STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning August 20, 2019 to September 4, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 112. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 20, 2019 through September 4, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 112. The survey sample size was 52 residents. Abbreviations/definitions used in this report are as follows: > - Greater than; < - Less than; Accucheck- blood glucose monitor used to check blood sugar levels; ADON - Assistant Director of Nursing; AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with	F 000		

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

Electronically Signed | 10/07/2019

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antipsychotic medications;
Albuterol- medication used to open airways to make it easier to breathe;
Alert and oriented times 3 (AOX3) - Alert and oriented to person, place, and time;
Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness;
BID - twice a day;
BiPAP - machine that helps the patient breathe;
B/L - both sides:
BLE (ble) - bilateral lower extremities; in/on both legs;
B12 Level - A vitamin important for the normal formation of red blood cells and the health of the nerve tissues. Undetected and untreated vitamin B12 deficiency can lead to anemia and permanent nerve and brain damage;
BMI - Body Mass Index- a measure of body fat that gives an indication of nutritional status;
BMP - (Basic Metabolic Panel) a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys are functioning;
Cataracts - develops when proteins in the eye form clumps, preventing normal movement of light through the eye, to the retina. The lens becomes cloudy, and objects appear blurry, hazy, or faded in color. The condition can be treated surgically;
Catheter - a small tube used to drain fluid;
CBC - (Complete Blood Count) is a blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia;
Ceiling Lift - a motorized device that lifts and transfers a person from point to point along an overhead track that is mounted on a ceiling;
CM (cm) - Centimeter - a metric measurement of

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F 000	Continued From page 2 length, 1 centimeter = 0.39 inches; CMP - (Comprehensive Metabolic Panel) a series of blood tests that give your doctor a snapshot of your body's chemistry and the way it is using energy (your metabolism); CNA - Certified Nurse's Aide; CO2 (Carbon Dioxide) - gas formed during breathing; Consultation - a meeting with an expert or professional, such as a medical doctor, in order to seek advice; Contact precautions - series of procedures used to minimize the transmission of infectious organisms by direct or indirect contact, such as wearing gloves and a gown; Corticol blindness - the eye affected is physically healthy and normal but the damage to your brain causes partial or full loss of vision; CPAP - machine for breathing assistance during sleep; Chronic respiratory failure - A long-term condition that happens when your lungs cannot get enough oxygen into your blood; Contusion - a bruise; CRE (Carbapenem-resistant Enterobacteriaeae) - a bacteria that is resistant to a certain class of antibiotics; CRP - C-reactive protein/blood test used to detect inflammation; D/C - Discontinue; Diaphoretic - Producing or increasing perspiration (sweat); DON - Director of Nursing; Droplet precautions- used for diseases or germs that are spread by coughing and sneezing; workers should wear a mask while in the room; EHR - Electronic Health Records; EKG - Electrocardiogram, used to study and record the electrical activity of the heart;	F 000		

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F 000	Continued From page 3 EMAR - Electronic Medication Administration Record; ER - emergency room; ESR - Erythrocyte Sedimentation Rate/blood test that indirectly measures the degree of inflammation present in the body; ETAR - Electronic Treatment Administration Record; Ferritin Level - The major protein concerned with iron storage; Ferritin TICB - (Total Iron Binding Capacity) is a type of blood test that gauges whether there is too much or too little iron in your bloodstream; Five rights of medication administration - Right patient, Right medication, Right dose, Right time, and Right route; Folate - One of the B vitamins that if you do not have enough of it can cause anemia (a condition in which the number of red blood cells is below normal); Hematocrit - ratio of red blood cells to the total volume of blood; normal range for adult male is 37.5-55.5; less than or equal to 21.0 is a critically low level; Hematoma - collection of blood as a result of trauma, such as a black eye; Hemoglobin - protein in red blood cells to carry oxygen from lungs to the body; normal range for adult male is 13.5-17.5; less than or equal to 7.0 is a critically low level; HgbA1c - (Glycated hemoglobin Test) is a test for a type of hemoglobin that is chemically linked to sugar/glucose. Higher levels are indicative of excessive sugar in the blood stream often indicative of diabetes; Homeostasis - the ability of the body to seek and maintain a condition of equilibrium or stability within its internal environment when dealing with external changes;	F 000		

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F 000	Continued From page 4	F 000		

Hydralazine - Medication used to treat high blood pressure;
Hypertension - High blood pressure;
Hypoglycemia - low blood sugar; may experience symptoms such as sweating, shakiness, pale skin, alteration in mental status and seizures;
Indwelling catheter- a flexible tube inserted into the bladder to drain urine;
Iron Level - A group of blood tests that are done to evaluate the iron level in the blood, the body's capacity to absorb iron, and the amount of iron stored in the body. Iron is an essential trace element; it is necessary for the formation of red blood cells and certain enzymes;
KUB (kidneys, ureters, and bladder) - A plain film of the abdomen, providing information about abdominal organs including the kidneys, ureters, and bladder;
Labs/Lab Draw - Blood draw: Removal of blood, usually by venipuncture (phlebotomy, venous blood sampling). Common term for blood sampling for laboratory analysis;
Lab Tech - (Nickname for) Phlebotomist: A person who draws blood for diagnostic tests or to remove blood for treatment purposes;
Lateral - farther from the median; relating to the side;
Lipid Profile -A lab test that usually includes the blood levels of total cholesterol, high-density lipoprotein (HDL) cholesterol, triglycerides, and the calculated low-density lipoprotein (LDL) cholesterol;
LPN- Licensed Practical Nurse;
Lymphedema - swelling in arm or leg most commonly caused by blockage in a blood vessel;
MAR - Medication Administration Record;
MASD - moisture associated skin damage;
MDS - Minimum Data Set, an assessment tool used in long term care facilities;

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F 000	Continued From page 5 Mechanical ventilation - Use of a machine called a ventilator or respirator to improve the exchange of air between the lungs and the atmosphere; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; mg - Milligram- A unit of mass; Milliliters (ml or mL) - A unit of liquid volume or capacity in the metric system, 5 ml equals 1 teaspoon or metric measurement of liquid volume, 5 mL equals 1 teaspoon; Morphine - Opioid medication- used to treat moderate to severe pain; Mottled - Skin that has patchy and irregular colors. The skin may have red and purple marks, streaks, or spots. It may also have a marbled appearance with different colors; Nasal cannula- A tube placed into nostrils to deliver oxygen; Neuro check - A brief neurological assessment; NHA - Nursing Home Administrator; NP - Nurse Practitioner; OOB - Out of bed; Paraplegia - impairment in motion or feeling of the lower extremities; PCP- primary care practitioner (physician/nurse practitioner); Persistent vegetative state - a condition in which a patient is completely unresponsive to psychological and physical stimuli and displays no signs of higher brain function, being kept alive only by medical intervention; Plantar - relating to the sole of the foot; POA - power of attorney- person legally able to make health decisions for patient; Prealbumin - a blood test that is used to see if you are getting enough nutrition in your diet; Pressure Ulcer Stage IV (4) - full thickness skin	F 000		

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loss with extensive destruction, tissue necrosis (tissue death), or damage to muscle, bone, or supporting structures caused by persistent pressure;
PRN - as needed;
Protein Calorie Malnutrition - a nutritional deficiency which alters a person's immune response, inflammatory reaction, and tissue regeneration, all of which are essential for wound repair;
Quadriplegia - paralysis of all four limbs;
Respiratory Failure - occurs when too little oxygen passes through the lungs or they fail to stop carbon dioxide from entering your blood;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
RT - Respiratory Therapist;
Serous - a thin, clear, light yellow watery fluid found in many body cavities;
Sharps container - a container that is designed for the disposal of sharp objects such as needles;
STAT- medical term meaning urgent or immediately;
Systolic Blood Pressure (SBP) - the top number of the blood pressure reflects pressure in the blood vessels when the heart is beating;
TAR - Treatment Administration Record;
TIBC - (Total iron binding capacity) a blood test to see if you have too much or too little iron in your blood;
Tracheostomy - a surgically created hole through the front of one's neck and into the windpipe (trachea) to provide an air passage to help one breathe when the usual route for breathing is obstructed or impaired. A tracheostomy is often needed when health problems require long-term use of a machine (ventilator) to help one breathe;
Transferrin Sat. - (Transferrin saturation) the main

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F 000	Continued From page 7 protein that binds iron in the blood, this value tells a clinician how much serum iron is bound; Transfusion - receiving blood products into a vein; Urethra- tube that drains urine from the bladder; Urology - a surgical specialty which deals with diseases of the male and female urinary tract; VDRF - Ventilator Dependent Respiratory Failure/a person that relies on a breathing machine when they cannot breath on their own; WCN - Wound Care Nurse.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and interview, it was determined that the facility failed to provide R33, a resident who was blind, services with reasonable accommodation of resident needs and preferences. Findings include: Review of R33's clinical record revealed: 6/22/19 - The quarterly MDS assessment stated that R33 had highly impaired vision and an active diagnosis of cortical blindness. 8/21/19 at 9:12 AM - An observation of R33 revealed the resident sitting in a wheelchair in the resident's room on the right side of the bed. R33 was observed calling out for the nurse with the	F 558	F558 Reasonable Accommodations Needs/Preferences A. Resident R33 call bell was placed within reach when it was brought to the attention of the staff that she was unable to reach her call bell. B. All residents that have impaired vision have the potential for not being able to locate their call bell by tactile sensation if the call bell is not within reach. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Nursing and activity staff members will be re-educated by the Staff Educator on the importance of call bell placement for residents with visual impairment. The	11/11/19

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F 558	Continued From page 8 door opened. R33 responded when the surveyor knocked and asked permission to enter the room. The surveyor asked R33 why he/she was reaching out and around the wheelchair. R33 stated that he/she wanted a cup of water. The surveyor told her there was no cup of water present and then asked R33 if he/she had a call bell. R33 stated no. The surveyor observed R33's call bell wrapped around the left side bed rail on the opposite side of the bed, which was out of R33's reach. The surveyor stepped outside into the hallway and observed E23 (activity staff) talking to another resident. E23 responded to R33's room and asked R33 if he/she needed anything. R33 asked for a sweater and E23 retrieved a sweater and assisted R33 to put it on. E23 then stated that he/she will get R33 a glass of water. The surveyor asked E23 as he/she was about to exit R33's room if R33 had her call bell. E23 confirmed that R33 did not have his/her call bell. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 558	need for the resident to be able to feel the device is imperative for the resident to be able to utilize the call bell. Education is to include: placement per resident□s preference; communicating to the resident where the call bell is located (ex: hands of a clock); and to ask the resident to feel / touch the call bell prior to exiting the room. D. The Respiratory Director/ designee will audit the placement of the call bell for residents with a visual impairment. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		11/11/19

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F 580	Continued From page 9 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

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F 580	Continued From page 10 Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for 1 (R209) out of 52 sampled residents, the facility failed to consult with the resident's physician when R209 repeatedly refused a physician-ordered treatment. Findings include: Cross refer to F695 The facility's policy entitled "Refusal of Medications and Treatments", last revised on 1/18/19, stated, "...Guidelines: In order for a resident to exercise their right appropriately to make informed choices about care and treatment or to refuse treatment, the facility, provider and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. Documentation pertaining to a resident's refusal of medication, treatment, or procedures should include: What the resident is refusing. The reasons for refusal, if known. Advising/educating the resident/responsible party about risks/consequences of refusal (i.e. deterioration in condition). Physician notification and response. Steps that were taken to address the resident's concerns and alternatives that were offered...". Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/21/19 - A physician's order stated for R209 to wear BIPAP every night with 3 liters of oxygen. 6/22/19 at 7:22 AM - A nurse's note stated,	F 580	F580 Notify of Changes A. R209 was discharged from the facility. B. All residents that refuse a Physician ordered BiPAP have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. A root cause analysis determined that nursing failed to notify the Physician after a resident refused to wear a BiPAP. It was determined that the facility failed to have a system in place to track refusals and notify the Physician when a refusal was documented. As a result, the facility Unit Manager/Supervisor will review the 24 hour facility activity report daily to review any resident care refusals. The audit will include assuring the Physician was notified for additional orders. D. The Director of Nursing/Designee will audit the facility activity report for residents who refuse physician ordered services and notification of Physician daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly for three consecutive weeks or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed in the Quality Assurance Committee.	

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F 580	Continued From page 11 "...Resident put on CPAP some of the night and took off because (R209) felt like it was too 'heavy' on (his/her) face. Resident states (he/she) will have family bring in the mask (he/she) uses...". 6/22/19 through 6/28/19 - Review of R209's eTAR revealed that nursing staff were documenting BIPAP "Refused" every night for a total of 6 nights. 6/21/19 through 6/27/19 - Review of 209's clinical record lacked evidence that the resident's physician was notified of R209's repeated refusals of a physician-ordered treatment of wearing BiPAP every night. 9/3/19 at 8:30 AM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to consult with the resident's physician when R209 repeatedly refused a physician-ordered treatment until a critically high lab result was received and reviewed by E4 (NP). 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		11/11/19

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F 585	Continued From page 12 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585		

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F 585	Continued From page 13 receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and	F 585		

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F 585	Continued From page 14 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for 1 (R212) out of 52 sampled residents, the facility failed to ensure that corrective action was taken as a result of R212's grievance on 6/24/19, specifically addressing the nurse's lack of response when R212 was experiencing breakthrough pain and requested pain medication. Findings include: Cross refer to F697 The facility's policy entitled "Grievances", last revised on 10/12/18, stated, "...Procedure: ...f. Any corrective action taken or to be taken by the facility as a result of the grievance...". Review of R212's clinical record revealed: 6/13/19 - R212 was admitted to the facility for short-term rehabilitation. 6/13/19 - A physician's order stated to give R212 PRN Tylenol for pain every 6 hours. 6/19/19 - R212 was care planned for the potential for pain with approaches that included, but were not limited to the following: administer pharmacological pain interventions as ordered, ensure ordered therapy interventions are administered and notify physician of uncontrolled pain.	F 585	F585 Grievances A. No corrective actions could be taken for R212 since she was discharged on June29, 2019, prior to the survey. B. All residents have the potential to be affected by the failure to appropriately respond to grievances related to pain management. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The root case analysis determined that the nurse failed to administer the medication in a timely manner and failed to consult with the physician when the medication for breakthrough pain was ineffective. All grievances related to pain will be brought through morning meeting and will be reviewed for appropriate corrective action and/or effectiveness of the action. D. The Director of Nursing or designee will randomly audit progress notes to evaluate if nurses are documenting their assessments after other disciplines clinical concerns. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100%	

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F 585	Continued From page 15 6/24/19 at 2:12 AM - Review of R212's eMAR revealed that the resident received PRN Tylenol for a pre-pain level assessment of 10/10 (worst possible pain). The post-pain level assessment was 0/10 (no pain); the pain medication was effective. 6/24/19 - A facility's Resident Concern/Compliment Form stated, "...(checked) concern...Brief Description: pt. asked for pain medication at 7am; nurse brought all medications at 8:10; resident requests that when (he/she) asks for pain medication (he/she) gets it right away and doesn't want to wait for (his/her) other medications until after...Dept. Head Response: Resident seen by DON (E2) and ADON (E3) on 6/24/19. Resident also evaluated by (E48, MD name). Plan of care updated to include routine Tylenol BID and PRN as well. Resident agreed to plan of care, daughter was present as well as social worker (name). We apologized for (him/her) having to wait for the tylenol, (he/she) did accept the apology...Preventative Measures Enacted (provide specific details): (blank)...". Despite the 6/13/19 physician's order that stated to give Tylenol every 6 hours and R212's request for pain medication 5 hours after the last Tylenol dose was administered, E49 (RN) failed to consult with the physician about R212's breakthrough pain and hisher request for PRN pain medication at 7 AM. R212 waited for over one hour to receive PRN Tylenol. 6/24/19 at 8:15 AM - Review of R212's eMAR revealed that the resident received PRN Tylenol for a pre-pain level assessment of 6/10 (severe pain). The post-pain level assessment remained at the same level of 6/10 and the pain medication was not effective.	F 585	compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 585	Continued From page 16 6/24/19 at 4:39 PM - R212's physical therapy daily treatment note stated, "...Resident is frustrated because nurse did not provide (his/her) pain medication on time. Communicated to 7-3 pm nurse, (he/she) reported 'patient has every 6 hours order for pain medication, patient had pain medication this morning @ 8AM'...". 9/3/19 at 8:30 AM - Finding was reviewed with E1 (NHA) and E2 (DON). For R212, the facility failed to ensure that corrective action was taken as a result of R212's grievance on 6/24/19, specifically addressing the nurse's lack of response when R212 was experiencing breakthrough pain and requested pain medication. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		11/11/19

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F 656	Continued From page 17 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for three (R19, R51 and R58) out of 50 sampled residents reviewed, the facility failed to develop and implement a comprehensive care plan to include: R19's family and their non compliance with transferring R19 using the Hoyer (a sling-type hydraulic lift) and ceiling lifts, R51's refusal to have labs drawn, and R58's chronic pain. Findings include: 1. Review of R58's clinical record revealed:	F 656	F656 Comprehensive Care Plan (1) R19 A. Resident R19 no longer resides in the facility. No corrective actions could taken prior to her discharge. B. All residents who have responsible parties/family members that disregard transfer orders and act independent of facility recommendations may have care plan approaches that fail to address their noncompliance. Future residents will be protected from this deficient practice by	

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F 656	Continued From page 18 6/24/19 - R58 was admitted to the facility with diagnoses that included chronic pain syndrome. 8/8/19 - physician orders for R58 included: Oxycodone 10 mg every 6 hours for pain OxyContin 20 mg ever 12 hours for pain, Lidocaine pain relief patch once a day, Check pain every shift, and Non-pharmacological pain interventions attempted during each shift. A care plan for R58 with problem start dates beginning 6/25/19, and last revised 8/21/19 revealed no evidence of a care plan for pain. On 8/26/19 at 1:34 PM, during an interview, E17 (RNAC) stated the floor nurse would do a 48 hour care plan when the resident was first admitted. On 8/26/19 1:44 PM, during an interview, E8 (UM) stated that a care plan for pain should have been done and he/she would update R58's care plan. The facility failed to develop a pain management care plan for R8 who was prescribed routine narcotic pain medication. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM. Cross refer F684, example #1 2. A facility policy entitled Refusal of Medications and Treatments, (last revised 1/18/19), included: The resident's care plan should address the refusals, non-compliance/non-adherence to the recommended care; and the approaches	F 656	taking the corrective actions outlined below in Section C. C. The root cause analysis determined that the administrative staff were unaware of the extent of the resident□s family□s independent actions, as they were discovered at the time of the survey. The staff members had discussed with the son that family was not permitted to transfer the resident, but failed to care plan the approach. The Unit Managers/RNACs will be educated to Care Plan when the family is non-compliant with care approaches. The comprehensive care plan will state approaches that were taken by the facility to address compliance. D. Care plans for noncompliance will be initiated for residents and/ or responsible parties/ family members that prefer to disregard physician orders. The RNAC/ designee will audit care plans to determine if care plans for noncompliance are initiated when needed. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (2) R51 A. Review of resident R51□s care plans revealed that he had multiple care plans dating back to at least 2016 addressing his refusal of care, refusal of therapy and	

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F 656	Continued From page 19 implemented to address the refusals. Review of R51's clinical record revealed: 10/17/14 - R51 was admitted to the facility with paraplegia, chronic respiratory failure and was dependent on mechanical ventilation related to a motor vehicle accident. 6/14/19 - R51's physician orders included the following blood tests: Ferritin, Iron, TIBC, Transferrin Sat. Folate, and B12 level. Special Instructions: low Hemoglobin. R51 refused the blood draw for these labs on 6/15/19. 6/21/19 - R51's physician' order included the following blood tests: (H&H) Hemoglobin and Hematocrit. Again R51 refused for the labs to be completed. R51's Behavioral Symptoms Care Plan Problems included: 2/5/16 - Potential for safety hazard to self: refusing prescribed medications as ordered. 2/5/16 - Resistance to care: Verbally refuses showers, wound care dressing changes, getting out of bed, prescribed weight, refusing to turn and reposition every 2 hours, and trach care. 7/13/17 - Resistance to care: Verbally refuses showers. 7/27/17 - Resistance to care: Verbally refuses showers and requires air filtration system within room. 2/6/19 - Potential for non-healing wound or worsening wounds as evidenced by non-compliance with prescribed treatment and treatment scheduled.	F 656	prescribed treatments. The care plan did not specifically address his refusals for lab studies. On 9/4/19 the resident□s care plan was revised to include refusal of labs. A revided care plan was added to address that the resident prefers to be non-complaint and to refuse prescribed orders. B. Residents that prefer to be noncompliant/ or refuse various aspects of physician orders related to their care have the potential to be affected by a lack of specificity of a care plan. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Residents that refuse lab work will be reviewed to assure that their care plans address this specific preference for noncompliance or refusal of lab studies. The resident□s care plan will address approaches of education related to risk associated with refusing. The RNACs will review comprehensive care plans to assure that the care plans for non-compliance and refusals are specific to the individual resident. D. The RNAC/designee will audit the comprehensive care plans for residents that prefer to be noncompliant and/or refuse orders for lab studies. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice	

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F 656	Continued From page 20 R51's care plan did not address R51's refusal of labs, including interventions to aid in compliance to having blood work completed. The facility failed to care plan for R51's refusal of labs, including approaches implemented to address the refusals. 3. Review of R19's clinical records revealed: 2/24/17 - R19 was admitted to the facility with diagnoses including weakness and inability to walk in the usual way due to problems with the legs and feet. 4/29/17 at 3:15 PM - A progress note documented that, "Resident was observed on the sling above the bed. Son had disconnected the tube feeding and was using the lift to transfer his mother into the geri chair (wheelchair type- chair that reclines). A CNA (Certified Nurse's Aide) went into the room to assist and they refused. Family was aware that it is unsafe for them to transfer the resident without assistance. Supervisor made aware(sic)." 7/6/18 - A physician's order was entered by physical therapy for "Transfer Care Plan: Resident is 2 person assist rolling side to side, Hoyer lift machine with...transfers bed to wheelchair..." 8/14/18 - A physician's order was entered for R19 to be OOB (out of bed) in geri chair for 1-2 hour(s)/day as tolerated 3 times a week as tolerated on Mondays, Tuesdays and Thursdays between 3:00 PM - 11:00 PM. 8/23/19 at 8:49 AM - Review of R19's annual and	F 656	will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (3) R58 A. Resident R 58 was admitted to the facility with a diagnosis of chronic pain. A pain care plan was initiated during survey when it was determined that the care plan not been previously been developed. This resident has been discharged. B. All residents who have prescribed pain management approaches are at risk for not having an individualized plan of care to address their needs. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. A root cause analysis determined that the staff had failed to initiate a baseline care plan at the time of admission. The facility will institute the review of baseline care plans upon their completion. This will be done in morning meeting by the interdisciplinary team. D. The Social Service Director/ designee will audit the 48 hour care plans for completion and accuracy based on diagnosis. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 656	Continued From page 21 quarterly MDS (Minimum Data Set) assessment in March and June 2019 revealed that R19 was totally dependent and required two + person physical assist with transfer. 8/20/19 at 3:13 PM - During an interview, R19's son revealed to the surveyor that the family has been transferring R19 from the bed to the geri chair using the hoyer and the ceiling lift machines since R19 was admitted to the facility on 2/24/2017. 9/4/19 at 9:22 AM - Review of R19's clinical records revealed no evidence of a comprehensive person - centered care plan that included approaches addressing R19's family and their continued non - compliance with using the hoyer and ceiling lift machines to transfer R19.. 9/4/19 at 10:00 AM - Findings were discussed with E1 (NHA) and E2 (DON). Findings were reviewed during the exit conference on 9/4/19 at 7:30 PM with E1 and E2.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for two (R29 and R53) out of 52 sampled residents, the facility failed to meet professional standards of quality. For R29, the	F 658	F658 Service Provided Meet Professional Standards (1) R29 A. R29 had an acute change in	11/11/19

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F 658	Continued From page 22 nurse failed to document an assessment after being told that the resident had a decline in status on 12/18/18. For R53, the nursing staff failed to question R53's incorrect parameters on his PRN hydralazine order during their 24-hour chart checks from 4/4/19 to 8/27/19. In addition, on 4/8/19, R53's blood pressure was 179/83, R53 did not receive his/her ordered PRN Hydralazine, and the facility failed to clarify the physician ordered parameter. Findings include: The facilities policy titled, Documentation Guidelines, Revised 5/17/19, stated, "Resident care delivered is entered into the medical record legibly and timely...Progress notes should be entered during the shift care is delivered..." 1. Review of R29's clinical record revealed: 11/29/09- R29 was admitted to the facility with diagnoses including persistent vegetative stated and chronic respiratory failure. 12/18/18 5:05 AM- A progress note by E25 (RT) documented that R29 was very diaphoretic and was wiped at least 3 times and each time beads of sweat immediately reappeared. R29's heart rate was noted to be elevated at 116 and his/her respiratory rate was noted to be elevated at 24. E25 stated that the nurse, E24 (RN), was notified of E25's findings. 12/18/18 5:05 AM- 7:37 AM- Review of R29's clinical record revealed no evidence that E24 (RN) performed an assessment on R29 after receiving notification of a change in R29's status by E25 (RT). 12/18/18 7:38 AM- Review of R29's progress	F 658	condition. Although assessed at the time by the nurse, no supportive documentation was located in the medical record. R29 was sent to the hospital for evaluation related to an acute onset. B. All residents have the potential to have an acute significant change in condition. All residents may be impacted by failure to document assessments. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in section C. C. The root cause of this deficient practice was determined to be that the nurse charted by exception. The nurse found that the assessment was normal and therefore did not document it in the medical record. Nurses will be educated that anytime a clinical concern is brought to their attention, the assessment needs to be documented, even if the findings are normal. D. The Director of Nursing or designee will randomly audit progress notes to evaluate if nurses are documenting their assessments after other disciplines clinical concerns. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

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F 658	Continued From page 23 notes revealed that E26 (RN) stated that R29 was diaphoretic with a heart rate of 128, BP 130/93, temperature of 98.1. E26 documented that R29's abdomen was distended and firm with hypoactive to no bowel sounds. E26 documented that the NP was notified and a stat EKG and KUB was ordered. 12/18/18 8:22 AM- A progress note by E26 (RN) stated that R29's respiratory rate was now 38-40 and his/her bilateral lower extremities (legs) were mottled in appearance and cold to touch. The NP was notified and assessed the resident and ordered to send R29 to the Emergency Department (ED). 9/4/19 5:01 PM- An email from E24 (RN) to E2 (DON) stated that E25 (RT) mentioned that R29 looked diaphoretic and that she (E24) went to assess R29 like always after respiratory comes to her about a resident. E24 stated that she removed R29's covers, turned down the room temperature, and repositioned R29. E24 stated that since nothing was out of the ordinary she did not chart in R29's medical record. At the end of the shift during bedside report was when E26 (RN) noticed that R29 looked different. The facility failed to meet professional standards of quality as evidenced by E24's (RN) failure to document an assessment and care provided to R29 on 12/18/18 per the facility documentation policy. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). 2. Review of R53's clinical record revealed:	F 658	(2) R53 A. R53 was not negatively impacted by failure to administer the hydralazine. Per review of his records, he had one episode of hypertension, but was asymptomatic. B. All residents with orders for PRN antihypertensive medications have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #3. C. The root cause analysis determined to be that the order was not ordered correctly and the nurses did not accurately complete the 24 hour chart checks. All PRN antihypertensive medications will be reviewed for order accuracy and use of less than and greater than symbols. All nurses will be educated on completing 24 hours chart checks and how a PRN antihypertensive order should be written. D. The Director of Nursing or designee will randomly audit PRN antihypertensive medication orders for order accuracy including parameters and use of greater than and less than symbols. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 658	Continued From page 24 11/25/09- E53 was admitted to the facility with diagnoses including hypertension. 4/4/19- A physician's order was entered for R53 to receive Hydralazine (medication to treat high blood pressure) 25 mg 1 tab orally every 12 hours PRN (as needed) for a systolic blood pressure (BP) less than (<) 170. 4/4/19 1:42 PM- A physician's observation progress note stated that for hypertension R53 had an order for "Hydralazine PRN for systolic BP > (greater than) 170." 4/4/19-4/8/19- Review of R53's EMAR/ETAR revealed that nurses signed off every night that they did a 24-hour chart check. There was no evidence in R53's clinical record that any of the nursing staff that reviewed R53's chart questioned his/her PRN Hydralazine order. 4/8/19- Review of R53's EMAR/ETAR showed on 4/8/19 at 8:00 AM that R53's BP was 179/83. R53's systolic blood pressure was greater than 170, but R53 never received his/her PRN Hydralazine and nursing staff did not question the order. 4/9/19-5/23/19- Review of R53's EMAR/ETAR revealed that nurses signed off every night that they did a 24-hour chart check. There was no evidence in R53's clinical record that any of the nursing staff that reviewed R53's chart questioned his/her PRN Hydralazine order. 5/23/19- A physician's observation progress note stated that for hypertension R53 had "Hydralazine PRN for systolic BP >170."	F 658		

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F 658	Continued From page 25 5/23/19-8/27/19- Review of R53's EMAR/ETAR revealed that nurses signed off every night that they did a 24-hour chart check. There was no evidence in R53's clinical record that any of the nursing staff that reviewed R53's chart questioned his/her PRN Hydralazine order. 8/28/19- Review of R53's physician orders revealed that R53's PRN hydralazine order still stated to administer every 12 hours PRN if R53's systolic BP was < (less than) 170. 08/28/19 10:22 AM- During an interview, E9 (RN) stated that the hydralazine order must be a mistake and that she would talk to the ordering NP. The facility failed to meet professional standards of quality as evidenced by the nursing staff's failure to question R53's incorrect parameters on his/her PRN hydralazine order during 24-hour chart checks from 4/4/19 to 8/27/19. In addition, on 4/8/19, R53's blood pressure was 179/83, R53 did not receive his/her ordered PRN Hydralazine, and the physician was not questioned about the ordered parameters. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		11/11/19

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F 684	Continued From page 26 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for two (2) (R51 and R84) out of four (4) sampled residents reviewed for hospitalization and one (1) (R209) out of three (3) sampled residents for nutrition, the facility failed to ensure that residents received the treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. For R51, the facility failed to notify the physician/nurse practitioner of refusal of ordered labs, failed to re-educate R51 about the health risks of refusing labs, and failed to re-attempt to obtain the labs during a 39 day span. The facility failed to adequately assess and monitor the amount of blood loss from R51's wounds. This failure resulted in harm when R51 was hospitalized from 7/24/19 to 8/3/19 for blood transfusions and treatment for critically low Hemoglobin and Hematocrit levels. For R84, the facility failed to identify and treat a right foot wound on a resident that was susceptible to chronic wounds and infections until it was infested with maggots on 6/24/19 requiring hospital evaluation and treatment. For R209, the facility failed to follow the resident's plan of care to obtain a weight on 7/24/19 as per a 7/17/19 physician's order. For R84 and R209 there was no evidence to support harm level deficiencies. Findings include: A facility policy entitled Refusal of Medications and Treatments (last revised 1/18/19) included: Documentation pertaining to a resident's refusal	F 684	F684 Quality of Care (1) R51 A. R51 was transferred to the hospital related to a low hemoglobin level related to chronic anemia. The resident frequently refused lab studies which may have revealed the decrease in hemoglobin levels at an earlier date. B. All residents that are noncompliant with lab studies have the potential to be impacted by an incomplete clinical picture, lack of education on risks of refusing, lack of physician notification of refusals and failure to reattempt the lab. Future residents will be protected by taking the corrective actions outlined below in Section C. C. The root cause analysis determined that this resident has an extensive history of refusals of various aspects of care including lab studies. There was lack of supportive documentation of refusals and notification of the physician in the medical record. All nurses will be educated on the facility policy entitled Refusal of Medications and Treatments. D. The Director of Nursing or designee will audit the facility administration history report for refusals and supportive documentation including physician notification. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100%	

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F 684	Continued From page 27 of medication, treatment, or procedures should include: -What the resident is refusing. -The reasons for the refusal, if known. -Advising, educating the resident/responsible party about risks/consequences of refusal (i.e.: deterioration in condition). -Physician notification and response. -Steps that were taken to address the resident's concerns and alternatives that were offered. -For on-going refusals documentation should include: All the efforts made by the facility and the care team to render care; and encourage compliance and consideration of alternatives. The resident's care plan should address the refusals, non-compliance/non-adherence to the recommended care; and the approaches implemented to address the refusals. Review of R51's clinical record revealed: 10/17/14 - R51 was admitted to the facility with paraplegia, chronic respiratory failure and dependence on mechanical ventilation related to a motor vehicle accident. 4/19/19 - An annual MDS assessment documented that R51 was independent with decisions. 6/1/19-7/24/19 - R51's nursing progress notes lacked evidence of assessing and monitoring the resident's blood loss from his wounds. 6/13/19 - R51's physician orders included the following blood tests: CMP, Lipid Profile, HgbA1c, and CBC. 6/13/19 - R51's lab results revealed that R51's	F 684	compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (2) R84 A. R84 was assessed upon identification of the infestation of the wound and was transferred to the hospital for evaluation and treatment. R84 returned from the hospital. Wound care continues based on provider□s orders. B. All morbidly obese residents with chronic stasis ulcerations and lymphedema are at risk for infection. The facility has provided a Skin IQ negative airflow mattress cover to provide moisture control. The following measures have been instituted to improve identification of infectious processes for residents with these conditions. A licensed nurse will conduct bi-weekly skin assessments in place of weekly skin assessments for this resident and residents that present with similar characteristics (morbid obesity with lymphedema and chronic stasis ulcerations). C. The root-cause analysis determined that there was a documentation error by the aide related to skin checks but it is not determined if this directly impacted the notification of the nurse to a potential infectious process. The resident□s size and complexity of her condition would make it difficult for an unlicensed individual (Certified nurse	

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F 684	Continued From page 28 Hemoglobin was 7.0, and Hematocrit was 21.4. (Normal Hemoglobin and Hematocrit lab values per the facility contracted lab results were: Hemoglobin 13.5-17.5 and Hematocrit 37.5-55.5.) 6/14/19 - R51's physician orders included the following blood tests: Ferritin, Iron, TIBC, Transferrin Sat. Folate, and B12 level. Repeat H&H (Hemoglobin and Hematocrit) in one week. Special Instructions: low Hemoglobin. 6/15/19 - Although it was noted on the facility's contracted lab log that R51 refused to have the 6/14/19 ordered labs drawn (the following day) and the lab tech advised the facility nurse, R51's clinical record lacked evidence that: R51 refused the ordered labs to be drawn; that the facility educated R51 of the risks of refusing labs related to critical lab values; that the physician/practitioner was consulted about R51's refusal for the ordered labs; that any steps were taken to address R51 to feel more comfortable/compliant for lab draws (such as a familiar staff member was present during the procedure). The physician orders, nursing and physician/practitioner progress notes also lacked evidence of re-attempting to obtain labs from R51 after the 6/15/19 refusal. 6/21/19 - R51's physician's orders included the following blood tests: H&H (Hemoglobin and Hematocrit). 6/21/19 - It was noted on the facility contracted lab log that R51 refused to have the ordered labs drawn and that the tech notified the facility nurse. The facility's daily report and midnight census report documented that R51 refused ordered labs and stated the NP was notified. Although this	F 684	aide) to detect and report a change in the resident□s skin/ ulceration. Based on this root-cause the facility will initiate biweekly skin assessments to be performed by a nurse. This will promote identification of changes in this residents (and similar residents) skin ulcerations that may indicate infection. D. The facility wound nurse/designee will audit the biweekly skin assessments to determine compliance and documentation of skin conditions. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (3)R209 A. R209 was not adversely impacted by the failure to obtain weights per physician□s orders. Her BMI remained above ideal body weight and her weight stayed within her care planned goal. B. All residents have the potential for unrecognized weight loss by failure to obtain weights per physician□s orders. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The Root cause analysis determined that the Nurse Practitioner tasked the	

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F 684	Continued From page 29 information was recorded on in-house tools, R51's clinical record lacked evidence of R51's refusal to have the ordered labs drawn, re-education of consequences of refusal on resident's health status, that the physician or nurse practitioner was consulted, any steps that were taken to address the resident's concerns and alternatives that were offered, or a re-attempt to obtain the ordered labs. The facility lacked evidence of a system to ensure that the refusals that were noted on the contracted lab sign-off sheet were documented in the clinical record, and a method to ensure that the physician or nurse practitioner was consulted when blood draws were refused. Review of R51's physician orders lacked evidence of a standing order for weekly H&H's (Hemoglobin and Hematocrit blood levels). The lab orders for 6/14/19 and 6/21/19 were one time orders which resulted in not attempting to obtain another H&H in a timely fashion. 6/21/19 - The lab result from the contracted lab documented that the lab draw was refused, however, the lab sheet lacked evidence that a practitioner reviewed the result sheet or was consulted related to the refusal of the lab. The lab result paper hard copy provided by the facility was unsigned and undated. 6/22/19 - Again it was noted in the contracted lab log that R51 refused to have (H&H) Hemoglobin and Hematocrit blood tests and that the tech "told nurse." The clinical record lacked evidence of consultation with the physician or nurse practitioner and further re-attempts to obtain the labs. 7/23/19 - Although a progress note written by E4 (NP) documented that R51 refused labs, the	F 684	order in the electronic health record for weights inaccurately which prevented the nurses from completing the order. Providers will be provided a visual tool of how to correctly order weights by the staff educator D. The Dietician or designee will audit physician ordered weights for appropriate tasking to the electronic medication administration record. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 684	Continued From page 30	F 684		

practitioner's notes and review of the June 2019 orders lacked evidence of E4's knowledge of the particular dates and labs that R51 refused, and any re-attempts to obtain R51's labs. R51 was compliant with having labs drawn on 6/13/19 and 7/24/19, one day after the 7/23/19 nurse practitioner's progress note documented that R51 "refuses labs".

7/24/19 - R51's physician orders included the following blood tests: BMP, CBC, Iron, Ferritin TIBC, Transferrin sat, Folate and Vitamin B12 level.

The clinical record lacked evidence of consultation with the physician or nurse practitioner regarding the status of R51's labs and R51's refusal to consent to lab draws on 6/15/19 and 6/21/19 until 7/24/19 when the labs were re-ordered by E4 (NP), 39 days after the initial refusal on 6/15/19.

7/24/19 - R51's lab results revealed a Hemoglobin of 6.0 and a Hematocrit of 18.5 (down from a Hemoglobin of 7.0 and a Hematocrit of 21.4 on 6/13/19).

7/24/19 4:30 PM - A nursing progress note documented that (R51) was sent to the ER for a critical Hemoglobin of 6.0 and a Hematocrit of 18.5.

7/24/19 5:57 PM - A progress note written by E5 (NP) lacked evidence of knowledge of the resident's previous refusals of the 6/15/19 and 6/21/19 ordered lab draws.

7/24/19 - A hospital record History and Physical physician's note revealed:

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F 684	Continued From page 31 (R51) "is a 67 year old male patient with past medical history of paraplegia and ventilatory (sic) dependent, respiratory failure secondary to motor vehicle accident, ... chronic anemia, ...chronic decubitus ulcer who was sent from his long-term skilled nursing facility for low hemoglobin of 6.0. He was found to have blood oozing from his wounds. Acute on (sic) chronic blood loss anemia. This is likely secondary to blood loss from patient's wound. Homeostasis was achieved. Patient received 1 unit of blood transfusion. Monitor H&H (Hemoglobin and Hematocrit)." 7/24/19 - A hospital record physician's note included: "Skin: Numerous decubitus ulcers on his backside, with thick granulation tissue, with 2-3 areas of persistent bleeding with minimal agitation. I injected with lidocaine with epinephrine, attempted silver nitrate cautery but defaulted to hot dressing followed by 4 x 4's. This seemed to abate the bleeding. When he first came in ...posterior dressings were changed and we discovered numerous clots." 8/1/19 3:40 PM - R51's hospital discharge summary included: " He presents in a setting of anemia and bleeding from his chronic wounds sent from his long-term skilled nursing facility. Patient's anemia has been treated with 3 total units of blood throughout his stay." 8/3/19 - R51's discharge diagnosis from the hospital was acute on (sic.) chronic blood loss anemia bleeding from wound and multiple wounds.	F 684		

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F 684	Continued From page 32 8/26/19 1:35 PM - During an interview with E6 (Corporate Nurse), it was confirmed that there were physician orders for labs on 6/13/19, 6/14/19, 6/21/19 and 7/24/19 and that R51's record lacked evidence of lab results for the 6/15/19 and 6/21/19 orders. 8/27/19 10:10 AM - During an interview with E7 (RN, UM), it was confirmed that the clinical record lacked evidence of refusals of labs in the progress notes for 6/15/19 and 6/21/19, and there were no lab results for those dates. E7 confirmed that the same labs (from 6/15/19 and 6/21/19) were re-ordered on 7/24/19. 8/27/19 10:34 AM - During an interview, E4 (NP) reported that R51 often refused care, but did not know if E51 had refused the labs or not on 6/15/19 and 6/21/19. E4 stated that the labs were re-ordered related to lack of evidence of lab results for 6/15/19 and 6/21/19 in the medical record. 8/27/19 10:46 AM - During an interview, E3 (ADON) reported that sometimes the lab tech would go to nursing and report refusals for lab draws to see if staff can go in and explain the need for the labs, and encourage the resident to let the labs be drawn. The clinical record lacked evidence of that approach/intervention and/or that the nurse consulted the physician/practitioner. E3 added that the lab techs do not always report refusals to the nurse and the lab tech will make note of the refusals in the lab sign-off log. E3 confirmed that it was the expectation of facility nurses to re-attempt to complete the labs, consult the physician/practitioner, and complete a nursing progress note.	F 684		

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F 684	Continued From page 33 8/27/19 11:10 AM - During an interview with E1 (NHA) and E2 (DON), E2 presented the surveyor with physician, nurse practitioner and nursing progress notes, and stated there was documentation that R51 refused care and labs at times, but confirmed there were no specific dates of the lab refusals. E2 reported that it was common for R51 to refuse care. E2 confirmed there was a lack of evidence of R51's refusal of labs, physician/nurse practitioner notification, and interventions to re-attempt the lab draws in the nursing progress notes on 6/15/19 and 6/21/19. Review of the resident record revealed lack of evidence of any orders to re-attempt to draw the 6/15/19 and 6/21/19 ordered labs. E2 reported that E4 (NP) was at the facility every day, and staff report "those things" directly to E4 when at the facility. The clinical record lacked evidence that R51's refusals of the 6/15/19 and 6/21/19 labs were reported to E4 and or any other physician or nurse practitioner until 7/24/19 when E4 gained knowledge that there were no lab results for those days. The facility failed to notify the physician/nurse practitioner of R51's refusal of ordered labs, failed to re-educate R51 about the health risks of refusal of labs, failed to obtain further orders after the refusal of labs, failed to re-attempt to obtain the labs, and failed to accurately assess and monitor R51's blood loss from the resident's wounds (from 6/1/19-7/24/19) which resulted in R51's hospitalization from 7/24/19 to 8/3/19 for blood transfusions and treatment for critically low Hemoglobin and Hematocrit levels. 2. Review of R84's clinical record revealed: 1/5/17 - R84 was admitted to the facility.	F 684		

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F 684	Continued From page 34 4/28/19 - R84 was care planned for actual MASD of right posterior thigh to buttock and left posterior thigh (back of thigh) with approaches that included skin checks every 2 hours and turn and reposition every 2 hours and as needed. 6/24/19 - Review of R84's clinical record lacked evidence that a skin integrity issue and/or wound was identified on R84's right foot or if a current treatment was in place. 6/24/19 at 1:58 AM - Review of the CNA Point of Care History report revealed that E50 (CNA) signed off that he/she completed "Skin checks every 2 hours and report any changes to the nurse" AND "Turn and Reposition every 2 hours" during the 11 PM to 7 AM shift. It was unclear how E50 could sign off both of these tasks as "Done" only 3 hours after his/her 8 hour shift started. 6/24/19 at 11:41 AM - A nurse's note stated, "Resident noted with maggots to right foot during am/wound care at 1000 am. Right foot flushed by wound nurse. E48 (MD's name) at facility and informed of new development. E4 (NP's name), examined resident with this nurse. One maggot still visible. Right lower extremity red with increase edema (swelling)....Received order to send to ER for evaluation for maggots...to right foot...". 6/24/19 at 4:22 PM - E4's (NP) progress note stated, "...Asked to eval (evaluate) due to increase erythema (redness) and drainage ble...Maggots found in wound right foot...". 6/24/19 at 7:41 PM - The hospital record's history	F 684		

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F 684	Continued From page 35 and physical stated, "...Patient is coming from a nursing home where (he/she) was found today to have maggots in (his/her) feet...(R84) has chronic wounds on her lower extremities secondary to bedbound state...". 6/24/19 at 7:45 PM - The hospital record progress note stated, "...Wound noted to bottom of R (right) foot, 6 cm x 3.5, red, hypergranulation tissue (excessive granulation filling a wound bed; tissue is raised) noted, area just above, yellow necrotic (dead tissue) skin flap, 14 maggots removed from this...". 6/25/19 at 12:13 PM - The hospital's infectious disease consult stated, "...Maggots in wounds...Patient has had difficulties with immobility, progressive lower body/LE (lower extremity) lymphedema and stasis ulcerations (venous wounds due to abnormal veins). Chronic ulceration right plantar lateral foot and right lateral calf more recently noted. (He/she) subsequently noted maggots on (his/her) feet yesterday...Patient notes that since admission overnight 18 more maggots were removed from (R84's) foot. (He/she) states 'I know there are flies around, I have a fly sweater (sic) at my bedside.'...Right foot...moderate-copious serous drainage...Assessment/Plan...Infestation, maggots...Important to keep wounds with drainage covered to prevent ongoing infestation...Additional Recommendation or Comments...admitted with progressive stasis ulcerations/maggot infestation, super infection (previous infection and develops another strain of infection on top of the first one) suspect right lower extremity/plantar foot...". 9/3/19 at 8:30 AM - Findings were reviewed with	F 684		

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F 684	Continued From page 36 E1 (NHA) and E2 (DON). The facility failed to identify and treat a right foot wound on a resident that was susceptible to chronic wounds and infections until it was infested with maggots on 6/24/19 requiring hospital evaluation and treatment 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 3. Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/29/19 - R209 was care planned for potential for alteration in hydration with an approach to obtain weights as ordered. 7/17/19 - A physician's order stated to obtain R209's weight on Monday, Wednesday and Friday once a day at 12:30 PM. 7/24/19 - Review of R209's clinical record lacked evidence that the resident's weight was taken on Wednesday, 7/24/19. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to follow R209's plan of care to obtain a weight on 7/24/19. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 684		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		11/11/19

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F 686 SS=D	Continued From page 37 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: Based on observation, record review and staff interview, it was determined that the facility failed to ensure that one (R4) out of three (3) residents reviewed for pressure ulcers, received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Findings include: The facility's undated Skin Integrity Manual stated, "...Cadia Healthcare Core Standards:..No lift devices for turning and repositioning...Consistent weekly wound rounds...Wound care nurse will document weekly assessment on the Weekly Wound Observation Form in the electronic health record (EHR). If the wound is assessed by a wound consultant, documentation is completed on their preferred form. Assessments are reviewed and signed by the Attending Provider and placed within the EHR...Skin Care...Resident should be turned and	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer A. R4 does not currently reside in the facility and will be reassessed upon readmission. No corrective actions could be taken. B. All residents with wounds have the potential to be impacted by failure to follow the wound nurse practitioner□s recommendations for labs, failure to complete weekly wound assessments, failure to administer treatments as ordered, and failure to take measures to prevent shearing. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined that there was no process in place for review of wound care consultant□s recommendations, completing weekly	

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F 686	Continued From page 38 repositioned based upon need. A draw sheet under resident is important to prevent shearing during bed mobility or transfers...". Review of R4's clinical record revealed the following: 11/09 - R4 was admitted to the facility. R4 had diagnoses that included ventilator dependent respiratory failure (VDRF), quadriplegia, anemia, protein calorie malnutrition and a Stage IV (4) pressure ulcer. 9/19/18 - A care plan for actual pressure ulcer, last reviewed 8/28/19, was developed and included interventions to "measure on weekly wound rounds...skin treatments as ordered...". A. 1/8/19 - The wound care consultant's note stated, "Recommend checking CBC, ESR, CRP, Prealbumin." Although the note was signed by the facility NP, it was undated and there was no evidence that an order was written to obtain the recommended blood work. There was no evidence that these blood tests were drawn at this time. 1/15/19 - The wound care consultant's note stated, "Recommend checking CBC, ESR, CRP, Prealbumin - results not available to me." The note was signed by the facility NP, but was undated. 2/5/19 - The wound care consultant's note stated, "Please obtain CBC, ESR, CRP, prealbumin...". The note was signed by the facility NP, but was undated.	F 686	wound assessments if not followed by wound care consultant, review of treatment administration records, and lack of assessment by rehab services to address shearing. A system change was made to ensure that all recommendations made by the wound care consultant are brought to the physician□s attention by the facility wound nurse and orders are obtained at that time. The facility wound nurses will be educated on their responsibility of implementing the recommendation and assuring documentation is in place for weekly wound assessments and ordered treatments. Nursing staff will be educated by the therapy director/designee on proper lift techniques to be used to prevent shearing. D. The Director of Nursing or designee will audit 5 residents with wounds for weekly wound assessments, implementation of recommendations, and administration of treatments. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 686	Continued From page 39 2/6/19 - Review of the EHR revealed that the recommended blood tests were drawn as first requested on 1/8/19, approximately one month prior. 9/3/19 - After an interview, E2 (DON) was only able to provide blood test results from 2/6/19. There were none available from around 1/8/19. B. Review of R4's Weekly Wound Observation Forms from 12/4/18 through 8/27/19 revealed that the weekly assessments were not completed according to the facility policy and procedure, and professional standards of practice on the following dates: 2/12/19; 3/28/19; 4/25/19; 5/9/19; and 5/23/19. 9/3/19 - Although other documents were provided by E21 (WCN), none were the Weekly Wound Observations Forms from the above listed dates. C. 4/9/19 - A physician's order stated to cleanse the wound bed with dakins (sodium hypochlorite solution used to kill germs and prevent germ growth in wounds), apply promogran (contains collagen which stimulates wound healing) to wound bed and cover with foam dressing three (3) times weekly and as needed. Review of R4's TARs lacked evidence that wound treatments were provided on 4/24/19 and 4/29/19. 9/3/19 10:53 AM - During an interview, E21 (WCN) stated that she did not work on 4/24/19 and 4/29/19, so she can not say why the treatment was not completed. D. On 8/28/19 from approximately 9:35 AM to	F 686		

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F 686	Continued From page 40 10:00 AM, R4's wound care was observed being provided by E20 (LPN) with E22 (CNA) assisting. After wound care was completed, E20 and E22 attempted to lift R4 up in the bed. Using a drawsheet, they were only able to get R4 up a short distance in the bed while causing R4's backside (area of the pressure ulcer) to slide against the mattress (shearing - sliding of tissue layers against one another). E20 and E22 did not utilize a no lift device, nor did they request more staff to assist in positioning R4 higher in bed without causing shearing. 9/4/19 8:23 AM - All of the above findings were reviewed with E1 (NHA) and E2 (DON).	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 by:	F 688		11/11/19

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F 688	Continued From page 41 Based on observations, interviews, and record review, it was determined that for one (R67) out of three sampled residents, the facility failed to ensure that R67 who had limited mobility, received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Findings include: Cross refer F842 Review of R67's record revealed: A facility policy titled Documentation Guidelines, effective July 2013 and revised May 17, 2019 stated: Resident care delivered is entered into the medical record legibly and timely. CNA's document care delivery electronically. Unit managers/designees are required to review CNA documentation daily and address inconsistencies. R67 was admitted to the facility on 10/13/17 with diagnoses that included stroke, paralysis, and tracheostomy (an opening made in the throat to assist with breathing). 7/5/19 - A physician's order stated that R67 was to wear a left, blue resting hand splint during the day only and then off at night to prevent finger contractures. 7/5/19 - A note written by E35 (OT) stated that R67 was assessed for proper fit of the left hand splint, a splint schedule and orders were written, staff were educated on reactivating orders for the left hand splint and questions were answered	F 688	F688 Increase/ Prevent Decrease in ROM/Mobility A. R67 was assessed by the Physiatrist and by the Physician on September 4, 2019 related to increased tone and spasticity. The resident□s muscle relaxant was increased. It has been determined that the left hand splint is not appropriate at this time. The resident has been placed on Occupational Therapy caseload. B. Residents with orders for splinting devices have the potential for contractures and/ or increase in contractures by not following physician orders. C. The facility determined that a certified nurse aide failed to follow the physician orders for splint application and documentation was inaccurate. The facility will make a system change to promote application of the splints. Orders for splints will be tasked to the certified nurse aide□s plan of care and the Electronic Treatment Record. This will assure that splints are applied and documentation accurately reflects the application. The nursing staff will be notified of this change via e-mail notification and unit huddles. D. The Corporate Consultant/ designee will audit the application of splints through visual confirmation and written documentation. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100%	

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F 688	Continued From page 42 regarding splint application. 7/20/19 - A quarterly MDS revealed that R67 was rarely understood and that he/she was totally dependent on staff for daily care. The number of days for splint assisstance was zero. 7/24/19 - A care plan for the problem that R67 wears a splint was edited with the approach to put on/take off the splint as ordered. 8/28/19 at 10:36 AM - It was observed that R67 did not have a left hand splint on. Review of the August 2019 Point of Care History for R67 to wear a left blue resting hand splint during the day only and then off at night, was documented as done 26 out of 28 days in August. 8/28/19 at 11:49 AM - It was observed that R67 did not have a left hand splint on. Review of R67's electronic medical record revealed that his/her hand splint was documented as on. 8/28/19 at 11:57 AM - During an interview, E12 (CNA) stated he/she was familiar with R67 and had not seen R67 with a hand splint on for "awhile". Upon searching R67's room, E12 was unable to find the hand splint. There were multiple days in August 2019 when E12 documented that R67's hand splint was on. When the surveyor pointed out to E12 that he/she had documented other instances of putting the splint on R67, E12 stated 'that must've been a mistake'. 9/3/19 at 9:11 AM - E36 (CNA) documented in the Point of Care documentation that R67's hand splint was on.	F 688	compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 688	Continued From page 43 9/3/19 at 9:39 AM - E37 (PT Director) was observed entering R67's room and he/she applied R67's left hand splint. 9/3/19 at 9:51 AM - E36 (CNA) amended the Point of Care documentaion to read that R67's hand splint was not done at 9:11 AM. 9/3/19 at 2:29 PM - During an interview, E36 (CNA) stated that she did not put the hand splint on R67 and did not put the hand splint on yesterday either. E36 stated that he/she mistakenly logged it in the Point of Care documentation. The facility failed to ensure that R67's left hand splint was on as ordered. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that for two (R19 and R84) out of three residents sampled for accidents, the facility failed to ensure that the residents environment remained as free of	F 689	F689 Free of Accident Hazards/Supervision/Devices (1) R19 A. R19 no longer resides in the facility and corrective action could not be taken.	11/11/19

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F 689	Continued From page 44 accident hazards as possible and that each resident received adequate supervision to prevent accidents. For R19, the facility failed to ensure that R19's transfers were safely performed by qualified clinical staff when R19's son reported that the family had been using the hoyer (a sling-type hydraulic lift) and ceiling lifts to transfer R19 from the bed to the geri chair (wheelchair type- chair that reclines). For R84, the facility failed to ensure R84's safety on 4/13/19 when R84 was turned on the resident's left side and staff left the room; R84's right leg started to fall forward causing the resident's entire body to completely fall forward and the upper bed rail gave way; the resident fell from the elevated bed to the tiled floor, resulting in a facial contusion, a grossly large hematoma on the right shoulder and upper arm and sustained a laceration (cut) on her right elbow. In addition, a medication cart was observed unattended with a pill and a syringe with a closed needle sitting on top of the Sharps container. Findings include: 1. Review of R19's clinical records revealed: 2/24/17 - R19 was admitted to the facility with diagnoses including weakness and inability to walk in the usual way due to problems with the legs and feet requiring the use of a hoyer lift for transfers. 8/20/19 at 3:13 PM - During an interview, R19's son revealed to the surveyor that the family has been transferring R19 from the bed to geri chair using the hoyer and the ceiling lift machines since R19 was admitted to the facility on 2/24/2017. 8/29/19 at 10:39 AM - During an interview, E12 (CNA) stated, "I see the family come in around	F 689	B. All residents have the potential to be impacted due to a lack of facility policy that states only facility clinical staff may operate mechanical lifts. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The root cause analysis revealed that the facility did not have a policy in place to adequately reflecting that only clinical staff may use mechanical lifts. A policy entitled Non-Facility Staff Use of Mechanical Lifts was written and reflects the facility□s stance that non-facility clinical staff may not operate mechanical lifts. A memo will be sent to all residents requiring mechanical lifts for transfers and their responsible parties notifying them of this new policy. D. The Director of Rehabilitation or designee will randomly audit residents requiring mechanical lifts for inappropriate use of the lifts. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (2) R84 A. R84 was sent to the hospital for evaluation and treatment after her fall on 4/13/19. She returned to the facility on 4/14/19. Upon her return the facility	

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F 689	Continued From page 45 7PM when I work on the 3-11 shift. They want him/her out of bed by then. They are very hands on with their mother's care. If they come and he/she is not out of bed yet, they will transfer him/her by themselves using the ceiling lift. The two sons are usually there. Sometimes they call the aide for help ...other times they do the transfer on their own (sic)." 8/29/19 at 10:50 AM - During an interview, E13 (CNA) stated that R19's two sons usually come on the 3-11 shift and are the ones getting R19 out of bed to the geri chair. E13 further stated that the sons do not ask for help. 8/29/19 at 11:02 AM - In an interview, E14 (CNA) stated, " When I work on the 3-11 shift, the son will ask me to help him transfer his mom from the bed to the geri chair." 8/29/19 at 4:27 PM - During an interview, E1 (NHA) stated that the facility has no policy on the use of hoyer and ceiling lifts. E1 further confirmed that only the clinical staff are qualified to perform lift transfers to residents and that families are not allowed to use the hoyer, ceiling and other lift machines in the facility during transfers. Findings were reviewed during the exit conference on 9/4/19 at 7:30 PM with E1 (NHA) and E2 (DON). 2. Review of R84's clinical record revealed: 1/5/17 - R84 was admitted to the facility. 1/5/17 - R84 was care planned for falls with approaches that included, but were not limited to, encourage resident to use handrails or assistive devices properly and keep bed in low/lowest	F 689	implemented the following interventions (1) resident not to be left alone during bowel movements; (2) bed in lowest position per manufacturer□s guidelines; and (3) bilateral fall mats. The resident has not experienced a similar event since the implementation of these measures. B. Per review of current residents, it was determined that no other residents are at risk of a similar event occurring. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The root cause analysis revealed that we failed to follow manufacturer guidelines for use of the bariatric specialty bed and that by following the resident□s preference of being alone for defecation the resident was at risk for falls. Due to the resident□s unique manner of defecating it was determined, with discussion with the resident, that a staff member would be present while the resident is defecating. D. The unit manager/designee will conduct random audits of R84 to determine if preferences for defecation were met. The measures that the facility has implemented after discussion with the resident have been determined to be successful. The resident has not experienced a fall event since this time. (3) Surveyor Observation of Staff A. No residents were impacted. Upon notification of surveyor□s observation, immediate corrective actions were taken to properly dispose of the syringe and the pill. B. All residents have the potential to be	

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F 689	Continued From page 46 position that is appropriate for resident. 2/8/19 - The quarterly MDS assessment stated that R84 was cognitively intact, had active diagnoses that included, but were not limited to dependence on a ventilator, morbid obesity, lymphedema of the bilateral lower extremities, was totally dependent with 2+ staff person physical assistance for toileting, and weighed 560 lbs. (pounds). 4/13/18 at 6 PM - A late entry nurse's note entered on 4/14/19 at 1:28 AM stated, "Resident found on the floor in her room by RT who went in to answer a stat call that came from (his/her) room, resident denied hitting (his/her) head on the floor, vital signs WNL (within normal limits) and no visible signs of respiratory distress noted, resident sustained skin tears B/L elbows. Head to toe assessment completed and together with the other staff we helped the resident into a sitting position, paged 911 stat for the ambulance and the resident was transferred to ER for further evaluation. pcp and poa both notified." 4/13/19 at 6:27 PM - A respiratory progress note stated, "I heard a stat page to resident's room at approx (approximately) 1725 (5:25 PM). I entered the room and found resident face down on the floor. I once again paged for more staff members to report to the room due to the large size and weight of resident. Resident was turned face up and Sats (oxygen saturation- amount of oxygen in the blood) were 97%/HR (heart rate) 80. Resident was awake and alert and talking. No respiratory distress noted at this time. Resident out with 911." 4/13/19 at 7:01 PM - According to the State Survey Agency's Incident Report, the facility	F 689	affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The root cause analysis determined that the nurse did not dispose of a syringe and pill. All nurses will be educated on facility policies entitled Disposal of Sharps, Disposal of Non-Controlled Medications, and Controlled Medication Storage and Disposal. Nurses will acknowledge understanding of this policy by signing an affidavit that they have read and understood. D. The Staff Educator will perform observational audits of all medications carts for appropriate disposal of sharps. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 689	Continued From page 47 stated, "Found resident laying on floor. Sent to hospital due to being on Coumadin (blood thinning medication)." 4/13/19 at 7:37 PM - The hospital ED (emergency department) physician record stated, " ...This patient arrived via EMS (Emergency Medical Services) at 1839 (6:39 PM) ...is at (name) nursing home today when (he/she) says they rolled (him/her) on (his/her) ...side against the rail for (R84) to go to the bathroom and then the staff left the room and the rail gave way and (R84) fell about 3 feet to the floor suffering an injury to (his/her) right upper arm and contusions to her right face without loss of consciousness ... has obvious contusions to her right face and a very large hematoma of her right upper arm ...". 4/14/19 at 12:36 PM - According to the hospital's discharge planning notes, the facility was not able to readmit R84 to the facility until his/her broken bed was fixed. 4/14/19 (untimed) - According to E40's (CNA) statement regarding the 4/13/19 incident, E40 stated, " ...Patient was on the floor but I didn't see (R84) falling. (R84) refused to lay on (his/her) back when the dinner trays were up ...". 4/17/19 (untimed) - According to the facility's 5-day follow up report to the State Survey Agency, the facility stated, "Resident was found on the floor in (his/her) room. Resident interview conducted on 4/15/19. Resident stated (he/she) was having a bowel movement when (he/she) felt (his/her) leg sliding and ...could not stop (his/her) weight from rolling and slid out the bed. Resident sent to the ED for evaluation and returned in less than 24 hours ...Root cause analysis determined	F 689		

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F 689	Continued From page 48 to be resident slid off bed because (R84) was unable to support ...own weight when lying on (his/her) side. Fall interventions (1) Staff present during bowel movements. (2) Bed in lowest position during bowel movements. (3) Fall mat to sides of bed." The facility's investigation failed to address anything about how and why R84's bed rail broke. 9/3/19 at 11:26 AM - During an interview, E51 (Maintenance Director) confirmed that R84's left bed side rail on his/her bariatric bed was replaced in April 2019. Review of the manufacturer's 2015 Operation Manual for R84's bariatric low bed stated, " ...Cautions and Warnings ...The bed should be left in the lowest position when unattended in order to reduce the risk of injury due to falls while getting into or out of bed, or while lying on the bed." 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure R84's safety on 4/13/19 when R84 was turned on the resident's left side and staff left the room; R84's right leg started to fall forward causing the resident's entire body to completely fall forward and the upper bed rail gave way; the resident fell from the elevated bed to the tiled floor, resulting in a facial contusion, a grossly large hematoma on the right shoulder and upper arm and sustained a laceration on the right elbow. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 689		

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F 689	Continued From page 49 3. 8/22/19 8:42 AM- E18 (RN) was observed walking away from a second floor medication cart. On the side of the medication cart there was a sharps container that had a pill and a syringe with a capped needle sitting on top where it was accessible to residents. E18 was half way down the hallway walking towards the nurse station and the medication cart was unsupervised. The surveyor stopped E18 and showed her the pill and syringe with the capped needle sitting on top of the sharps container on the medication cart. E18 (RN) confirmed the finding and pushed the pill and the syringe with the capped needle into the sharps container. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		11/11/19

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F 690	Continued From page 50 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, interview and review of facility documentation as indicated, it was determined that for one (R84) out of three (3) sampled residents for catheter care, the facility failed to ensure that a resident with an indwelling catheter received appropriate treatment and services as per the plan of care, as well as facility policy. Findings include: The facility's policy entitled "Appropriate Indwelling Catheter Use", last revised 1/14/19, stated, "...Residents with an indwelling catheter will receive daily catheter care...". Review of R84's clinical record revealed: 1/17/17 - R84 was care planned for use of an indwelling foley (brand of urinary catheter) catheter with approaches that included to check	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI a. It has been determined that the catheter leakage for R84 is due to a patulous urethra and it is a medical condition that cannot be resolved. The facility provided the resident with a specialty mattress overlay in an effort to reduce the moisture associated by the leakage. b. Female residents that have conditions requiring urinary catheter usage have the potential to be affected by this deficient practice. c. A root-cause analysis determined that the resident□s catheter leakage will continue. Additional measures were taken as the existing specialty mattress was not adequately controlling the	

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F 690	Continued From page 51 for leakage around the urethra every shift and as needed and monitor the collection bag for odor every shift and report findings to MD (Medical Doctor). 4/3/19 - The hospital urology consult progress note stated, "...states (he/she) does have leakage of (his/her) foley catheter which typically happens when tension is applied to the catheter tubing which occurs when the patient is turned...Patient with long-standing history of chronic indwelling foley catheter...(He/she) has chronic leakage of urine around the catheter which is not surprising as he/she most likely has a patulous (spread widely apart)urethra with some erosion of the catheter which is an expected finding when someone has had an indwelling catheter as long as he/she has. He/she states he/she does have significant leakage around the catheter at (nursing home name)...". 8/21/19 at 4:27 PM - During an interview with R84, this surveyor observed a strong urine odor. 8/28/19 at 8:33 AM - An observation revealed E47 (LPN) in R84's room wearing a PPE gown, gloves and a mask which was scrunched up under his/her nose and not covering his/her mouth. At 8:39 AM, this surveyor and another surveyor were standing in the hallway in front of R84's room and smelled a strong urine odor coming from the resident's room. 8/28/19 at 2:37 PM - An observation of this surveyor standing in the hallway revealed that a urine odor remained present, although not as strong as during the 8:33 AM observation. 8/29/19 at 7:57 AM - An observation of this	F 690	moisture around her legs and groin area. The facility has obtained a skin IQ negative air flow mattress cover to promote moisture control. A consult was placed with a surgeon to determine if the resident as a candidate for a suprapubic catheter. d. Observational auditing will be conducted by the Unit manager/ nursing designee to determine the presence of sustained moisture on or beneath the resident. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee	

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F 690	Continued From page 52 surveyor and another surveyor revealed a strong urine odor coming from R84's room. 8/29/19 at 10:30 AM - An observation by this surveyor revealed that even after R84 was provided morning care, there was still a strong urine odor while standing in the hallway outside of R84's door. 9/3/19 at 7:50 AM - An observation of this surveyor revealed a small puddle of fluid under the footboard of R84's bed. 9/3/19 at 9:52 AM - An observation of this surveyor upon entering R84's room to observe morning care revealed a strong urine odor. This surveyor observed a puddle of brown fluid on the floor at the end of the bed under the footboard. This surveyor asked E40 (CNA) what was the puddle from and R84 answered by saying it was a mixture of weeping from his/her lower extremities, blood and urine leaking. This surveyor observed E40 clean the puddle on the floor using the Microkill bleach wipes. 9/3/19 at 1:40 PM - During an interview, E29 (Housekeeper) was asked about the puddling of brown fluid at the end of R84's bed under the footboard. E29 stated that it was coming from the resident's mattress. E29 stated that he/she thoroughly cleans the resident's room and sometimes the puddle reappears after the floor was cleaned. E29 stated that staff throws linens on top of the area where the puddling occurs. E29 acknowledged there was a strong odor coming from R84's room. 9/3/19 at 2:05 PM - During an interview, when asked about the continuous puddling of brown	F 690		

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F 690	Continued From page 53 fluid accumulating at the end of R84's bed under the footboard and the strong odor coming from the room, E33 (Housekeeping Director) acknowledged that the puddling was coming from R84's mattress. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that a resident with an indwelling catheter received appropriate treatment and services as per the plan of care. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 690		
F 692 SS=E	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	F 692		11/11/19

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F 692	Continued From page 54 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for 2 (R30 and R3209) out of 3 sampled residents, the facility failed to ensure that residents maintained acceptable parameters of nutritional status based on the residents' comprehensive assessments. For R209, the facility failed to ensure that the resident did not exceed the physician-ordered 1200 ml fluid restriction from 6/25/19 through 7/18/19. Findings include: 1. Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/24/19 at 8:53 AM - A history and physical stated, "...start fluid restriction...". 6/25/19 - A physician's order stated, "...1200 mL Fluid Restriction...". 6/25/19 through 7/18/19 - Review of R209's total fluid intake per day as recorded in the clinical record revealed that R209 exceeded the 1200 ml fluid restriction on 19 out of 24 days: - 6/25/19 = 1,260 ml; - 6/26/19 = 1,310 ml; - 6/27/19 = 1,680 ml; - 6/28/19 = 990 ml; - 6/29/19 = 1,320 ml; - 6/30/19 = 1,680 ml; - 7/1/19 = 960 ml; - 7/2/19 = 1,710 ml; - 7/3/19 = 1,140 ml; - 7/4/19 = 1,500 ml;	F 692	F692 Nutrition/Hydration Status Maintenance (1) R209 A. R209 did not have any negative outcomes. She no longer resides in the facility and no corrective action could be taken. B. All residents with a physician□s order for a fluid restrictions are at risk for this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The root cause analysis determined that nursing staff was not monitoring the fluid consumption for a resident with an ordered fluid restriction The Unit Managers, Supervisors, and Admissions Nurse will be educated on placing a sticker with a picture of a cup with a line through it outside the door to signify to staff that a resident is on a fluid restriction. A list of residents on fluid restriction will be kept at the water filling station. Unit Managers will report fluid consumption daily at morning meeting and interventions will be taken if resident exceeds their allotted amount. D. The Dietitian or designee will audit residents with physician ordered fluid restrictions for adherence to their allotted amount. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive	

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F 692	Continued From page 55 - 7/5/19 = 1,560 ml; - 7/6/19 = 1,580 ml; - 7/7/19 = 1,340 ml; - 7/8/19 = 780 ml; - 7/9/19 = 1,800 ml; - 7/10/19 = 1,500 ml; - 7/11/19 = 1,560 ml; - 7/12/19 = 1,080 ml; - 7/13/19 = 1,380 ml; - 7/14/19 = 1,500 ml; - 7/15/19 = 1,540 ml; - 7/16/19 = 1,540 ml; - 7/17/19 = 1,620 ml; - 7/18/19 = 2,090 ml. 6/29/19 - R209 was care planned for the potential for systemic complications related to congestive heart failure with an approach to monitor for appropriate food and fluid intakes. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that R209 did not exceed the physician-ordered 1200 ml fluid restriction from 6/25/19 through 7/18/19. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 2. Review of R30's clinical record revealed: 6/22/16- R30 was admitted to the facility. 6/24/18- A care plan was initiated stating that R30 needed to maintain good nutrition and hydration in spite of a BMI above 80, and that no further weight gain was desired. Approaches included to obtain weights as ordered.	F 692	weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (2) R30 A. R30 did not have any negative outcomes related to her weight changes. She continues to be noncompliant with recommendations from the Registered Dietitian. B. All residents have the potential to be impacted by failure to recognize, assess, and implement interventions for significant weight changes. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined that the facility failed to identify a significant weight change. A system change was implemented that the Dietitian will review all weights and address all residents with significant weight changes. D. The Director of Nursing or designee will audit all weights to determine significant weight changes and supportive documentation of assessment and interventions, if needed. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will	

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F 692	Continued From page 56 6/5/19-8/5/19- Review of R30's weights revealed that on 6/5/19 R30 was 409.2 lbs. On 7/8/19, R30 was 349.8 lbs, which was a 7.45% significant weight change. R30 was not reweighed until 8/5/19 and was 440.8 lbs. 8/28/19- Review of R30's clinical record showed no evidence that E16 (Dietician) was aware of R30's significant weight change on 7/8/19, and there was no evidence that an assessment of this weight change was completed. 8/28/19 4:06 PM- During an interview, E16 (Dietician) stated that if a resident had a significant weight increase or decrease a reweight was completed within 24 to 48 hours. E16 stated that the nurses typically enter the monthly weights on R30's floor and nursing staff was expected to notify her (E16) if a resident had a significant weight change. E16 stated that regarding R30's weight change she would look to see if an assessment was ever done after R30's significant weight gain on 7/8/19. 8/28.19 4:29 PM- During an interview, E17 (Corporate Nurse) confirmed that she looked with E16 (Dietician) and there was no evidence that R30's significant weight gain on 7/8/19 was assessed and evaluated. The facility failed to recognize, evaluate, and address R30's significant weight change of 7.45% from 6/5/19 to 7/5/19. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 692	be reviewed by the Quality Assurance Committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/11/19

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F 695	Continued From page 57 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for 1 (R209) out of 3 sampled residents, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with the comprehensive person-centered care plan. For R209, the facility failed to ensure that a physician-ordered treatment for BIPAP was provided every night from 6/22/19 through 6/27/19 until a critical lab on 6/28/19 revealed that R209's CO2 was at a critically high level of 43 (normal range 22-29). The facility failed to notify the physician when R209 repeatedly "refused" the physician-ordered treatment for 6 nights and failed to determine the reason as to why R209 repeatedly "refused". Findings include: Cross refer to F580 The facility's policy entitled "Bi-level Positive Airway Pressure (BiPAP)...and Other Types of Non-invasive Ventilation Support Machine Use and Administration", last revised on 1/14/19, stated, "...Procedure: The Licensed Nurse and/or Respiratory Therapist is responsible for the safe and correct usage and administration of	F 695	F695 Respiratory/Tracheostomy Care and Suctioning A. R209 was discharged from the facility. B. All residents that refuse a Physician ordered BiPAP have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. A root cause analysis determined that nursing failed to notify the Physician after a resident refused to wear a BiPAP. It was determined that the facility failed to have a system in place to track refusals and notify the Physician when a refusal was documented. As a result, the facility Unit Manager/Supervisor will review the 24 hour facility activity report daily to review any resident care refusals. The audit will include assuring the Physician was notified for additional orders. D. The Director of Nursing/Designee will audit the facility activity report for residents who refuse physician ordered services and notification of Physician daily until 100% compliance is achieved for three consecutive days. Random audits	

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F 695	Continued From page 58 BiPAP...". Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/21/19 - A physician's order stated for R209 to wear BIPAP every night with 3 liters of oxygen. 6/22/19 at 7:22 AM - A nurse's note stated, "...Resident put on CPAP some of the night and took off because (he/she) felt like it was too 'heavy' on (his/her) face. Resident states (he/she) will have family bring in the mask (he/she) uses...". Despite a physician's order for BIPAP, nursing staff were documenting that R209 had CPAP. 6/22/19 through 6/28/19 - Review of R209's eTAR revealed that the nursing staff were documenting BIPAP "Refused" every night for a total of 6 nights. 6/23/19 at 10 PM - A nurse's note stated, "pt refused c-pap machine." 6/24/19 at 21:36 PM - A nurse's note stated, "pt refused to wear C-pap." 6/28/19 at 12:15 PM - Review of R209's lab result report revealed that the facility was notified by telephone regarding the resident's critically high lab result of CO2=43 (normal range 22-29). 6/28/19 at 1:25 PM - A nurse's note stated, "...Patient did not have BiPAP on this AM at change of shift."	F 695	will continue once weekly for three consecutive weeks or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed in the Quality Assurance Committee.	

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F 695	Continued From page 59 6/28/19 at 2:11 PM - A progress note, written by E4 (NP), stated, "...Refuses to wear BiPAP at night. Seen by respiratory therapy who has discussed with pt and tried several masks...". 6/28/19 at 3:10 PM - A progress note, written by E45 (RT), stated, "the NP just told me that the Resident Co2 is 44 this is due to the Resident continued to refuse to wear the bipap. I went to speak to the Resident about the increase of (his/her) co2 and asked (R209) to please use the mask, (R209) agreed and i put (him/her) on settings 10/5. (R209) tolerated it well and stable without any Respiratory Distress, Saturation is 98% on 2 liters of oxygen and HR 75. I also called the Unit Manager (name) and 3-11 supervisor (name) to the Resident room and gave them the information on what I have done for the Resident, and i also gave the NP the same information on what i have done for the Resident and (R209) is pleased with it. I also advice (sic) both (name) and (name) to make sure the incoming nurse to monitor the Resident because (R209) is on bipap. I will also sent (sic) a RT tonight through Monday night to put (R209) on the bipap." Review of R209's clinical record from 6/21/19 through 6/28/19 lacked evidence that the resident's physician was notified of R209's repeated refusals of a physician-ordered treatment to wear BIPAP every night. 9/3/19 at 8:30 AM - Finding reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that a physician-ordered treatment for BIPAP was provided every night from 6/22/19 through 6/27/19 until a critical lab result received on 6/28/19 revealed that R209's CO2 was at a critically high level of 43 (normal range 22-29);	F 695		

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F 695	Continued From page 60 failed to notify the physician when R209 repeatedly "refused" the physician-ordered treatment for 6 nights; and failed to determine the reason as to why R209 repeatedly "refused" BIPAP. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 695		
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 clinical record review, interview and review of facility documentation as indicated, it was determined that for one (R212) out of two (2) sampled residents, the facility failed to ensure that pain management was provided to the resident who required such service, consistent with the comprehensive person-centered care plan and the resident's goals and preferences. For R212, the facility failed to consult with the physician to obtain an order to administer PRN pain medication when the resident requested pain medication at 7 AM for breakthrough pain, instead E49 (RN) administered PRN Tylenol to R212 at 8:10 AM, over an hour later. Findings include: Cross refer to F585	F 697	F697 Pain Management A. R212 no longer resides at the facility. B. All residents with orders for PRN pain medications that continue to experience break-through pain have the potential to be adversely affected by the lack of consultation with the Provider for additional orders when needed. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in section C. C. The root-cause analysis revealed that the nurse failed to consult with the Provider when the resident expressed ineffective pain management measures for break-through pain. Nursing education will be provided by the Staff Educator/ designee to review the facility policy	11/11/19

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F 697	Continued From page 61 The facility's policy entitled "Pain Management", last revised on 1/17/19, stated, "...Procedure: ...All residents will be assessed/monitored every shift for new onset of pain, and/or the effectiveness of current pain management measures; Pre and post pain medication administration assessments are performed and documented in the electronic medication record (EMAR); The prescribing physician is alerted when medication adjustment may be required (reports of ineffective pain control, resident dissatisfaction pain management...". Review of R212's clinical record revealed: 6/13/19 - R212 was admitted to the facility for short-term rehabilitation. 6/13/19 - A physician's order stated to give R212 PRN Tylenol for pain every 6 hours. 6/19/19 - R212 was care planned for the potential for pain with approaches that included, but were not limited to the following: administer pharmacological pain interventions as ordered, ensure ordered therapy interventions are administered and notify physician of uncontrolled pain. 6/20/19 - The admission MDS assessment stated that R212 was cognitively intact. 6/24/19 at 2:12 AM - Review of R212's eMAR revealed that the resident received PRN Tylenol for a pre-pain level assessment of 10/10 (worst possible pain). The post-pain level assessment was 0/10 (no pain); the pain medication was effective.	F 697	entitled Pain Management. This policy will be added to new hire orientation and annual mandatory review for licensed nursing staff. Staff competency for understanding will be determined by signed acknowledgment and random auditing. D. DON/designee to audit the electronic medical records of 10% of residents with PRN pain medications for effectiveness of pain management. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Performance Improvement Committee	

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F 697	Continued From page 62 6/24/19 - A facility's Resident Concern/Compliment Form stated, "...(checked) concern...Brief Description: pt. asked for pain medication at 7am; nurse brought all medications at 8:10; resident requests that when (he/she) asks for pain medication (he/she) gets it right away and doesn't want to wait for (his/her) other medications until after...Dept. Head Response: Resident seen by DON (E2) and ADON (E3) on 6/24/19. Resident also evaluated by (E48, MD name). Plan of care updated to include routine Tylenol BID and PRN as well. Resident agreed to plan of care, daughter was present as well as social worker (name). We apologized for (him/her) having to wait for the tylenol, (he/she) did accept the apology...". Despite the 6/13/19 physician's order that stated to give Tylenol every 6 hours and R212 requested pain medication 5 hours after the last Tylenol dose was administered, E49 (RN) failed to consult with the physician about R212's breakthrough pain and (R212's) request for PRN pain medication at 7 AM. R212 waited for over one hour to receive PRN Tylenol. 6/24/19 at 8:15 AM - Review of R212's eMAR revealed that the resident received PRN Tylenol for a pre-pain level assessment of 6/10 (severe pain). The post-pain level assessment remained at the same level of 6/10; the pain medication was not effective. 6/24/19 at 4:39 PM - R212's physical therapy daily treatment note stated, "...Resident is frustrated because nurse did not provide her pain medication on time. Communicated to 7-3 pm nurse, (he/she) reported 'patient has every 6 hours order for pain medication, patient had pain medication this morning @ 8AM'...".	F 697		

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F 697	Continued From page 63 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). For R212, the facility failed to consult with the physician to obtain an order to administer PRN pain medication when the resident requested pain medication at 7 AM for breakthrough pain, instead E49 (RN) administered PRN Tylenol to R212 at 8:15 AM, over an hour later. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 697		
F 725 SS=D	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.	F 725		11/11/19

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F 725	Continued From page 64 §483.35(a)(2) Except when waived under 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 records review, it was determined that the facility failed to employ sufficient staff to provide care and services in assisting residents to attain or maintain their highest practicable level of physical and functional well being for three (R1, R48, and R56) out of 50 sampled residents. Findings include: 1a. Review of R1's clinical record revealed: Review of the July 2019 CNA documentation for urine/bowel movements revealed that R1 was changed: 7/5/19 at 10:57 AM then not again until 7/6/19 at 1:34 AM - 13.5 hours. 7/17/19 at 7:51 PM then not again until 7/18/19 at 2:13 PM - 18 hours. 7/21/19 at 3:13 AM then not again until 7/21/19 at 10:34 PM - 19.5 hours. 7/30/19 at 6:49 AM then not again until 7/30/19 at 10:50 PM - 16 hours. Review of the August 2019 CNA documentation for urine/bowel movements revealed that R1 was changed: 8/17/19 at 6:33 AM then not again until 8/18/19 at 6:28 AM - 24 hours. 8/23/19 at 10:20 PM then not again until 8/24/19 at 12:14 PM - 14 hours. 8/25/19 at 9:39 AM then not again until 8/26/19 at 5:09 AM - 20 hours. 8/31/19 at 12:58 PM then not again until 9/1/19 at	F 725	F725 Sufficient Staffing A. R1 and R56 were not directly harmed by this deficient practice. R48 no longer resides in the facility B. All residents requiring incontinence care are at risk for this deficient practice. Future residents will be protected by this deficient practice as outlined in Section C. C. A root cause analysis was conducted and it was determined that the residents affected by this deficient practice stated they were not offered toileting every 2 hours or when needed. The facility will develop a Purposeful Rounding Program which includes the 5 □P approach: Pain, Positioning, Potty (toileting needs), Presence and possessions. In initiating this proactive approach, customer satisfaction should improve related to timeliness of care needs. The facility will continue to conduct Vacancy Meetings to determine open positions within the facility and to assure recruitment measures continue until qualified staff are obtained. Nursing Documentation will be audited every shift by the unit manager/supervisor to assure documentation was completed.	

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F 725	Continued From page 65 1:18 AM - 12 hours. 8/3/19 - A quarterly MDS assessment revealed that R1 was cognitively intact and was totally dependent on staff for care. On 8/21/19 at 2:49 PM - During a screening interview, R1 stated that he/she waited 23 hours to be changed. R1 stated it was three days ago (8/17/19) on the 11-7 shift, he/she put the call bell on and no one came. R1 stated he/she knew what time it was by looking at the clock on the wall. On 8/27/19 at 2:24 PM - During an interview, E34 (CNA) stated she worked day and evening shifts. E34 stated residents who do not go into the bathroom to toilet are changed in the morning when they get up, after lunch, at the start of the evening shift, after dinner, and whenever else the resident requested to be changed. 1b. Review of R48's clinical record revealed: 7/15/19 - An admission MDS assessment revealed that R48 was cognitively intact and required extensive two person staff assistance for toileting. Review of the July 2019 CNA documentation for urine/bowel movements revealed that R48 was toileted: 7/12/19 at 10:02 AM then not again until 7/13/19 at 4:07 AM - 16 hours. 7/13/19 at 4:07 AM then not again until 7/13/19 at 9:35 PM - 17.5 hours. 7/14/19 at 2:28 AM then not again until 7/14/19 at 7:02 PM - 14.5 hours. 7/21/19 at 8:15 PM then not again until 7/22/19 at	F 725	D. The Director of Nursing/designee will audit 10 resident□s plan of care documentation for tioleting documentation and will meet with residents who are able to verbalize to determine if they are receiving appropriate continence care. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Performance Improvement Committee	

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F 725	Continued From page 66 11:42 AM - 15.5 hours. 7/24/19 at 9:01 AM then not again until 7/25/19 at 1:28 AM - 16.5 hours. Review of the August 2019 CNA documentation for urine/bowel movements revealed that R48 was toileted: 8/11/19 at 2:23 AM then not again until 8/11/19 at 7:56 PM - 17 hours. 8/11/19 at 7:56 PM then not again until 8/12/19 at 9:15 AM - 13 hours. 8/15/19 at 4:07 AM then not again until 8/15/19 at 9:26 PM - 17.5 hours. 8/23/19 at 2:57 AM then not again until 8/23/19 at 9:38 PM - 18.5 hours. 8/23/19 at 9:38 PM then not again until 8/24/19 at 1:54 PM - 17 hours. 8/26/19 at 10:25 AM then not again until 8/27/19 at 5:34 AM - 19 hours. 8/28/19 at 10:39 AM then not again until 8/29/19 at 1:32 AM - 15 hours. 8/29/19 at 1:32 AM then not again until 8/30/19 at 4:57 AM - 26 hours. On 8/21/19 at 1:58 PM - During a screening interview, R48 stated that he/she has to wait a long time for staff to answer the call bell, especially during the night shift. 1c. Review of R56's clinical record revealed: 7/22/19 - An admission MDS assessment revealed that R56 was cognitively intact and was totally dependent on staff for care. 7/29/19 - A physician's order was written to check and change every shift. August 2019 CNA documentation for urine/bowel	F 725		

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F 725	Continued From page 67 movements revealed that R56 was changed: 8/2/19 at 2:43 PM then not again until 8/3/19 at 1:05 AM - 22 hours. 8/4/19 at 6:58 AM then not again until 8/4/19 9:43 PM - 14.5 hours. 8/8/19 at 6:51 AM then not again until 8/8/19 at 10:34 PM - 15 hours. 8/11/19 at 10:24 PM then not again until 8/12/19 at 2:37 PM - 16 hours. 8/15/19 at 11:47 PM then not again until 8/16/19 at 2:24 PM - 15 hours. 8/21/19 at 11:43 PM then not again until 8/22/19 at 2:38 PM - 15 hours. 8/22/19 at 11:46 PM then not again until 8/23/19 at 2:27 PM - 15 hours. 8/28/19 at 2:32 PM then not again until 8/29/19 at 4:47 AM - 14 hours. On 8/20/19 at 3:32 PM - During a screening interview, R56 stated that sometimes his/her call bell is on for over an hour and he/she has to yell to get staff attention. R56 stated weekends are the worst. The facility failed assure that there was sufficient nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Findings were discussed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		11/11/19

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F 756	Continued From page 68 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and 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 and interview, it was determined that the facility failed to consistently	F 756	F756 Drug Regimen Review (1) R30	

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F 756	Continued From page 69 act on irregularities identified during medication regimen reviews (MRRs) by the pharmacist for two (R30 and R53) out of five residents sampled for unnecessary medications. Findings include: 1. Review of R30's clinical record revealed: 1/3/19- Review of R30's MRR revealed a pharmacist recommendation stating that R30 had an order for an AIMS assessment and was not on any antipsychotic medication at this time. The pharmacist recommended evaluating the continued need for an AIMS assessment and to discontinue if not clinically appropriate. E4 (NP) responded to the recommendation writing "D/C" and checking agree. E4 signed the recommendation, however, there was no date indicating when it was signed. 3/5/19- Review of R30's MRR revealed a pharmacist recommendation stating that R30's AIMS assessment was discontinued from the 1/3/19 recommendation, but the discontinuation was not transcribed. The pharmacist wrote to cancel the AIMS assessment if appropriate. The physician responded to the recommendation writing "D/C'd" and signed the recommendation on 3/13/19. 3/14/19- R30's physician ordered AIMS assessment was discontinued. 6/9/19- Review of R30's MRR revealed a pharmacist recommendation stating that R30 had PRN (as needed) order for albuterol every 4 hours and the MAR did not reflect that. The pharmacist recommended changing the MAR to reflect the order. E4 (NP) signed the recommendation on 6/11/19, but did not write a	F 756	A. R30 was not harmed by this deficient practice. B. All residents have the potential to be affected by this deficient practice. The process for review of pharmacy recommendations is outlined below in section C. C. A root cause analysis was conducted and it was determined that the process for reviewing the consultant pharmacist recommendations was noted as not being followed. The recommendations were found to lack appropriate documentation by the Providers and timely implementation by the nursing administrative team. Guidelines and expectations related to reviewing and implementing the approved recommendations will be reviewed with the providers by the consultant pharmacist. Members of the nursing administrative team (Unit Managers, Assistant Director of Nursing and Director of Nursing) will be re-educated by the consultant pharmacist regarding the guidelines to follow for pharmacy recommendations. Audits will be initiated to assess for the completion of the pharmacist recommendations and to determine if the review and education was effective. D. The Corporate Nurse/designee to audit the responses to the pharmacy on a monthly basis until 100% compliance is achieved for 3 consecutive months. Random audits will be conducted at least quarterly for 1 year. All audits will be reviewed by the Quality Assurance Performance Improvement Committee	

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F 756	Continued From page 70 response to the recommendation or check off whether they agreed or disagreed with the recommendation. 8/28/19- Review of R30's current physician orders revealed that R30's albuterol PRN order was not changed in the MAR per the pharmacist's recommendation. The facility failed to ensure the physician reviewed and took action for the pharmacists identified irregularities for R30's 1/3/19 and 6/9/19 MRRs. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). 2. Review of R53's clinical record revealed: 4/4/19- A physician's order was entered for R53 to receive Hydralazine (medication to treat high blood pressure) 25 mg 1 tab orally every 12 hours PRN (as needed) for a systolic blood pressure (BP) less than (<) 170. 4/4/19 1:42 PM- A physician's observation progress note stated that for hypertension R53 had "Hydralazine PRN for systolic BP >(greater than) 170." 5/10/19- Review of R53's MRR revealed a pharmacist recommendation stating that R53's PRN hydralazine order stated to administer every 12 hours PRN for a systolic blood pressure < (less than) 170. The pharmacist stated to please evaluate this parameter and questioned if it should read if > (greater than) 170. The physician checked disagree and signed the recommendation on 5/23/19.	F 756	(2) R53 A. The resident was not harmed by this deficient practice B. All residents who have an order for as needed antihypertensive medications have the potential to be affected by this deficient practice C. A root cause analysis was conducted and it was determined that the facility□s Cardiology Consultant placed an order that contained a greater than/less than symbol instead of a written word format for parameters. The Corporate Nurse Consultant met with the Cardiologist to explain the need for words to reflect parameters in orders and not using symbols. Providers will be instructed via e-mail regarding order entry for greater than/less than parameters being in written form. Our pharmacist consultant will continue to monitor for appropriate order entry during their monthly reviews. An audit will be initiated related to antihypertensive medications with parameters per the schedule noted in the response below (D). D. The Corporate Consultant /designee will audit antihypertensive medications order entries that include greater than /less than parameters. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by	

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F 756	Continued From page 71 5/23/19- A physician's observation progress note stated that for hypertension R53 had "Hydralazine PRN for systolic BP >170." 8/28/19- Review of R53's physician orders revealed that R53's PRN hydralazine order still stated to administer every 12 hours PRN if R53's systolic BP was < (less than) 170. The physician failed to appropriately respond to the pharmacist's recommendation on 5/10/19 to evaluate R53's Hydralazine PRN order to administer every 12 hours if R53's systolic BP was less than 170. The physician signed off stating disagree when physician notes documented that the order was to be greater than 170. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 756	the Quality Assurance Performance Improvement Committee	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		11/11/19

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F 757	Continued From page 72 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to ensure that one (R1) out of five (5) residents, who's drug regimen was reviewed, was free from unnecessary drugs. The facility failed to discontinue two (2) medicated eye drops (Ilevro and Prednisolone) after cataract surgery according to physician's orders. Findings include: Review of R1's clinical record revealed the following: 5/14/19 - R1 had cataract surgery of the left eye. Discharge/Transfer Instructions post cataract surgery listed the schedule for eye drops (Ilevro and Prednisolone) to be administered for the subsequent four (4) weeks. The discharge instructions stated that both the Ilevro and Prednisolone were to be stopped after the fourth week. That date would have been June 11, 2019. Review of the MAR from 5/14/19 through 8/28/19 revealed that the facility continued to administer the Ilevro and Prednisolone eye drops despite the physician's order that they be discontinued after four (4) weeks. 8/28/19 at 11:28 AM - During an interview, E17 (RNAC) stated she would follow up with the	F 757	F757 Drug Regimen is Free from Unnecessary Drugs A. R1 was not harmed by this deficient practice. The order for eye drops has been discontinued. B. All residents who have cataract surgery and ordered eye drops are at risk for deficient practice. The Corrective action will be taken as noted below in section C. C. A root cause analysis was conducted and it was determined the error in continuation of the eye drops occurred related to the resident being transferred to the hospital. Upon return the eye drops were noted as current medications on the hospital discharge medication list. The stop dates that were present when the resident was transferred to the hospital were not reflected on the discharge orders received from the hospital upon re-admission. The Admission Nurses will be re-educated to review the medications orders received upon re-admission as well as the medications that the resident had been receiving prior to transfer to an acute care facility. Discrepancies will be brought to the Provider□s attention for clarification. The facility will continue to	

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F 757	Continued From page 73 physician regarding the eye drops. 8/28/19 at 2:00 PM - During an interview, E17 (RNAC) stated that she had spoken with the physician and that the eye drops should have been stopped after four (4) weeks. 8/29/19 - Review of the MAR revealed that the Ilevro eye drops had been discontinued. 9/3/19 - Review of the MAR revealed that the Predisolone eye drops continued to be administered. 9/4/19 at 8:23 AM - Findings were reviewed with E1 (NHA) and E2 (DON). 9/4/19 approximately 10:00 AM - During an interview, E2 (DON) stated that according to her review, both the eye drops should have been discontinued after four (4) weeks and as of now they have been. The facility failed to ensure that R1 did not receive any unnecessary medications when two (2) eye drops, Ilevro and Prednisolone, continued to be administered despite physician's orders that they be discontinued after four (4) weeks. The facility failed to discontinue the eye drops and administered them for approximately an additional two (2) and a half months. 9/4/19 approximately 7:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 757	review all admissions and re-admissions for appropriate stop dates related to indication for the medication. D. The facility will continue to review medication orders upon admission and re-admission. The Consultant /designee will audit admission and re-admission orders for appropriate stop dates. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Performance Improvement Committee	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		11/11/19

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F 760	Continued From page 74 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews and review of facility documentation as indicated, it was determined that for 3 (R90, R209 and R211) out of 8 sampled residents, the facility failed to ensure that its residents are free of any significant medication errors. For R211, the facility failed to follow the pharmacy's policy, dated 1/7/19, entitled "Administration Procedures for All Medications" when R211, a non-diabetic, was incorrectly administered 4 units of Humalog insulin that was meant for his/her roommate, which resulted in close monitoring of R211's blood sugar levels by the administration of four (4) physician-ordered Accuchecks over 8 hours. For R209, the facility failed to ensure a physician ordered INR lab was transcribed and obtained for a resident on Warfarin, a blood thinner medication that required close monitoring of the resident's specific blood level. For R90 the facility failed to be free from significant medication errors as evidenced by on 4/19/19 R90 received a 90 mg dose of morphine Extended Release when the order was for 45 mg of morphine Extended Release. Findings include: The facility's pharmacy policy entitled "Administration Procedures for All Medications", dated 1/7/19, stated, "To administer medications in a safe and effective manner...Procedures: ...E. Identify resident using two identification methods before administering medication...". 1. Review of R211's clinical record revealed:	F 760	F760 Resident are Free of Significant Med Errors (1) R211 A. R211 has been discharged from the facility. B. All residents are at risk for a medication error. The nurse involved in the incident immediately received education regarding medication administration practices. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. The root cause analysis determined that the nurse became distracted during the medication administration process. She immediately identified her error and immediately reported it to the provider. Appropriate actions were taken to monitor the resident for adverse effects and none were noted. This appears to be an isolated event. Education was provided to the nurse. In an effort to reduce the likelihood of a medication error in the future, the facility will have all licensed nurses complete a course in Relias on Medication Administration on an annual basis. D. Medication errors will continue to be tracked and trended to the facility and presented in Quality Assurance and Performance Improvement Meetings. All medication errors will be reviewed weekly in the facility High Risk Meeting to	

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F 760	Continued From page 75 6/17/19 - R211 was admitted to the facility for short-term rehabilitation. 6/19/19 - Review of the physician's history and physical (timed at 11:21 AM), R211's eMAR and physician orders revealed that R211 did not have a diagnosis of Diabetes and was not ordered insulin medication. 6/19/19 - A physician's order stated, "Accu-check q (every) 2 hours x (times) 8 hours. Every 2 hours (x 4) at (8:15 PM, 10: 15 PM, 12:15 AM, 2:15 AM). 6/19/19 at 9:04 PM - A nurse's note stated, "Resident alert and oriented x3. New order received this shift from E46 (NP) for accu-checks q2hrs x8hrs. Order implemented...". 6/20/19 at 2:52 AM - A nurse's note stated, "...Accuchecks done as ordered, no s/s (signs or symptoms) of hypoglycemia...". Review of facility documentation provided to this surveyor revealed the following: - Signed (undated) statement from E47 (LPN): "While I was on my way to give schedule (sic) insulin to another patient, I got distracted by more than one staffs (sic) communicating with me concerning other residents. That how I ended up administering the wrong medication to the wrong patient. I did apologize to family and patient." - The facility performed a urine drug test on E47 (LPN) on 6/19/19 during 3-11 PM shift which revealed negative results. - Review of the In-Service Record for Medication Administration Patient Identification, dated 6/19/19 on the 3-11 PM shift, revealed that E47 (LPN) was in-serviced on "when administering	F 760	determine if any system wide changes are needed and additional training is needed. (2) R209 A. R209 no longer resides in the facility. Per review of her records. B. All residents receiving warfarin are at risk for transcription errors related to lab studies necessary for dosing. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause was conducted and it was determined that the nurse made a transcription error. It was determined that when the nurse ordered the lab studies, he did not change the date to the next day. All nurses will be educated on how to order Prothrombin studies. This education will be added to New Hire Orientation and the education will be reviewed annually thereafter.. D. The Director of Nursing or designee will audit all labs related to warfarin usage to ensure they were ordered correctly and obtained. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. (3) R90 A. R90 was not harmed by this deficient practice B. All residents are at risk for a	

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F 760	Continued From page 76 medications, always use two patient identifiers." - Review of the In-Service Record for Medication Administration, dated 6/24/19, revealed that 15 nurses participated in training regarding "Know the Rights: right drug, dose, time, route, resident, documentation, check wrist band, check computer...compare 6 to med cards." - E47 (LPN) completed 1 hour of training on 6/27/19 for "Assistance with Medication Administration". 6/27/19 at 10:27 AM - The facility reported the Medication Error incident to the State Survey Agency nine (9) days later. The incident description was: "Resident received incorrect medications, family and doctor were notified." The facility failed to report R211's medication error incident to the State Survey Agency within the eight hours of the incident. 7/1/19 - The facility's 5-day follow up report to the State Survey Agency stated, "...Root cause determined the nurse did not follow the rights of medication administration. Result of Investigation: Resident received 4 units of Humalog insulin on 6/19/19. (E47) LPN became distracted before administering the insulin to resident in error. Resident blood sugar was monitored every 2 hours for 8 hours...and resident reported no ill effects related to insulin administration. Root cause determined the nurse did not follow the rights of medication administration. Nurse educated on patient identifiers...". 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). For R211, the facility failed to follow the pharmacy's policy, dated 1/7/19, entitled "Administration Procedures for All Medications" when R211, a non-diabetic, was	F 760	medication error. The nurse involved in the incident immediately received education regarding medication administration practices. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined that the nurse did not follow the 5 Rights of Medication Administration when administering the morphine dose. Licensed Nurses will be educated on the 5 rights of medication administration and medication safety. The staff educator and consultant pharmacist will complete monthly medication pass audits to assure the 5 rights are followed. D. Medication errors will continue to be tracked and trended to the facility and presented in Quality Assurance and Performance Improvement Meetings.	

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F 760	Continued From page 77 incorrectly administered 4 units of Humalog insulin that was meant for his/her roommate, which resulted in close monitoring of R211's blood sugar levels by the administration of four (4) physician-ordered Accuchecks over 8 hours. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 2. Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/21/19 - R209 was care planned for the potential for excessive bleeding related to anticoagulant therapy use with an approach that included labs as ordered. 6/24/19 at 2:03 PM - A nurse's note stated, "...INR 3.6; per (E4) NP: hold warfarin 6/24/19; recheck labs in am." 6/25/19 - Review of R209's clinical record lacked evidence that E4's 6/24/19 order to recheck R209's INR lab the next day was transcribed as a physician's order and the INR lab draw was not obtained on the morning of 6/25/19. 6/27/19 - R209's next INR lab result revealed a critically high level of 5.3 (recommended range 2.0 to 3.0). 9/3/19 at 4:56 PM - Findings were confirmed with E2 (DON). The facility failed to ensure a physician ordered INR lab was transcribed and obtained for R209, who was on Warfarin, a blood thinner medication that required close monitoring of the	F 760		

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F 760	Continued From page 78 resident's specific blood level. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 3. Review of R90's clinical record revealed the following: 12/2/16- R90 was admitted to the facility with diagnoses that included chronic pain. 4/19/19 10:02 PM- A progress note stated that around 7:30 PM E19 (LPN) was asked by E33 (Nursing Supervisor) to help pass medications on the long term care section of the facility. E19 stated that she initially declined, but later changed her mind and went to help. E19 stated that she mistakenly gave R90 the wrong dose of Morphine. R90 was to receive 3 tabs of Morphine 15 mg Extended Release (45 mg total), but instead R90 received 3 tabs of Morphine 30 mg Extended Release (90 mg total). E19 noted that safety precautions were initiated immediately with vital signs every 15 minutes, neuro checks, and 2 liters of oxygen via nasal cannula. The on call NP was notified and ordered to send R90 to the ED (Emergency Department) for further evaluation. R90 was sent to the ER around 9:50 PM. R90 was noted to be stable with no signs/symptoms of respiratory issues, he/she was alert, and was able to make his/her needs known. 4/19/19 10:23 PM- A progress note stated that R90 was sent to the ED (Emergency Department) for evaluation status post administration of morphine 90 mg. It was noted that prior to transfer to the ED, R90 was in no acute distress, was alert and oriented times three, cooperative, and had stable vital signs.	F 760		

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F 760	Continued From page 79 4/21/19 10:59 AM- A progress note stated that R90 was readmitted back to the facility from the hospital around 10:00 AM. R90 was noted to be alert and oriented with no signs of distress noted. 4/29/19 9:00 PM- Review of the facilities follow up to the incident revealed that R90 returned from the ED with no new orders and remained stable during his/her ED visit. Upon return to the facility, the NP evaluated R90 and R90's pain medication was increased. The root cause analysis determined that the medication error occurred because the 5 rights of medication administration were not performed before R90 received the medication. The primary nurse was educated on the rights of medication administration and medication observation was completed with E19 (LPN). The facility failed to ensure that R90 was free from significant medication errors as evidenced by on 4/19/19 R90 received a 90 mg dose of morphine Extended Release when the order was for 45 mg of morphine Extended Release. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		11/11/19

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F 761	Continued From page 80 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that for four out of four medication carts, the facility failed to date and discard expired medications. Findings include: 9/4/19 at 10:25 AM - An observation of the first floor medication cart #4 revealed one opened Lantus insulin multi - dose vial that was undated. This was immediately confirmed by E9 (RN). 9/4/19 at 10:35 AM - An observation of the first floor medication cart #2 revealed one opened bottle of Vimpat oral solution that was undated. This was immediately confirmed by E10 (LPN). 9/4/19 at 11:15 AM - An observation and inspection of the second floor medication cart #2 revealed two opened multi - dose vials of Lidocaine; one of the vials was undated and the	F 761	F761 Label/Store Drugs and Biologicals A. This was based on an observation of medication carts during the survey. B. All residents have the potential to be impacted by inappropriate labeling and storage of medication. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined that the nursing staff were not following the guidelines related to medication storage and dating upon opening. All medications now have a printed copy of the guidelines for reference. Nursing staff will be educated by the Staff Educator/ designee regarding medication storage, labeling, and disposal upon expiration. D. The Corporate Nurse/designee will	

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F 761	Continued From page 81 other vial was dated 5/31/19 (expired). An undated insulin pen was also found in the top drawer of the medication cart. These were immediately confirmed by E11 (RN). 9/4/19 at 11:23 AM - An observation of the second floor medication cart #1 revealed one opened Humalog insulin multi - dose vial that was undated. This was immediately confirmed by E11 (RN). Findings were reviewed during the exit conference on 9/4/19 at 7:30 PM with E1 (NHA) and E2 (DON).	F 761	audit all medication carts for expired medications and appropriate labeling. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee	
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R76) out of one resident sampled for radiologic/diagnostic services, the	F 776	F776 Radiology/ Other Diagnostic Services A. R76 no longer resides in the facility.	11/11/19

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F 776	Continued From page 82 facility failed to provide and obtain the x-rays that were ordered. Findings include: Review of R76's clinical records revealed: 7/22/19 - R76 was admitted to the facility with diagnoses including a broken right elbow and right arm. 7/29/19 - A physician's order from the orthopedic specialist prescribed a follow up x-ray of the right elbow and right humerus (arm) and to send x-ray CD (compact disc used for storage of data)) with R76 for his/her follow up appointment on 8/12/19. 8/2/19 - A physician's order was entered into the EHR (Electronic Health Record) for x-rays of the right elbow and right femur (thigh bone). 8/20/19 at 10:16 AM - During an interview, R76's spouse reported to the surveyor that the facility made an error in obtaining an x-ray of her husband's right femur (thigh) instead of an x-ray to the right arm. R76's spouse also stated that R76 had to have an x-ray of the right arm at the ortho clinic on the follow up visit on 8/12/19. 8/28/19 at 11:24 AM - During an interview, E8 (RN) confirmed there was a transcription error when entering the physician's order into the EHR. 9/4/19 at 8:45 AM - Findings were discussed with E1 (NHA) and E2 (DON). Findings were reviewed during exit conference on 9/4/19 at 7:30 PM with E1 and E2.	F 776	Corrective action was taken at the time of the occurrence and the orthopedic specialist was able to obtain the correct diagnostic study. B. All residents have the potential to be impacted by inaccurate diagnostic order transcription. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined that the nurse inadvertently transcribed the order incorrectly into the electronic medical record. All nurses will be educated on how to order radiology studies. This education will be added to New Hire Orientation. D. The Director of Nursing or designee will audit all radiology orders to ensure the order was transcribed correctly to the electronic medication administration record. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		11/11/19

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F 791	Continued From page 83 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		

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F 791	Continued From page 84 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R30) out of 3 sampled residents, the facility failed to provide the opportunity for routine dental services. Findings include: 6/22/16 - R30 was admitted to the facility with diagnoses that included respiratory failure. R30 is ventilator dependent. 6/18/19 - R30's annual MDS indicated he/she was cognitively intact and had no broken teeth or mouth pain. 6/19/19 - R30's dental care plan was edited. Care plan approaches included arrange for dental consult as needed. 8/20/19 at 3:54 PM - During an interview, R30 stated he/she had a broken tooth. R30 stated he/she called the nurse's desk approximately 2 months ago and asked to see the dentist. R30 stated his/her sister also went to the nurse's desk to request a dental visit. 8/26/19 at 8:35 AM- During an interview E3 (ADON) stated she was unaware of R30's request to see the dentist. 8/27/19 at 9:16 AM - During an interview, E1 (NHA) provided documentation that R30 was seen 4/18/18 for a routine dental visit. E1 stated that since R30 is ventilator dependent he/she is	F 791	F791 Routine/ Emergency Dental Services A. R30 was not harmed by this deficient practice. The facility, upon notification, contacted a dentist to assess the resident. Dental examination completed on 8/28/19. Follow-up dental services were arranged. No treatment was required at that time. B. All residents have the potential to be affected by a delay in dental services. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined the facility was unaware of the resident□s concern regarding dental services. Upon notification, the facility contacted the dental provider as per the regulations. Social Services is notified of residents with dental concerns and arranges dental services. D. Social Services or designee will audit residents identified as needing dental services and or presenting with dental concerns to determine if appropriate interventions were initiated. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100%	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 85 seen by a special dentist, and not by the dental provider offered to facility residents. E1 stated he/she would arrange for dental services for R30 due to his/her broken tooth. The facility failed to obtain annual routine dental services for R30, and failed to obtain dental services when requested by R30 for a broken tooth. Findings were discussed with E1, E2, and E3 on 9/4/19 at 11:00 AM.	F 791	compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee	
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, 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 observations and interviews, it was determined that the facility did not store food and	F 812	A. The ice machine was cleaned immediately upon identification	11/11/19

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F 812	Continued From page 86 utensils in a sanitary manner. Findings include: The following were observed on 8/20/19 from 8:00 AM to 9:00 AM during the initial kitchen tour: 1. The ice machine in the kitchen was dirty; 2. The cooking utensil drying mat by the 3 compartment sink was dusty. Findings were reviewed and confirmed with E15 (food service director) on 8/20/19 at approximately 9:00 AM.	F 812	B. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient by taking the corrective actions outlined in section C. C. A root cause analysis was conducted and it was determined that the kitchen staff was not assigned to clean the ice machine in the kitchen. The Food Serviced Director will educate kitchen staff on proper cleaning techniques and the cleaning schedule for the ice machine. D. The Nursing Home Administrator/designee will audit the ice machine to see that it is cleaned in a sanitary manner. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. they are stored in a sanitary manner. A. The dry mats were cleaned immediately upon discovery during the survey. B. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient by taking the corrective actions outlined in section C. C. A root cause analysis was conducted and it was determined that the dry mats	

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F 812	Continued From page 87	F 812	did not have a cleaning schedule in place. The dietary staff will be re-educated by the food Service Director on the new cleaning schedule set forth for the drying mats. D. The Food Service Director/ designee will audit the dry mats to see that it is cleaned in a sanitary manner. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. they are stored in a sanitary manner.	
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 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-	F 842		11/11/19

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F 842	Continued From page 88 (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- (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;	F 842		

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F 842	Continued From page 89 (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 maintain medical records for one (R67) out of 50 sampled residents that were in accordance with accepted professional standards and practices. Findings include: Cross refer to F688 A facility policy titled Documentation Guidelines, effective July 2013 and revised May 17, 2019 stated: Resident care delivered is entered into the medical record legibly and timely. CNA's document care delivery electronically. Unit managers/designees are required to review CNA documentation daily and address inconsistencies. Review of R67's clinical record revealed the following: R67 was admitted to the facility on 10/13/17 with diagnoses that included stroke, paralysis, and a tracheostomy (an opening made in the throat to assist with breathing).	F 842	F842 Resident Records □ Identifiable Information A. R67 was not affected by this deficient practice B. All residents with orders for splinting devices have the potential for inaccurate documentation of application and/ or removal. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. Root cause analysis determined that the certified nurse aides had failed to appropriately document the care provided related to application of a splinting device. All certified nurse aides will be educated by the Staff Educator on accurate documentation by the staff educator. D. The Corporate Consultant/designee will audit the application of splints through visual confirmation and written documentation. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100%	

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F 842	Continued From page 90 7/5/19 - A physician's order stated that R67 was to wear a left, blue resting hand splint during the day only and then off at night to prevent finger contractures. Review of the August 2019 Point of Care History for R67 to wear the left blue resting hand splint during the day only and then off at night, was documented as done 26 out of 28 days in August. 8/28/19 at 11:49 AM - It was observed that R67 did not have a left hand splint on. Review of R67's electronic medical record revealed that his/her hand splint was documented as on. 8/28/19 at 11:57 AM - During an interview, E12 (CNA) stated he/she was familiar with R67 and had not seen R67 with a hand splint on for awhile. Upon searching R67's room, E12 was unable to find the hand splint. There were multiple days in August 2019 when E12 documented that R67's hand splint was on. When the surveyor pointed out to E12 that he/she had documented other instances of putting the splint on R67, E12 stated 'that must've been a mistake'. 9/3/19 at 9:11 AM - E36 (CNA) documented in the Point of Care documentation that R67's hand splint was on. 9/3/19 at 9:39 AM - E37 (PT Director) was observed entering the room to apply R67's left hand splint. 9/3/19 at 9:51 AM - E36 (CNA) amended the Point of Care documentaion to read that R67's hand splint was not done at 9:11 AM. 9/03/19 at 2:29 PM - During an interview, E36	F 842	compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 842	Continued From page 91 (CNA) stated she did not put the hand splint on R67 and did not put the hand splint on yesterday either. E36 stated he/she mistakenly logged it in the Point of Care documentation on 9/2/19. The facility failed to to ensure that R67's hand splint was recorded accurately in the Point of Care documentation. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §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 clinical records and facility documentation, observations and interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to identify and implement corrective actions with respect to infection control practices occurring in the facility. Findings include: Cross refer to F880 9/4/19 at 3:44 PM - During an interview, E1 (NHA) was asked if the facility's QAPI program identified and corrected any quality deficiencies with respect to infection control practices in the facility. E1 stated that prior to this survey, the facility's QAPI program identified that PPE gowns	F 867	F867 QAPI/QAA Improvement Activities A. No residents were directly harmed by this deficient practice. B. All residents, staff and visitors have the potential to be affected by this deficient practice. C. A root cause analysis determined that there was lack of observational audits included in the Quality Assurance Program which would have identified the infection control issues of improper cohorting, handwashing and improper cleaning by the facility housekeeping staff. The facility will implement infection control observation weekly rounds to include handwashing, use of personal protective	11/11/19

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F 867	Continued From page 92 were not being tied. The facility ordered new PPE "cloth" gowns that arrived right before the survey started. The facility did not implement the new PPE gowns and did not in-service the staff on the new gowns. E1 stated that audits were being done to check isolation carts for PPE supplies and appropriate equipment and to ensure that staff know the reason residents are on isolation. E1 stated this had being going on for about one month and the audits are ongoing. E1 confirmed that the QAPI program did not identify the improper cohorting of 2 residents with 2 different transmittable MDRO organisms, lack of or improper use of PPE by staff and visitors, lack of or improper sanitizing/handwashing of hands and medical equipment, and lack of or improper housekeeping and laundry practices. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 867	equipment, cleaning and cohorting of residents who have multidrug resistant organisms. D. The facility will include the findings of the weekly observational rounds at the monthly Quality Assurance Performance Meetings and based on the results of the findings will determine if a Performance Improvement Plan (PIP) will be developed. The Cooperate Consultant or designee will audit Quality Assurance Performance Improvement meetings to ensure the infection control observation rounds are included and performance improvement plans are implemented if needed. These audits will continue until 100% compliance for 3 consecutive months.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		11/11/19

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F 880	Continued From page 93 §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 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	F 880		

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F 880	Continued From page 94 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 observations, staff interviews, review of hospital records, and review of facility policy and procedures, it was determined that the facility failed to ensure that it's infection control program was implemented in regards to isolation and cohorting (a group of people who share a characteristic, in this case the same microorganism) of residents with transmittable organisms, staff and visitor use of personal protective equipment (PPE), sanitizing of hands and medical equipment, and housekeeping and laundry practices. Findings include: The facility policy titled Standard and Transmission-Based Precautions, revision date July 23, 2019, stated "...Types of Precautions: 1. Standard precautions should be used in the care of all residents at all times to reduce the risk of transmission of microorganisms. Clean, non-sterile gloves when touching or coming into contact with blood, body fluids, secretions or excretions. Remove gloves after use. Discard before touching non-contaminated items or environmental surfaces, and before providing care to another resident. Wash hands after	F 880	F-880 Infection Prevention and Control Cohorting of Residents requiring Isolation A. R94 and R29 were not harmed by this deficient practice. B. No corrective actions were taken related to the room assignment of the two residents (R-94; R-29). The facility□s Infectious Disease physician and the State Epidemiologist, were called upon during survey, and both agreed that no room changes were needed at this time. The residents could remain together. The facility has made the following changes to its Admission and Re-Admission procedure for residents requiring isolation, as the results of this finding. See changes listed below in section C. C. A root cause analysis was conducted and determined that the facility□s Infectious Disease physician will be consulted prior to admission or readmission of a resident who will require isolation. The Infectious Disease physician will review the records for residents prior to cohorting. The	

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F 880	Continued From page 95 removing gloves. 2. Contact precautions are used for residents that have an infection that can be spread by contact with the person's skin, mucous membranes, feces, vomit, urine, wound drainage, or other body fluids, or by contact with equipment or environmental surfaces that may be contaminated by the resident or by his/her secretions and excretions. In addition to standard precautions wear a gown and gloves upon room entry of a resident on contact precautions. 3. Droplet precautions are used for residents with an infection spread through close respiratory or mucous membrane contact with respiratory secretions. In addition to standard precautions wear a mask upon room entry... 5. Special Situations:..Carbapenem-Resistant Enterobacteriaceae (CRE): Residents with known CRE should continue on contact precautions if they are in one of the following high risk categories: Tracheostomy; Vent (ventilator) dependent; Wounds requiring dressing changes more than once a day; Active antibiotic therapy... Resident Placement: Whenever possible, place residents that require transmission-based precautions in a private room, to reduce opportunities for transmission of microorganisms. When a private room is not available, cohort the resident with an appropriate roommate. Residents infected by the same microorganism can usually share a room provided the residents are not infected with other transmissible microorganisms and the likelihood of re-infection with the same organism is minimal. If a private room is unavailable and an appropriate roommate is not possible, consult with the infection control provider, prior to placement... Resident Care Equipment and Articles: Equipment contaminated with blood, bodily fluids,	F 880	Physician will determine the proper placement of residents based on the infectious organism and isolation needs. D. The facility will document the review of the admission/ re-admission of a resident by the Infectious Disease Specialist. Approval for cohorting will be noted in the electronic medical record. Implementation of the Infection Control Program A. No residents, staff, or visitors will be harmed by this deficient practice B. All residents, staff and visitors have the potential to be affected by this deficient practice. Corrective actions. C. A root cause analysis was conducted and determined that there was a lack of adherence to the infection control program and lack of understanding of the importance for infection control measures for the health and safety of residents, staff, and visitors. Staff will be required to complete education on Infection Control and to demonstrate understanding of infection control procedures. Observational audits will be conducted by the Administrative Staff and Department Heads. Staff members who are found to demonstrate continued non-adherence to our infection control program will receive disciplinary action, which may include termination. D. Auditing will be conducted for all isolation activity occurring in isolation rooms. The audits will be conducted by nursing, respiratory and housekeeping directors and performed by observational	

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F 880	Continued From page 96 secretions, or excretions is cleaned and disinfected after use. Disposable resident care equipment should be used when available. Linen and Laundry: Melt-away laundry bags are used for collection of contaminated laundry and linen... Routine and Terminal Cleaning: The room and bedside equipment of residents on isolation precautions are cleaned using the same procedures used for other residents, unless the infecting microorganism (s) and the amount of environmental contamination indicates special cleaning. The methods, thoroughness and frequency of cleaning and the products used are determined by facility policy...". The facility's contracted environmental services provider's policy and procedure titled "Contaminated Isolation Room Cleaning MRSA (Methicillin Resistant Staphylococcus Aureus - a type of staph bacteria [types of germs commonly found on the skin or in the nose of even healthy individuals. Most of the time, these bacteria cause no problems or result in relatively minor skin infections] that's become resistant to many of the antibiotics used to treat ordinary staph infections) stated, "...Scrub hands and arms for 3 minutes with disinfectant soap. Dress in isolation clothes: 1st Booties, 2nd Cap, 3rd Mask, 4th Gown, 5th Gloves...Begin the Isolation Room Cleaning using the guidelines below: 1. Empty trash...7. Damp mop...If using Microfiber flat mop - Use a new pad for every room, never re-insert pad into mop bucket...Remove your mop head and double bag so there is NO CROSS CONTAMINATION..Exit Room: Take off all isolation clothes and double bag and properly dispose as you exit the room. Take all double bagged linens, mops and curtains to the dirty linen room and let the laundry employees know	F 880	methods. The audits will focus on: guidelines for use of and disposal of personal protective equipment (PPEs); the use of disposal equipment; the disposal of or cleaning of contaminated items; the cleaning of rooms and the items used to clean rooms, and the proper changing of gloves and hand washing. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 880	Continued From page 97 you have just completed an Isolation Room cleaning. Mop water MUST be changed after completing the isolation room procedure. Disinfect all tools utilized to clean the MRSA room using the EPA (Environmental Protection Agency) approved solution. Wash hands and arms using the proper hand washing technique...". The CDC Guideline for Hand Hygiene in Healthcare Settings, October 25, 2002, recommends: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin.Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times (https://www.cdc.gov/handhygiene/providers/index.html). 1. Review of R29's and R94's clinical records, hospital records and observations revealed the following: A. R94 was originally admitted to the facility in 11/09. R94 has diagnoses that included chronic vegetative state, quadriplegia, and tracheostomy with ventilator dependence. 7/3/19 - Review of the hospital record revealed R94's past medical history included MDR (Multi-Drug Resistant) Acinetobacter baumanii	F 880		

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F 880	Continued From page 98 carrier (an opportunistic pathogen in humans, affecting people with compromised immune systems, and is becoming increasingly important as a hospital-derived [nosocomial] infection). 7/9/19 - The hospital Interagency Discharge Orders and the Interagency Nursing Communication Record did not state or identify that R94 was on any type of isolation precautions. 7/10/19 - R94 was re admitted to the facility post hospitalization. 7/24/19 - A physician's order stated R94 required Contact/droplet isolation precautions due to being a carrier of carbapenem resistant acinetobacter baumannii (CRAB) in the lungs. B. R29 was originally admitted to the facility in 11/19. R29 has diagnoses that included persistent vegetative state and tracheostomy with ventilator dependence. 5/23/19 - A hospital Interagency Nursing Communication Record noted that R29 was on isolation precautions for CRE (Carbapenem-Resistant Enterobacteriaceae, a family of germs that are difficult to treat because they have high levels of resistance to antibiotics). 5/27/19 - R29 was readmitted to the facility post hospitalization. A physician's order stated R29 was to be on contact isolation precautions for CRE in the urine. 8/4/19 - A culture of R29's trachea secretions revealed heavy growth of an organism. The organism was not CRE or CRAB.	F 880		

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F 880	Continued From page 99 8/20/19 at approximately 9:05 AM - Observation of R29 and R94 revealed that they shared a room. An isolation sign was posted at the entry way into the room and PPE was stored outside of the room. Review of R29's and R94's Resident Census Lists revealed that they have been roommates since 11/20/18. Review of written data contained on the isolation cart revealed that R29 was on contact precautions for CRE in the urine and R94 was on droplet precautions for CRAB in the lungs. 8/27/19 - During email communications, S1 (State Epidemiologist) stated that these two (2) residents should not have been cohorted together, but that "they've been together for so long not sure it will make a big difference to separate them at this point." The facility failed to ensure that residents with different organisms were not cohorted. 9/4/19 at 7:56 AM - During an interview, E26 (Staff Educator/Infection Control Nurse) was asked about the cohorting of R29 and R94. E26 stated that she asked the same question and that the facility had consulted with someone about this issue and that she would look for the information. 9/4/19 at 8:23 AM - The findings were reviewed with E1 (NHA) and E2 (DON). 9/4/19 - E1 and E2 provided a printed copy from a text message from facility staff and the facility's Infectious Disease physician regarding the cohorting of the residents. The physician's reply	F 880		

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was "...Yes we can cohort them together...Acinetobacter is considered MDRO-hence can be cohorted with CRE."

The following observations were made;

2. 8/20/19 at 8:55 AM - E27 (RT) was observed providing care to R7. R7 had a trachesotomy, was ventilator dependent, and was on contact precautions for CRE in the urine. E27 was wearing an isolation gown that was not secured at the neck causing it to fall down to near E27's waist, exposing E27's uniform scrub top. E27 was also wearing a mask and gloves. After providing care to R7, E27 was observed removing the gloves, applying new gloves and proceeding to provide care to R50, the roommate who was on droplet precautions for CRE in respiratory secretions.

E27 failed to change the gown, mask and gloves before going from R7 to R50 to provide care. E27 also failed to handwash or sanitize his/her hands before applying new gloves.

8/20/19 at approximately 9:05 AM - During an interview, E27 was questioned about failing to sanitize his/her hands after removing and reapplying gloves. E27 stated, "Oh, I'm sorry."

3. 8/20/19 at 10:22 AM - Observation revealed R101 had a visitor who was wearing an isolation gown and gloves. The isolation gown did not fit the visitor properly exposing their upper body clothing. R101 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent.

4. 8/21/19 at 11:26 AM - During a resident

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F 880	Continued From page 101 interview with R101, who was on contact precautions for CRE in the urine, E28 (RT) entered the room to provide respiratory care wearing an isolation gown and gloves. E28 checked R101's ventilator tubing, and suctioned the resident, who had a tracheostomy and was on a ventilator. E28 removed a stethoscope that was under his/her isolation gown and listened to R101's lungs. After assessing the lungs, E28 placed the stethoscope back on his/her neck after touching it with his/her contaminated gloved hands. E28 removed his/her PPE, washed his/her hands and then left the room to enter data for R101 on a rolling computer terminal. E28 failed to sanitize the stethoscope after using it to assess R101's lungs. 5. 8/23/19 at 1:13 PM - E31 (Housekeeper) was observed in R4's (who was on contact precautions for MRSA in a wound) room wearing gown and gloves. E31 used the mop and water/cleaner that was on the housekeeping cart to mop the bedroom and bathroom floor. E31 discarded the PPE, came out of the room and used hand sanitizer that was on the wall in the hallway. E31 then proceeded to gown and glove and went into R95's room, who was on contact precautions for CRE in the urine. After cleaning the bathroom, E31 used the same mop and water/cleaner that had been used to clean R4's room to mop R95's bedroom and bathroom. E31 was then observed removing the mop head and placing it into a large, clear plastic bag that contained used cleaning rags, hanging on the side of the housekeeping cart. E31 then discarded the isolation gown and gloves, used hand sanitizer, took the cart into the janitor closet where running water could be heard through the closed door. E31 came out of the janitor's closet	F 880		

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F 880	Continued From page 102	F 880		

approximately 10 minutes later and went to R51's, who was on contact precautions for CRE in wounds, applied PPE and began cleaning the room.

6. 8/27/19 at 10:17 AM - E30 (RT) was observed in R4's room (on contact precautions for MRSA in wound) providing repiratory care. R4 had a tracheostomy and was ventilator dependent. E30 discarded his/her PPE into the red container inside R4's room then proceeded into the bathroom. E30 came out of the bathroom after approximately two (2) seconds (suveyor counting 1-1000, 2-1000) and then came out into the hallway. E30 stood in the hallway looking for any call lights that needed to be answered and then proceeded into the respiratory therapy office. E30 did not sanitize his/her hands.

7. 8/27/19 at 11:46 AM - Observation revealed E30 in R4's room (who was on contact precautions for MRSA in a wound) wearing an isolation gown, gloves and mask. The isolation gown was not tied at the neck causing it to slip down exposing E30's scrub top. E30 was observed pulling the isolation gown up to his/her shoulders then pulling the privacy curtain. After several minutes of providing respiratory care, E30 pulled the privacy curtain open and went into the bathroom wearing the PPE. E30 remained in the bathroom for approximately 9 seconds (surveyor counting 1-1000, 2-1000...9-1000). E30 came out of R4's bathroom and proceeded directly to room 167, which did not have any isolation precautions. E30 failed to wash his/her hands adequately (if hand washing occurred while E30 was in the bathroom) and failed to sanitize his/her hands, as there was no hand sanitizer in R4's bathroom.

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F 880	Continued From page 103 8. 8/27/19 at 12:12 PM - E30 (RT) was observed entering R4's room wearing an isolation gown, mask and gloves. R4 was on contact isolation for MRSA in a wound and had a tracheostomy and was on a ventilator. E30's isolation gown was not secured at the neck causing it fall down off the shoulders exposing his/her uniform scrub top. After providing respiratory care, E30 went into the bathroom where he/she discarded the PPE and exited after approximately 10 seconds (surveyor counted 1-1000 to 10-1000). If E30 performed handwashing while in the bathroom it was inadequate. 9. 8/28/19 at 9:35 AM - Wound care was observed for R4 provided by E20 (LPN) with E22 (CNA) assisting. R4 was on contact precautions for MRSA in a wound, had a tracheostomy and was on a ventilator. Both E20 and E22 wore isolation gowns and gloves. After completion of R4's wound care, E20 and E22 applied a clean brief and changed a drawsheet that was under R4. E22, still wearing his/her contaminated gloves, went to open the top right cabinet near the window, went back to R4 and removed soiled linens and placed them into the bathroom hamper. E22 removed the contaminated gloves, applied new gloves without first sanitizing his/her hands and assisted in turning R4. While turning R4, E20 removed the draw sheet from under the resident and threw it on the floor. The draw sheet was soiled with feces. After completion of repositioning R4, E20 picked up the draw sheet from the floor and placed it into the bathroom hamper. E22 while wearing the contaminated gloves touched the bed controls at the foot of the bed, the TV control panel and R4's call bell apparatus.	F 880		

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F 880	Continued From page 104 10. 8/29/19 at 1:35 PM - E29 (housekeeper) was observed cleaning room 154, a non isolation room. E29 cleaned and mopped the room, placed the mop in the water/cleaner bucket, changed gloves, did not sanitize hands, applied new gloves and went into room 155, a non isolation room, to clean and mop. 9/3/19 at 10:05 AM - During an interview, E29 (Housekeeper) explained how he/she proceeds with cleaning resident's rooms. E29 stated that the "Red Rooms" the rooms with red isolation bags or isolation signage are left for last and the non isolation rooms are cleaned first. E29 stated that if an isolation room is very dirty, he/she will start with the isolation rooms and leave the non isolation until the end. E29 stated that the water and cleaning solution in the mop bucket is changed approximately every four (4) rooms in non isolation rooms depending on how dirty they are. E29 stated that for isolation rooms, the water and cleaning solution is changed every two (2) rooms. E29 stated the mop heads are changed every four to five (4-5) non isolation rooms and and every two (2) isolation rooms. E29 stated he/she wears gloves to clean every room and that at times will double glove. E29 stated he/she looks at the folder in the isolation cart to see what PPE to wear. E29 stated that he/she uses hand sanitizer to clean hands after each isolation room and "most times" will sanitize hands after cleaning the non isolation rooms. 9/4/19 at approximately 2:15 PM - During an interview, C1 (Regional Housekeeping Director) was requested to review the procedures for the cleaning of isolation and non isolation rooms. C1 stated that non isolation rooms are cleaned first, isolation rooms are cleaned last. C1 stated that	F 880		

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F 880	Continued From page 105 for isolation rooms, proper PPE is used and hands are washed for 3 minutes before applying gloves. C1 stated that hand sanitizers are not used prior to applying gloves. C1 stated that the sequence of room cleaning consists of emptying the trash, cleaning surfaces, dusting floors and then mopping floors. C1 stated that for non isolation rooms the water and detergent are changed at least every three (3) rooms and the mop head, dependent on how dirty it is, is changed every 6-9 rooms. C1 stated that for isolation rooms the water. detegent and mop are to be chnaged after every room is cleaned. C1 stated cleaning items such as mops and cleaning rags used in isolation rooms are to be placed into the dissolving plastic bags for delivery to the laundry. 11. 8/20/19 at 12:03 PM - Observation revealed a visitor wearing an isolation gown and gloves entering R95's room. R95 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. At 12:13 PM, the visitor was observed opening the bathroom door with gloves on, then leaving the bathroom with one glove still on their right hand. The visitor walked to the door as if to leave the room, turned around, removed the glove and opened the bathroom door again and disposed of the glove. There was no sound of running water to indicate the visitor was handwashing. The visitor then exited the room. 12. 8/20/19 at 12:25 PM - Observation revealed E41 (CNA) removing an isolation gown and gloves and placing them in the trashcan in R84's room. E41 did not wash or sanitize his/her hands. R84 was on contact precautions for CRE in	F 880		

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F 880	Continued From page 106 wounds, had a tracheostomy and was ventilator dependent. After leaving R84's room, E41 went to the nurses station, got a cup with ice, returned to R84's room, applied an isolation gown, but did not tie it properly, did not apply gloves and went into the room and delivered the ice. E41 then walked to R84's door, disposed of the gown, sanitized his/her hands and left the room. 13. 8/20/19 at 2:12 PM - Observation revealed a cleaning cart positioned outside of R7's and R50's room. R7 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. R50 was on droplet precautions for CRE in respiratory secretions, had a tracheostomy and was ventilator dependent. E29 (Housekeeper) was observed stepping out of the room into the hallway while still wearing an isolation gown, gloves and mask to retrieve something from the cleaning cart. E29 then went back into the room. 14. 8/20/19 at 2:53 PM - Observation revealed a visitor entering R95's room with no isolation gown on but wearing gloves. R95 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. 15. 8/28/19 at 9:03 AM - Observation of E42 (CNA) revealed him/her applying an isolation gown, but not securing it at the neck, and not applying gloves. E42 entered R84's room, wrote the staff assignment on R84's white board while talking with the resident. E42 then went into the bathroom and running water could be heard for less than 15 seconds (surveyor counted 1-1000 to 6-1000). E42 did not sanitize his/her hands. R84 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator	F 880		

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F 880	Continued From page 107 dependent. 16. 8/28/19 at approximately 10:00 AM - After completion of morning care, E41 (CNA), E42 (CNA), E43 (CNA), and E44 (CNA) were observed placing R84's soiled linen into four (4) regular clear plastic bags, instead of the dissolvable laundry bags that are to be used for isolation rooms. R84 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator dependent. At 10:10 AM, E44 removed his/her PPE, did not hand wash or sanitize his/her hands and proceeded to exit the room carrying two (2) of the clear plastic bags containing soiled linen. 17. 8/23/19 at 1:47 PM - E31 (housekeeper) was observed going from isolation room 158 to isolation room 159 without changing his/her gown. 18. 8/26/19 at 1:51 PM - E31 (housekeeper) was observed wearing PPE and cleaning R95's room. R95 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. When E31 finished cleaning the room, he/she came out of the room into the hall, took off the isolation gown and gloves, then walked back into the bathroom in R95's room, threw away the isolation gown and gloves, and without washing or sanitizing his/her hands went 10 feet down the hallway to the janitor's closet which required a push code to enter. 19. 8/26/19 at 2:09 PM - E31 (housekeeper) was observed wearing PPE and walking in and out of R7 and R50's room to get items from the housekeeping cart in the hall. R7 was on contact precautions for CRE in the urine, had a	F 880		

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F 880	Continued From page 108 tracheostomy and was ventilator dependent. R50 was on droplet precautions for CRE in respiratory secretions, had a tracheostomy and was ventilator dependent. 8/29/19 at 2:29 PM - During an interview, E33 (housekeeping director) stated laundry from isolation rooms is placed into melt away bags in the isolation room before coming to the laundry room. In the dirty laundry room the melt away bags are placed directly into the washer. E33 stated the melt away bags have a red top so that laundry staff can distinguish them from non-isolation laundry. 20. 9/4/19 at 1:52 PM - E29 (housekeeper) was observed exiting R51's room and placing the mop head into a standard clear trash bag with other rags and mop heads on the housekeeping cart. E29 stated when he/she was done cleaning he/she would bring the bag of soiled rags and mop heads to the laundry. R51 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator dependent. The housekeepers failed to properly follow the facility Contaminated Isolation Room Cleaning guidelines: Damp Mop - remove mop head and double bag so there is no cross contamination. Take off all isolation clothes and properly dispose of as you exit the room. Take all double bagged linens and mops to the dirty linen room and let the laundry employees know you have just completed an isolation room cleaning. Wash hands and arms using the proper hand washing technique.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

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F 880	Continued From page 109 The facility failed to ensure that it's infection control program was implemented in regards to isolation and cohorting (a group of people who share a characteristic, in this case the same microorganism) of residents with transmittable organisms, staff and visitor use of personal protective equipment (PPE), sanitizing of hands and medical equipment, and housekeeping and laundry practices. 9/4/19 approximately 7:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 880		

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

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3 Mill Road, Suite 308
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(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehab. Pike Creek DATE SURVEY COMPLETED: September 4, 2019

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF 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 survey was conducted at this facility from August 20, 2019 through September 4, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 112. The survey sample size was 52 residents.	Cross refer to CMS 2567 -L survey completed September 4, 2019: F558, F580, F585, F656, F658, F684, F686, F688, F689, F690, F692, F695, F697, F725, F756, F757, F760, F761, F776, F791, F812, F842, F867, and F880.	
3201	**Regulations for Skilled and Intermediate Care Facilities**		11/4/19
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 CMS 2567-L survey completed September 4, 2019: F558, F580, F585, F656, F658, F684, F686, F688, F689, F690, F692, F695, F697, F725, F756, F757, F760, F761,		

Provider's Signature Mary Callen RN Title VHA Date 10/7/19

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	F776, F791, F812, F842, F867, and F880.		
3201.9.0	**Records and Reports**		
9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.**		11/11/19
9.8	**Reportable incidents are as follows:**	R90	
9.8.4.4	**Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours.**	1. R90 was not harmed by this deficient practice 2. All residents have the potential to be affected by this deficient practice 3. A root cause analysis was conducted, and it was determined that the nurse mistakenly gave the wrong dose of morphine to R90. The nurse was immediately educated on reviewing the order and the blister pack prior to administering a medication. Safety precautions were initiated immediately, and the resident was transferred to the hospital. The facility failed to report this incident to the Division of Healthcare Quality timely as required. 4. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed monthly by the Quality Assurance Committee.	19
	This requirement was not met as evidenced by:		
	Based on record review and interview, it was determined that for two (R90 and R211) out of 52 sampled residents, the facility failed to report significant medication errors that required monitoring to the state agency within eight hours of the occurrence of the incident. Findings include:		
	1. Review of R90's clinical record revealed:		

Provider's Signature MK Collier QA Title NHA Date 10/7/19

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	12/2/16- R90 was admitted to the facility with diagnoses that included chronic pain (of long duration). 4/19/19 10:02 PM- A progress note stated that around 7:30 PM E19 (LPN-Licensed Practical Nurse) was asked by E39 (evening Nurse Supervisor) to help pass medications on the long term care section of the facility. E19 stated that she initially declined, but later changed her mind and went to help. E19 stated that she mistakenly gave R90 the wrong dose of Morphine (narcotic pain medication). R90 was to receive 3 tablets of Morphine 15 mg (milligrams) (45 mg total) Extended Release, but instead R90 received 3 tabs of Morphine 30 mg (90 mg total) Extended Release. E19 noted that safety precautions were initiated immediately with vital signs every 15 minutes, neurological checks, and 2 liters of oxygen via nasal cannula. The on call Nurse Practitioner was notified and ordered to send R90 to the Emergency Department (ED) for further evaluation. R90 was sent to the ED around 9:50 PM. R90 was noted to be stable with no signs/symptoms of respiratory issues, alert, and able to make needs known. 4/21/19 10:59 AM- A progress note stated that R90 was readmitted back to the facility from the hospital around 10:00 AM. R90 was noted to be alert and oriented with no signs of distress noted. 4/25/19 11:58 AM- The facility reported the incident to the state at this time. This was six days after the incident occurred.	R211 1. R211 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis was conducted and it was determined that the nurse mistakenly gave insulin to the wrong resident that did not have an order for insulin. The facility failed to report this incident to the Division of Healthcare Quality timely as required. The nurse was educated on medication administration 4. The audit will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met the deficient practice will be considered resolved. All audits will be reviewed monthly by the Quality Assurance Committee.	11/1/19 11/1/19

Provider's Signature [signature] Title MHA Date 10/7/19

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NAME OF FACILITY: Cadia Rehab. Pike Creek **DATE SURVEY COMPLETED: September 4, 2019**

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	4/29/19 9:00 PM- The facility submitted a follow up to the incident to the state at this time. The facility failed to ensure that a reportable significant medication error requiring monitoring was submitted to the state within 8 hours. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). 2. Review of R211's clinical record revealed: 6/17/19 – R211 was admitted to the facility for short-term rehabilitation. 6/19/19 – Review of the physician's history and physical (timed at 11:21 AM), R211's eMAR and physician orders revealed that R211 did not have a diagnosis of Diabetes and was not ordered insulin medication. 6/19/19 – A physician's order stated, "Accu-check (blood glucose/sugar test) q (every) 2 hours x 8 hours. Every 2 hours (x 4) at (8:15 PM, 10:15 PM, 12:15 AM, 2:15 AM)." Review of facility documentation provided to this surveyor revealed the following: - Signed (undated) statement from E47 (LPN): "While I was on my way to give schedule (sic) insulin to another patient, I got distracted by more than one staffs (sic) communicating with me concerning other residents. That (sic) how I		10/11/19

Provider's Signature [signature] Title NHA Date 10/7/19

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	ended up administering the wrong medication to the wrong patient. I did apologize to family and patient." 6/27/19 at 10:27 AM – The facility reported the Medication Error incident to the State Survey Agency eight (8) days later. The incident description was: "Resident received incorrect medications, family and doctor were notified." The facility failed to report R211's medication error incident to the State Survey Agency within eight (8) hours of the incident. 9/3/19 at 8:30 AM – Finding was reviewed with E1 (NHA) and E2 (DON). 9/4/19 at 7:30 PM – Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).		10/11/19

Provider's Signature _____ Title NHA Date 10/7/19