Nurses monitored for R85 being withdrawn (Cymbalta) and confusion (Risperdal). - Aides monitored for being demanding or disruptive. - R85 did not experience any confusion in the facility. The facility failed to identify R85's delusions and	F 758		

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F 758	Continued From page 64 failed to monitor for the behavior for which the Risperdal was ordered. 8/21/19 2:09 PM - During an interview, E9 (RN) revealed that R85 had hallucinations at home when the resident saw the spouse who died last year. E9 added that R85 had been fine here. 8/22/19 8:28 AM - During an interview, E6 (RN, UM) revealed that behavior monitoring included confusion and not delusions and that the goal for R85's behaviors was not individualized or measurable. 8/22/19 (9:26 AM) - E8 (SW) supplied a copy of the 7/22/19 and 8/9/19 psychiatric NP notes. Review of these notes revealed no evidence of an assessment of R85's delusions outside of a statement that delusions were reported by nursing. The facility failed to ensure an adequate indication for the use of an antipsychotic and failed to monitor behaviors of delusions or hallucinations which would warrant the use of Risperdal. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		10/4/19

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F 812	Continued From page 65 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety by not properly covering and labeling stored food and not having evidence of maintaining proper temperatures of food that was in storage or being served. Findings include: The following observation, interview and record reviews were completed on 8/18/19 at 8:15 AM: - An observation was made of a tray of small, uncovered, unlabeled containers of food in the walk-in refrigerator. E27 (dietary aide) confirmed this finding at the same time, and revealed that the containers were full of tartar sauce. -The temperature log for the walk-in freezer in the dry storage area did not have temperatures recorded for 8/15/19, 8/16/19 or 8/17/19. -The temperature logs for the walk-in refrigerator and walk-in freezer located in the kitchen did not have temperatures recorded for 8/16/19 or 8/17/19.	F 812	F-812 1. No individual was cited 2. Current residents have the potential to be affected. An audit was done, also an RCA was completed. Staff were reeducated on product covering, refrigeration temperature logs, and cooking temperatures. 3. An RCA was completed. As a result of the findings the account manager or designee will do daily rounds to ensure food products are properly covered, labeled, and dated. Target results is 100% compliance daily. Food and sanitation audits include all areas of food services including cited areas. Target results for this area will be 100%. Food and sanitation audits will be conducted weekly for the next 3 months until at least 85% compliance is met consistently. The account manager will audit refrigeration temperatures log daily to assure compliance. Target for the log is 100%.	

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F 812	Continued From page 66 The following record reviews and interview were completed on 8/21/19 from 11:34 AM - 11:54 AM: -The temperature log for the walk-in freezer in the dry storage area did not have temperatures recorded for 8/18/19. -The temperature log for the double door refrigerator in the kitchen did not have temperatures recorded for 8/16/19, 8/17/19 or 8/18/19. -The temperature logs for the walk-in refrigerator and walk-in freezer located in the kitchen did not have temperatures recorded for 8/18/19. -The milk refrigerator did not have temperatures recorded for July or August. -Inconsistent evidence was provided for the final cooking temperatures. The record for 6/24/19 did not have evidence of lunch temperatures. The record for 7/25/19 did not have evidence of lunch or dinner temperatures. There was a lack of final cooking temperature monitoring evidence for August. More monitoring records were requested and after searching files, E26 (Dining Director) confirmed that monitoring was not consistent. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 812	Cooking temperatures log audits will be done weekly for 3 months. Account manager will review the cooking temperature log daily with a target of 100% compliance. 4. All audits will be brought into the monthly QAPI meeting for review and recommendations. Goal is 100% compliance.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		10/4/19

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F 842	Continued From page 67 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 68 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure the clinical record was accurate and complete for one (R85) out of five residents sampled for medication review. Findings include: Review of R85's clinical record revealed: a. Unlabeled 7/19/19 - R85 was admitted to the facility for rehabilitation after a hospitalization. 7/19/19 - A form entitled Psychotropic Medication Administration Disclosure did not contain R85's name on the form. Although R85 signed the form, the signature was not legible. 8/6/19 - R85 was admitted to long term care after a failed attempt to live at home.	F 842	F842 1. R85 still resides in the facility. The Psychotropic medication administration disclosure form now has a name on the top of the form and the missing psychiatric consultations are in the medical record. 2. All active residents have the potential to be effective by this deficiency. Any residents receiving psychotropic medications will have their charts audited for completion of the form and corrected as needed. All active residents that has been consulted or seen by the psychiatric MD or NP will have their consultation put into their medical records. 3. Root cause analysis was completed. The Unit manager/designee will review any new admission and new orders for psychotropic medications and ensure that	

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F 842	Continued From page 69 8/6/19 - A form entitled Psychotropic Medication Administration Disclosure did not contain R85's name on the form. Although R85 signed the form, the signature was not legible. 8/21/19 2:06 PM - During an interview, E40 (Unit Clerk) confirmed the Psychotropic Medication Administration Disclosure forms did not include R85's name. b. Missing 7/22/19 and 8/6/19 - R85's physicians' orders included a psychiatric consultation. There was no evidence in the clinical record that a psychiatric consultation was completed. 8/22/19 8:35 AM - During an interview, E8 (SW) revealed that the psychiatric NP saw R85, but did not provide the facility with the notes. 8/22/19 9:26 AM - E8 (SW) supplied a copy of two psychiatric NP notes, dated 7/26/19 and 8/9/19, and stated they were now included in R85's clinical record. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 842	the Psychotropic medication administration disclosure was filled out accurately and completely. The social worker/designee will make a note in the chart once the psychiatric MD or NP sees the patient until the note is received and put in the chart. Any recommended medication changes will be written as a telephone order. The Social worker will audit to ensure the notes are received by the facility within 30 days and put on the chart. 4. The Unit manager/designee will audit any new admission and new orders for psychotropic medications and ensure that the Psychotropic medication administration disclosure was filled out accurately and completely. 100 % of the orders/new admission will be reviewed x 2 weeks for compliance than 50% weekly x 4 weeks and then 25 % monthly x 3 months. The social worker/designee will audit to ensure a note is in the chart after the psychiatric MD or NP sees the patient until the note is received and put in the chart. Any recommended medication changes will be written as a telephone order. The Social worker will audit to ensure the notes are received by the facility within 30 days and put on the chart. 100 % of the patients seen by psychiatry will be audit x 2 weeks for compliance and then 50 % weekly x 4 weeks and then 25% monthly x 3 months.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		10/4/19

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F 867	Continued From page 70 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, review of cited deficiencies from the facility's annual survey on 10/18/18 and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program, failed to correct previously cited deficiencies. This has the potential to affect all 110 residents in the facility. Findings include: During the QAPI interview on 8/22/19 at 2:04 PM with E1 (NHA) and E2 (DON), it was confirmed that the team meets at least quarterly and meetings include the required meeting members. During the same interview, E1 was made aware that the survey team identified deficiencies in the following areas: Care Plan Timing and Revision, ADL Care Provided for Dependent Residents, Treatment and Services to Prevent/Heal Pressure Ulcers, Increase/Prevent Decrease in ROM/Mobility, Nutrition/Hydration Status Maintenance, and Food Procurement, Store/Prepare/Serve - Sanitary. Review of the facility 10/18/18 annual survey identified that deficiencies were cited for: Care Plan Timing and Revision, ADL Care Provided for Dependent Residents, Treatment and Services to Prevent/Heal Pressure Ulcers, Increase/Prevent Decrease in ROM/Mobility, Nutrition/Hydration Status Maintenance, and Food Procurement, Store/Prepare/Serve - Sanitary.	F 867	F-867 1. Cross refer to F657, F677, F686, F688, F692 and F812 for resolution and residents affected. 2. Cross refer to F657, F677, F686, F688, F692, and F812 for resolution and residents affected. 3. The QAPI committee completed an RCA to identify underlying causes for audits not sustaining compliance for the above F tags. As a result off the RCA the above F tags will be reviewed consecutively for the next 6 QAPI monthly committee meetings. Education will occur and will include discussions about the goals of the committees in being proactive in recommending preventive measures to ensure quality outcomes and sustained improvement. 4. The QAPI committee will meet monthly to review and monitor ongoing improvements activities which include discussions of audit results as well as committee changes in action plans to achieve 100% sustainable improvement. Results of all audits will be present to QAPI committee for review and recommendations.	

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F 867	Continued From page 71 1. Care Plan Timing and Revision - The facility's plan of correction for a deficiency regarding Care Plan Timing and Revision cited during the 10/18/18 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey, cited under F657 revealed that the QAPI committee was ineffective in correcting this deficient practice. 2. ADL Care Provided for Dependent Residents - The facility's plan of correction for a deficiency regarding ADL Care Provided for Dependent Residents cited during the 10/18/18 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey, cited under F677 revealed that the QAPI committee was ineffective in correcting this deficient practice. 3. Treatment and Services to Prevent/Heal Pressure Ulcers - The facility's plan of correction for a deficiency regarding Treatment and Services to Prevent/Heal Pressure Ulcers cited during the 10/18/18 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendation to achieve sustainability. The results of the current survey, cited under F686 revealed that the QAPI committee was ineffective in correcting this deficient practice. 4. Increase/Prevent Decrease in ROM/Mobility -The facility's plan of correction for a deficiency	F 867		

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F 867	Continued From page 72 regarding Increase/Prevent Decrease in ROM/Mobility cited during the 10/18/18 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve compliance. The results of the current survey, cited under F688 revealed that the QAPI committee was ineffective in correcting this deficient practice. 5. Nutrition/Hydration Status Maintenance -The facility's plan of correction for a deficiency regarding Nutrition/Hydration Status Maintenance cited during the 10/18/18 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendation to achieve the goal. The results of the current survey, cited under F692 revealed that the QAPI committee was ineffective in correcting this deficient practice. 6. Food Procurement, Store/Prepare/Serve - Sanitary - The facility's plan of correction for a deficiency regarding Food Procurement, Store/Prepare/Serve - Sanitary cited during the 10/18/18 survey revealed that the QAPI committee would assess and evaluate the data collected and provide recommendations to obtain and maintain compliance. The results of the current survey, cited under F812 revealed that the QAPI committee was ineffective in correcting this deficient practice. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 867		
F 880	Infection Prevention & Control	F 880		10/4/19

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F 880 SS=F	Continued From page 73 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 74 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, review of policies and procedures and review of other facility documentation, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to identify and control the development and transmission of communicable diseases and infections. a. The facility failed to obtain tuberculosis (TB) testing results for two (R81 and R458) out of five	F 880	F880 1. R81 is no longer a resident at this facility. R458 had a CXR to r/o tuberculosis due to his refusal of the ppd. The resident R458 does not have tuberculosis. 2. All other residents have the potential to be affected. An audit of residents in the facility has been completed to ensure records indicate negative ppd or chest	

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F 880	Continued From page 75 residents sampled for infection control. b. The facility's tuberculosis management policy failed to address resident refusal of the skin testing. c. The facility failed to ensure a clear process for the identification of rooms used by residents on transmission-based precautions which need environmental surface cleaning and disinfection strategies with respect to antibiotic-resistant microorganisms when precautions were discontinued or the resident was moved out of the room. d. The facility failed to ensure personal protective equipment (PPE - disposable gown, gloves, mask) was worn by staff when in a room identified as transmission-based precautions for C. difficile (C. diff - a bacteria causing diarrhea that can live on surfaces for up to five months). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4313175/. e. The facility failed to ensure hand hygiene was performed after removing single-use gloves. Findings include: 1. Tuberculosis. Review of the facility policy entitled Tuberculosis Screening (last revised 11/28/16) documented that "All patients will be screened for tuberculosis on admission to the Center according to Centers for Disease Control and Prevention (CDC) and local/state Health Department regulations and recommendations." CDC's Latent Tuberculosis Infection: A Guide for Primary Health Care Providers (last reviewed 10/20/14) included that the tuberculin skin test (TST) was used to determine if a person is infected with tuberculosis. The skin test is	F 880	x-ray with no active tuberculosis. 3. A root cause analysis was completed. All new admissions and readmission residents will be offered the 2 step ppd unless contraindicated and then a chest x-ray would be ordered. Per the medical director of Silver Lake if a resident refuses to do the two step PPD than a chest x-ray is ordered to r/o tuberculosis. The NPE/designee will inservice the nursing staff and other physicians about the medical director□s new directive about doing chest x-ray if a refusal happens. 4. The infection control nurse/designee will audit all new admissions and readmissions within 24 hours to ensure ppd was given or chest x ray ordered. The audit will be 100% daily x 4 weeks for compliance and then 50 % weekly x 1 month and then 25 % monthly x 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and/or make recommendations to achieve the goal 1. R 460 is still a resident and no longer requiring isolation. Housekeeping will be notified by Nursing about anyone that is on isolation. The housekeeping staff will also check daily/shift with the charge nurse of the unit/hallway about any residents that is on isolation and any rooms where isolation has been discontinued. 2. All residents have the potential for this to affect them. Nursing staff will leave isolation signs on the room when isolation is discontinued or resident moved from	

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F 880	Continued From page 76 administered by injecting a small amount of purified protein derivative (PPD) solution under the skin. Reading an interpretation of the TST reactions should be conducted within 48-72 hours of administration. Some people infected with tuberculosis may have a negative reaction to the TST if many years have passed since infection. They may have a positive reaction to subsequent TST because the first step stimulated their ability to react to the test. For this reason, the two-step method is recommended at the time of initial testing for people who may be tested periodically. If the second test is positive, consider the person infected. The second step PPD should be administered 1 - 3 weeks after the first step. https://www.cdc.gov/tb/publications/ltbi/diagnosis.htm. A. Review of R81's clinical record revealed: 7/23/19 - R81 was admitted to the facility after a hospitalization for a fall at home. July 2019 - The MAR documented that the step 1 PPD was negative and step 2 was to be administered on 8/2/19. August 2019 - Review of the MAR and nursing notes revealed that the step 2 PPD was not administered on 8/2/19 or the rescheduled dates of 8/14/19 or 8/18/19. There was no evidence in nursing notes of resident refusal or re-attempts to complete the step 2 PPD. 8/19/19 - R81 transferred to the hospital for treatment of a medical condition. 8/22/19 - During an interview with E9 (RN) to review the current MAR, E9 confirmed a PPD	F 880	the room to another room. The housekeeping and nursing staff will communicate on each daily/shift on whom is on isolation and whom has had isolation terminated. The housekeeping staff will also check daily/shift with the charge nurse of the unit/hallway about any residents that is on isolation and any rooms where isolation has been discontinued. Nursing will leave a STOP sign in reference to isolation room in place. Housekeeping will remove the STOP sign once all the required terminal cleaning for isolation room is completed. 3. Root cause analysis was completed. The NPE/Infection Control Nurse will inservice nursing and housekeeping staff on communication about isolation rooms and the use of the STOP sign on the room until terminal cleaning has been completed. Housekeeping Manager/designee will inservice the housekeeping staff about the required cleaning per the policy labeled Contaminated Isolation Room Cleaning for each room to ensure policy is followed. 4. The infection control nurse/designee will audit isolation rooms daily to ensure STOP signs are in place and that the housekeeping staff are aware whom is on isolation or when isolation is terminated. This audit will be done daily for two weeks for 100% compliance then 3 times a week for a month and then 50% weekly for 3 months. The Housekeeping Manager/designee will audit the housekeeping staff to ensure that they are aware of the isolation and performing terminal cleaning as per the	

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F 880	Continued From page 77 was administered on 8/20/19 when R81 returned from the hospital. The facility failed to timely administer R81's step 2 PPD. B. Review of R458's clinical record revealed: 8/15/19 - R458 was admitted to the facility. 8/16/19 11:27 PM - A nursing note documented that R458 refused the "1st step PPD this shift. Resident interrupted when education attempted to be provided, stating I'm allowed to refuse." 8/19/19 - Review of R458's record found no evidence of alternative TB testing (i.e., blood test, chest x-ray). 8/20/19 11:35 AM - Chest x-ray results from a recent hospitalization were provided to the surveyor. The chest x-ray result was dated 7/12/19 and showed no active disease. 8/20/19 1:20 PM - During an interview with E16 (Infection Control Preventionist) when asked about the process for TB testing when a resident refused the skin test, E16 stated, "We get a chest x-ray." E16 added that he/she would write the date the chest x-ray was ordered on the immunization section of the electronic record. The surveyor informed E16 that the facility obtained chest x-rays results (dated 7/12/19) that morning for R458 who was admitted five days earlier and that the tuberculosis management policy did not address steps for a resident who refused the PPD. E16 offered no additional information for either issue.	F 880	Contaminated Isolation Room Cleaning policy daily x 2 weeks until 100% compliant and then 3 times a week for a month and then 50% weekly for 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and or make recommendations to achieve the desired goal. 1. R460 resident did not have any abnormal events due to the staff not properly wearing PPE when in the resident□s room. 2. All other residents in isolation room have the potential for the staff to not wear PPE properly and hand hygiene after removing gloves and PPE. The staff (Nursing/Housekeeping) will be inserviced by the NPE/designee on the proper technique on wearing PPE□s and hand hygiene after removing the PPE. 3. Root cause analysis was completed. The NPE/designee will inservice nursing/Housekeeping staff on wearing PPE□s and hand hygiene after removing the PPE. The Housekeeping manager/designee will review the policy Contaminated Isolation Room Cleaning to ensure staff area aware of the potential for spreading infection when terminally cleaning rooms. 4. The NPE/Housekeeping Manger/Designee will audit the staff in wearing proper PPE and the removal and hygiene after removal. This will be monitored daily x 2 weeks until 100%	

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F 880	Continued From page 78 2. Contact Precautions The facility policy entitled Contact Precautions (last revised 6/15/19) included that contact precautions would be used for disease transmitted by direct or indirect contact with the patient or the patient's environment. Process: 1. Place patient in private room, if possible. 2. Place a "STOP. Please see nurse before entering room" sign on door. .. 4. Staff must use barrier precautions when entering the room...Wear gown and gloves, wear eye protection if splashing of infectious material is likely. Change gloves and gowns during care if gloves/gowns and perform hand hygiene before providing care to other patient in the room. Before exiting room, remove and bag gown and gloves and wash hands upon exiting room...Once the patient is no longer at risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions. The facility infection control policy entitled Discontinuing Transmission Based Precautions (last revised 11/18/16) listed the following steps when discontinuing transmission based precautions is appropriate: - Notify all departments. - Instruct patient and visitors that Precautions were no longer needed. - Return patient to his/her room if a move to a separate room occurred, if indicated. - Inform the housekeeping department to perform discharge / turnover cleaning. - Remove "STOP" signs. Procedure from [name of the contracted housekeeping company] entitled Contaminated Isolation Room Cleaning: C-diff Spores (last	F 880	compliant and then 3 times a week for a month and then 50% weekly for 3 months. The CNE/designee will report results of the audits to the monthly QAPI meeting to discuss progress and or make recommendations to achieve the desired goal.	

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F 880	Continued From page 79 revised June 2016) identified the first step of the procedure was to identify the presence of a sign posted regarding an isolation room...scrub hands and arms for 3 minutes...dress in isolation clothes by putting on booties first, cap second, mask third, gown fourth and gloves last. Steps for isolation room cleaning included: empty trash, disinfect all surfaces using the EPA approved bleach solution and let air dry; clean walls; remove curtains; clean bathroom; dust mop; damp mop with bleach solution; exit room (remove isolation clothes, change mop water, disinfect all tools used to clean the room, wash hands and arms with soap and water). This procedure referred to double-bagging trash, dirty linen/curtains/mops which is not consistent with current standards. https://www.ncbi.nlm.nih.gov/books/NBK214342/. a. 8/18/19 8:40 AM - An observation was made of R460's room with a white paper "STOP" taped to the wall to the left of the doorway above the three drawer isolation cabinet outside the room. The paper "STOP" sign was taped along the top in the center and the paper curled with most of the wording hidden. Review of R460's clinical record revealed R460 was on transmission based precautions (contact isolation) for C-diff. 8/20/19 8:30 AM - An observation was made that R460 was moved to a private room and the "old" room was empty and had been stripped of bed linens and trash/waste. The "STOP" sign outside of the room was no longer hanging outside of the "old" room and there was no signage to indicate the "old" room had been previously used for contact isolation.	F 880		

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F 880	Continued From page 80 8/20/19 11:52 AM - 12:09 PM - During an interview with E37 (Housekeeper) about the process for cleaning isolation rooms, E37 stated that isolation rooms were cleaned last. E37 added that the "STOP" sign lets housekeeping staff know the room was an isolation room. When asked how E37 would know if a room had been used for isolation when the room was empty, E37 did not answer the question, but stated there was a sign when the resident was there. E37 pushed the housekeeping cart in front of R460's "old" room. When asked if there was a resident room on the unit that had been used for isolation and needed to be terminally cleaned, E37 said, "No, they did not tell me." The surveyor informed E37 that the room he/she was about to enter had been used for contact isolation for C-diff and not to enter without PPE and that terminal cleaning was needed. E39 (Housekeeper) joined the conversation and informed E37 that the curtains would need to be changed. The surveyor asked E39 about the process for being notified of isolation rooms that needed cleaned after resident transfer. E39 said, "The nurses or aides let us know. Sometimes our boss will tell us after the meeting [morning meeting where interdisciplinary team meets to review facility concerns/residents] is done." 8/20/19 12:05 PM - During a random observation E37 (Housekeeper) was then seen removing the privacy curtain wearing disposable gloves and no gown in the "old" room. E39 (Housekeeper) informed E37 of the need to also wear a gown and mask. At 12:09 PM, E37 removed the PPE and performed hand hygiene then exited the room and carried the privacy curtain to laundry in a plastic bag. E37 stated that he/she was taking	F 880		

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F 880	Continued From page 81 the curtain to the laundry room. In a few minutes, E37 returned with the same bag containing the curtain and said that her boss said to do both (curtains)." 8/20/19 1:20 PM - During an interview, E16 (Infection Control) confirmed there was no formal process for notifying the need for terminal cleaning to housekeeping after isolation was discontinued. b. Review of R459's clinical record revealed: 8/18/19 8:40 AM - An observation was made of R459's room with a three drawer isolation cabinet outside the room. There was no paper "STOP" sign or other signage outside of the room or on the door. 8/18/19 around 9:30 AM - During an interview, E41 (PT) confirmed that R459 was in contact isolation for ESBL (type of bacteria) in the urine. 8/18/19 9:32 AM, 10:50 AM, 11:39 AM and 1:28 PM - Observations were made of R459's room without a "STOP" sign or other signage. 8/18/19 1:35 PM - During an interview, E9 (RN) confirmed there was no "STOP" sign and immediately placed a sign on R459's door to alert visitors and staff to see the nurse prior to entering the room. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/22/19 at 2:15 PM.	F 880		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
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Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: August 22, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual, complaint and emergency preparedness surveys were conducted was conducted at this facility from August 18, 2019 through August 22, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 110. The survey sample totaled fifty-one (51).	Cross refer to the CMS 2567 compiled LTC survey completed Aug 22, 2019. F582, F641 , F644, F656, F657, F676, F677, F679, F686, F688, F690, F692, F697, F698, F725, F744, F756, F758, F812, F842, F867, F880.	10/04/2019
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed August 22, 2019: F582, F641, F644, F656, F657, F676, F677, F679, F686, F688, F690, F692, F697, F698, F725, F744, F756, F758, F812, F842, F867, and F880.		

Provider's Signature William J Burke Title CED Date 9/03/19