DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	07/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

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F 000	INITIAL COMMENTS Correction date July 31, 2018 The following deficiencies are the result of the facilities annual health survey and investigation of complaints #74416-C, 75525-C, 75535-C and 75876-C. Investigation of facility-reported incident 75846-I resulted in deficiency. Investigation of facility-reported incident 75846-I did not result in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550	Resident # 1 and resident # 41 are treated with dignity and respect. Resident Council meeting was held on 6/29/18 to discuss grievance policy and response follow up. Educated SSD on proper grievance policy and response follow up on 6/27/18 and again 7/23/2018. Audits will be completed by the DON/ or Designee periodically to ensure compliance. Ongoing Results of audits will be reviewed through the Quality Assurance and Process Improvement (QAPI) Committee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kathleen J. Klimesh
Digitally signed by Kathleen J. Klimesh
DN: cn=Kathleen J. Klimesh, o=Rowley Masonic Community, ou=Admnistrator, email=kate@rowleymasoniccommunity.org, c=US
Date: 2018.07.27 13:10:46 -05'00'

TITLE: Administrator

(X6) DATE: 07/27/2018

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

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and resident interviews, facility staff failed to treat two residents (Residents #41 and #1) in a dignified and respectful manner. The facility identified a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/30/18 documented diagnoses that included muscular dystrophy, arthritis and peripheral vascular disease for Resident #41. The same MDS documented a Brief interview of Mental Status score of 15 (indicating intact cognition) and he felt down, depressed or hopeless for several days during the assessment cycle. Resident #41 required the assistance of 2	F 550		

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with bed mobility and toilet use, he did not walk and needed the assistance of one with dressing and personal hygiene.

Review of the comprehensive care plan for Resident #41 revealed no focus areas for behaviors, communication or cognition concerns. A care plan problem dated 4/23/18 identified an adjustment focus related to the loss of a favored former employee and staff direction to assist the resident to identify strengths and positive coping skills and encourage him to express his feelings.

During interview on 6/19/18 at 3:05 PM the resident stated he has been treated rudely and feels intimidated by the Director of Nursing (DON). The resident stated that he felt it had been his fault that a favored employee had been terminated by the facility for assisting him while she was not paid by the facility. This employee had cared for him several years prior to admission to the facility and also here at the facility on her assigned days and her off time. The resident stated the prior management of the facility knew and approved of the arrangement he had with this employee and had never been an issue until March/April of this year.

Resident #41 continued that he approached the DON and the current Administrator about the situation and they would not give him any information or listen to him about the prior employee; that bothered him. After he started asking for information, the DON or Administrator no longer spoke to him when passing in the hallway or in the common areas, even after he greeted them. He stated the DON talks with him in a condescending manner in order to intimidate him and he does not appreciate that. This has

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made his life here in the facility less enjoyable and he had been used to a friendly and caring environment with the former management of the facility. Resident #41 stated he feels the administrator and DON do not know him or care about him or would they would listen to the information he wanted to get to them about the former employee.

2. According to the MDS assessment dated 5/30/18, Resident #1 had a BIMS score of 15. The MDS documented diagnoses of diabetes mellitus type 2 and chronic total occlusion of the coronary artery.
The MDS documented the resident required the assistance of one staff for transfers, dressing and toilet use. The resident independently performed locomotion on and off his living unit.

The resident's comprehensive care plan, with a target date of 6/19/18, documented independence with ambulation, wheel chair use and electric scooter operation. The resident's care plan pocket plan documented resident as independent and to answer his call light promptly.

Observation on 6/18/18 revealed the resident as an independent ambulation with wheeled walker.

An interview on 6/19/18 at 9:15 AM with Resident #1 revealed he has been at the facility for 5 years. There have been several changes in the years but he had the most concerns since February of this year' the new Administrator and and new DON initiated ongoing concerns for themselves. He described a mass exit of long time staff, which caused fear for him and others. Replacement agency staff are not as caring, do not know the residents' needs or how to care for the residents

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and lacked the desire to get to know the residents. The resident declined to offer any names of staff that he described. Once, he questioned agency staff about medications. The staff member become upset when questioned about the medication and or time given.

The resident stated he felt shunned by the Administrator and the DON and had not been provided prompt responses. He felt he had been wrong to bring concerns to the attention of the Administrator and the DON. Repeatedly the resident stated he felt disrespected. He stated he knew the facility's grievance process and numbers to call and had followed protocol by going to the DON and the Administrator and to the Ombudsman.

An interview on 6/20/18 at 11 a.m. with Staff A, RN (Registered Nurse) stated Resident #1 can be harder to deal with at times. He speaks for his needs as well as for others and that is okay; staff need to listen, communicate his needs and continue to offer reassurance.

On 6/21/18 at 6:50 a.m. with Staff B, LPN (Licensed Practical Nurse) described the resident #1 as chronic complainer, with high expectations, who had his rules and way. Staff B thought resolution to the resident's concerns would come in time.

An interview 6/21/18 at 8 a.m. with the DON described Resident #1 as a daily visitor to his office and the resident speaks of any concerns. The DON revealed that both were of military background and the DON revealed the need for the resident to feel in charge and that he had to report concerns. The DON stated the need to

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F 550	Continued From page 5 document these chats and his responses back to the resident and that could help alleviate some of the residents' concerns. The DON stated Resident #1 had a history for blocking the nursing station, especially at the change of the shift, and backed up into others. The DON had no information as to times of occurrences.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565	Social Service Designee (SSD) was appointed on 6/20/18. SSD visited with Resident #35 regarding grievance response on 6/26/18. Resident Council meeting held on 6/29/18 to discuss grievance policy and response follow up. Educated SSD on proper grievance policy and response follow up on 6/27/18 and again 7/23/18. Audits will be completed by the DON/ or Designee periodically to ensure compliance. Ongoing Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 565	Continued From page 6 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident Council interviews, review of Resident Council minutes, resident interviews, staff interview and facility policy review, the facility failed to respond to concerns and grievances brought to the facility's attention and failed to follow up with residents regarding resolution of their concerns or provide rationale if no resolution found within 3 days for 5 of 5 residents present for the group interview and for one of 20 sampled residents (Resident #35). The facility reported a census of 42 residents. Findings include: 1. During a Resident Council meeting conducted on 6/18/18 at 1:26 p.m., 5 out of 5 residents in attendance voiced they did not feel the facility responded to their concerns. One resident commented he quit attending the meetings on a routine basis because nothing ever changed. The residents reported the nursing department changed things without telling them they were going to change them. The group could not voice who in the facility acted as the grievance official and 3 of the 5 residents did not know how to file a grievance. Two of the 5 residents in attendance felt they could not complain to the facility without worrying about retaliation. The group commented they could articulate but had concerns for other helpless residents who could not voice issues. One of the residents commented the	F 565		

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Administrator and the Director of Nursing (DON) did not know he existed, never acknowledged him and never followed up with him on concerns. Two of the residents reported when they brought up concerns to a representative of the facility, the representative responded they would be happy to find the resident another place to live.

In an interview with the Administrator and the DON on 6/19/18 at 4:30 p.m., the DON stated the book for the grievance procedure is located near the front door. The Administrator reported the facility recently changed the grievance process and the staff in charge of it. The DON had acted as the grievance officer since 6/1/18 but prior to that the Activities Director had been the official. The Administrator reported the Activities Director had started working at the facility in 2/18 and would have been responsible for following up on Resident Council concerns and get back to residents with rationales or resolutions of grievances. The DON stated he had no reported grievances since 6/1/18. The DON stated, honestly, he would have to dig to find old grievance forms as he did not know where they would be located.

In an interview on 6/20/18 at 5:25 p.m. the Activities Director stated she started working at the facility on 2/13/18. The Activities Director said to her understanding her job responsibilities were activities and Resident Council meetings. The Activities Director stated if a concern arose in Resident Council she recorded it, typed it up, and sent the concern to the appropriate department head. The Activities Director said when they gave a response about following up on the concern, she let the residents know and stated she kept the documentation. The Activities Director

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reported she then went over the concerns at the next Resident Council meeting. She stated to her knowledge she was not in charge, nor ever had been, assigned as the Grievance Official prior to the DON; she only took care of Resident Council concerns. The Activities Director reported the Resident Council usually reported concerns related to staffing every meeting. The group always said there were long call light times, call lights not getting answered, not having drinking water passed and the residents felt not listened too.

2. The Resident Council minutes dated 3/26/18 recorded they voiced concerns regarding the nursing department. The residents had concerns with ice water needing to be passed in rooms regularly, pool aides not knowing residents' habits and not always answering alarm call lights promptly. The minutes documented the DON joined the meeting to address resident concerns.

The Resident Council minutes dated 4/30/18 recorded the residents voiced concerns in the nursing department. They had concerns with dirty laundry not getting picked up, ice water not being passed regularly, forgetting to return after checking on the call light and waiting times the # 1 issue.

The Resident Concern form from Resident Council meeting 4/30/18 documented a response for the Activity Department. The undated, unsigned, handwritten response recorded the facility just hired more personnel and so issues should get resolved or improve significantly in the near future.

The Resident Council minutes dated 5/25/18

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recorded the residents voiced concerns in the nursing department. The minutes recorded concerns with laundry not always being picked up, beds not made or made late in the day, knowing about appointments in advance and ice water not always being passed.

The Resident Concern form from Resident Council meeting 5/25/18 documented a response for the Activity Department. The undated, unsigned, handwritten response documented that beds were getting made on a daily basis, they would address the laundry not being picked up, would educate the staff on ensuring communication for appointments - would be done ahead of time, and would remind staff about the importance of passing out ice water.

3. The Minimum Data Set assessment dated 5/18/18 for Resident #35 identified a Brief Interview for Mental Status score of 10 without signs/symptoms of delirium. A score of 10 indicated moderate cognitive impairment. The MDS documented diagnoses that included depression and chronic lung disease.

The care plan focus area dated 3/10/15 identified at times the resident could be a little forgetful but on interview able to state the year, month, and day of the week as well as repeat the words and repeat them later without cues.

In an interview on 6/20/18 at 9:35 a.m., Resident # 35 reported at night there was not enough help. Resident # 35 had reported concerns with receiving assistance and with not getting his breathing treatments in a timely manner. Resident # 35 said the problem with voicing concerns a resident had to prove it happened

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because management listened but didn't do anything about issues. Resident # 35 stated that it's nice the surveyor tried to help, but nothing would change. The resident had reported all these things and nothing ever gets done about it. Resident # 35 stated the concern had been going on for a long time. Resident # 35 repeated that he felt the management would not do anything about the staffing issue. Resident # 35 said some staff provide excellent help, but he felt most of the good help left because management didn't listen or pay attention to the concerns staff voiced. Resident # 35 stated he lived at the facility a long time and felt very aware of what went on in the facility. Resident # 35 voiced he felt management needed a change badly.

In an interview on 6/20/18 at 3:25 p.m., the DON reported he spoke with Resident #35 daily. The DON reported he heard other people say Resident #35 had concerns with people not paying attention and not talking to him, but the resident did not report any problems to him. The DON said the people who informed him the resident had concerns were the resident's daughter and some of his staff. The DON reported the concerns were reported within the last 3 weeks. The DON stated unfortunately he did not document any of his conversations with Resident #35 regarding the resident's concerns. The DON commented he should have documented them; lesson learned.

4. The Grievance Procedure for Residents, revised 10/1/17, instructed the following:
If any resident believes he/she has been treated unfairly by the staff, policies and procedures of this facility, or his rights have been violated, he may use the following procedure with the

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assurance that no coercion, discrimination or reprisals against him will follow because of his registering a grievance.
The procedure is designed to bring satisfaction in all cases where there is a problem to be solved.
The resident may first visit with the facility grievance official, DON, (with contact information listed for office location, phone number, and email address).
The responsibility of the Grievance official is to:
Point 1. Oversee the process
Point 2. Receive and track the grievance through to conclusion.
Point 3. Lead the investigation by the facility
Point 4. Maintain the confidentiality of all information associated with the grievance including the identity of the resident.
The resident may also file a grievance in many different ways
a. By verbally communicating with staff.
b. By written word via email or filing out the form located in the binder by the nursing offices and giving it to staff.
c. Or anonymously by completing the form and placing it under (a staff member's) office door or the business office door.
d. If staff cannot resolve the issue to both parties satisfaction immediately, the resident should proceed to the next step.
Upon reviewing the grievance the official will notify the administrator and a solution to the grievance will be determined within 3 days and communicated to the resident in writing by the end of the 3rd day.
If warranted, immediate action will be taken upon knowledge of the grievance if the report alleges neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property by anyone furnishing services to the

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F 565	Continued From page 12 resident on behalf of the provider as it is required by State law. Records of the written grievance will be kept in the business office and in confidence for a period of five years. Other agencies that may be notified and/or involved include: Department of Inspections and Appeals: 1/877-686-0027 Long Term Care Ombudsman program: 1-866-236-1430 The Police Department: 515-465-4636 The Resident Grievance Form contained a section to document Summary of findings and/or conclusions along with areas for resident and Administrator signatures	F 565		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644	Resident #19 had PASRR updated on his care plan on 6/27/18 to reflect recommendations. All residents were audited from 06/26/2018 to 07/25/2018 for PASRR recommendations. Educated the MDS nurse on 6/26/18 on care planning PASRR recommendations. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 644	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to incorporate PASRR (Preadmission Screening and Resident Review) recommendations into a resident's plan of care for one of one resident reviewed for PASRR recommendations (Resident #19). The facility identified a census of 42 current residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/20/17 documented Resident #19 had diagnoses that included depression, a psychotic disorder and obsessive compulsive disorder. The MDS assessment dated 4/18/18 for Resident #19 documented his diagnoses continued to include depression, a psychotic disorder and obsessive compulsive disorder. The PASRR evaluation dated 8/25/17 documented the resident met the criteria for having a diagnosis of mental illness as defined by PASRR. The evaluation gave recommendations for specialized services. These recommendations included: Socialization/Leisure/recreation/activities Supportive counseling from nursing facility staff Arrange public transportation Cleaning service Home Health aide Home evaluation for modifications or other needs Meal preparation including Meals On Wheels Case management for frail elders Psychiatric services by a psychiatrist to the evaluation response to psychotropic medications,	F 644		

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F 644	Continued From page 14 modify medication orders and to evaluate ongoing need for additional behavioral health issues. The resident's Plan of Care with a target date of 7/29/18 failed to address the PASRR recommendations for specialized services. During an interview on 6/21/18 at 10:18 a.m. the Director of Nursing stated the MDS Coordinator completed the PASRR care plan but the facility now had a new MDS coordinator and it was not completed.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656	Residents #8 care plan was updated with anticoagulation medication on 6/26/18. Residents care plans who are on anticoagulation medication were reviewed on 6/26/18 to ensure care plans reflect this type of medication. MDS Coordinator was educated on 6/26/18 on care planning anticoagulant medication. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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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 clinical record review and staff interview, the facility failed to ensure two residents had comprehensive care plans in place (Residents #8 and #38) and failed to ensure staff implemented planned interventions for one resident of 30 total residents sampled. The facility reported a census of 42.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/25/18 for Resident #8 documented diagnoses that included peripheral vascular disease (PVD), Non-Alzheimer's dementia and long term (current) use of anticoagulants. The MDS identified the resident received anticoagulation medication on 4 out of 7 days of the assessment reference period.

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The faxed order dated 6/20/18 documented an order to restart Coumadin 4 mg (milligrams) daily and recheck the resident's INR (international normalized ratio, an indication of how long it takes the blood to clot) lab in 2 days.

The resident's care plan, initiated on 3/1/16 and with a target date of 8/31/18, lacked any documentation pertaining to the use of Coumadin (an anticoagulant medication).

On 6/20/18 at 4:55 p.m., when questioned about Resident # 8's care plan not addressing the resident's anticoagulant use, the Director of Nursing (DON) stated the facility in the process of updating all care plans.

2. The MDS dated 5/23/18 documented diagnoses that included chronic atrial fibrillation, chronic embolism (blood clot) and thrombosis of unspecified deep veins of the left lower extremity and Non-Alzheimer's dementia for Resident #38. The same MDS documented the resident has short and long term memory loss, has 2 or more falls without injury and received daily anticoagulant medication (to prevent blood clots) during the assessment period.

a. The resident's Medication Administration Record (MAR) documented an order dated 11/30/17 to administer Eliquis (an anticoagulant medication) 2.5 mg (milligrams) two times daily.

The resident's care plan, with a target date of 9/5/18, failed to address his anticoagulant use.

The facility's Nursing 2017 Drug Handbook directed the following Nursing Considerations for Eliquis: monitor patient for bleeding and

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neurological impairment (midline back pain, sensory motor deficits such as numbness or weakness in the lower limbs, bowel or bladder dysfunction. The Handbook also directed the following Patient Teaching: caution patient that bruising or bleeding may occur more easily and to report unusual bleeding.

b. Incident reports dated 4/29/18 and 6/15/18, documented episodes of aggression towards other residents.

The resident's care plan, with a target dated 9/5/18, lacked any information regarding the resident's aggressive episodes or interventions to promote his and other residents' safety.

3. The MDS assessment dated 5/30/18 documented Resident #40 had a BIMS score of 2, indicating severe cognitive impairment. The MDS documented diagnoses of heart failure, Parkinson's disease and Non-Alzheimer's dementia. Resident #40 required the assistance of 2 staff with dressing.

Review of the care plan with a target date of 9/6/18, revealed staff direction to place Ted hose (antiembolism stockings) on for the resident in the a.m. and remove them in the p.m.

Observations throughout the survey, from 6/18/18 to 6/21/18, revealed Resident #40 did not wear Ted hose on her lower extremities.

An interview with Staff B, LPN (Licensed Practical Muse) on 6/21/18 at 6:50 a.m. revealed when she observed Resident #40, there were no Ted hose on her lower extremities. Staff B stated the Teds should be on in the a.m. She asked a passing

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F 656	Continued From page 18 CNA (certified nursing assistant) about the Ted hose and she told Staff B she didn't know where the resident's Teds were. An interview on 6/21/18 at 8 a.m. with the DON revealed he would check on the resident's Ted hose and find out why they were not on the resident. The DON acknowledged care needs and physician ordered care should be on the resident plan of care as directed unless documented otherwise.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657	QAPI action plan was completed on 6/21/18 Resident #35 care plan was updated to reflect the issue of depression and loss of his wife on 6/26/18 as well as an update with the fall intervention from 5/11/18. Residents care plans who have depression, family loss, and fall interventions were reviewed on 6/26/18. Fall interventions are reviewed during risk management weekly meetings. Care plans are reviewed and revised quarterly and prn to reflect changes in the plan of care. MDS Coordinator was educated regarding updating resident care plans to reflect depression, loved one loss, and fall interventions on 6/26/18. Floor Nurses will be educated on updating resident care plans to reflect fall interventions by 07/31/2018. MDS Coordinator was educated on interventions for care regarding pressure injuries being addressed in the care plan as of 7/26/2018.	

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F 657	Continued From page 19 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident and staff interviews, the facility failed to update resident care plans when indicated and for all staff members providing care for 3 of 30 total residents reviewed (Residents #35, #16 and #40). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/21/18 for Resident #35 identified a Brief Interview for Mental Status (BIMS) score of 12 without signs/symptoms of delirium; a score of 12 indicates moderate cognitive impairment. The Mood section of the MDS documented on 7 to 11 days of the previous 2 weeks, Resident #35 experienced all of the following: little interest or pleasure in doing things; he felt down, depressed, or hopeless; had trouble falling or staying asleep, or sleeping too much; felt tired or had little energy; and with a poor appetite or overeating. The MDS documented diagnoses that included depression and chronic lung disease. The MDS assessment of 5/18/18 documented Resident #35 now had a BIMS score of 10 without signs/symptoms of delirium (10 indicated moderate cognitive impairment). The mood section of the MDS documented during 2 to 6 days of the previous 2 weeks, Resident #35 felt down, depressed, or hopeless. The care plan focus area dated 3/10/15 identified	F 657	The SSD was educated on communicating residents with new depression and family loss to MDS Coordinator for care plan updates on 07/27/2018. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 657	Continued From page 20 a focus area of mood/psychosocial as the resident had depression and voiced little interest or pleasure in doing things. The care plan focus area dated 12/11/15 identified the resident took an antidepressant medication for depression and incontinence issues. The focus area recorded the resident remained mildly depressed and during the interview, he expressed he felt depressed and lacked concentration. The care plan lacked documentation of revisions to reflect the increased mood severity score from the 3/21/18 MDS assessment. The care plan lacked updates for the resident's spouse passing away on 3/17/18 or interventions related to social services for the grieving process. The Progress Notes dated 3/17/18 and 3/18/18 made no mention of the resident's wife, Resident #194, passing away. Resident #194's clinical record reflected she passed away on 3/17/18 at 6:55 p.m. The progress notes documented that on 3/18/18 at 2:33 p.m., the resident's family visited the facility. The Progress Notes dated 3/21/18 at 2:47 a.m. documented the resident commented his wife passed a couple days prior and he would be going to the visitation the next day. The resident told staff he didn't know what to do now, they were married 70 years and he reminisced about memories with his wife. At 10:56 a.m. the notes documented the resident continued to be sad and stayed in his room telling the nurse he would need help all day that day. The note recorded the resident to go to wife's funeral; comforts given but not much help. The Progress Notes dated 3/26/18 at 4:48 a.m. documented the resident continued with follow up	F 657		

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F 657	Continued From page 21 for signs/symptoms of depression and the resident was quiet that shift. Resident #35 displayed an upset mood at bedtime, stated he felt stressed and continued to express thoughts of his late wife. At 10:35 a.m. the notes documented the resident continued to be sad related to the death of his spouse and he did not want to get up that day; hospice chatted with the resident. The Bereavement notes completed on a hospice routine visit dated 4/18/18 documented hospice staff provided Bereavement Services that visit. The note recorded the team recommended a bereavement visit or 2 for Resident #35. The note documented the resident discussed his loss and reported the first few weeks were difficult but it had gotten better. The note recorded hospice left the 'When You are Grieving' booklet with the resident with plans to visit again in 2 to 4 weeks. On 6/20/18 at 9:35 a.m., Resident # 35 stated he had trouble with depression and he tried his best to keep getting out and about. Staff encouraged him to keep active since his wife's passing. Resident # 35 stated he and his wife attended a church and the minister visited every other week or 2. Resident # 35 said he had hospice services but he had improved, so he did not have hospice services anymore. In an interview on 6/20/18 at 4:55 p.m., the Director of Nursing, (DON), stated the facility in the process of updating all care plans. 2. The MDS assessment for Resident #16, dated 4/11/18, documented diagnoses of neurogenic bladder, retention of urine, anxiety disorder and chronic obstructive pulmonary disease(COPD).	F 657		

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F 657	Continued From page 22 The MDS documented the resident as alert and orientated with a BIMS score of 14. The MDS documented the resident required the assistance of one staff for transfers, dressing and personal hygiene. The MDS documented the resident as at risk for pressure ulcer development and documented the use of pressure reduction devices in her chair and the bed. The care plan review revealed no directions for the staff for May 5th, identified and documented stage 3 ulcer located on the resident's coccyx area. The plan of care directed staff to inspect the skin for bathing and personal cares, check for redness, open areas, scratches, cuts, bruises, and to report any changes to the nurse. The C-Wing Pocket Plan not dated failed to provide direction to the staff to care for the resident open skin area on the coccyx. An interview on 6/21/18 at 8 a.m. with the Director of Nursing (DON) identified the need for an initial assessment to had been completed to coincide with the documentation of the coccyx area on the hospice progress notes. An interview on 6/20/18 at 11 a.m. with Staff A, RN expressed the resident's coccyx area looked much better and revealed any documentation of the area would be on the computer Point Click Care program. An interview on 6/21/18 at 6:50 a.m. with Staff B, LPN revealed the process when any skin area had been identified an initial assessment would be completed with weekly followup. Staff B, LPN added notification to the family and physician and Director of Nursing would be documented as well.	F 657		

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F 657	Continued From page 23 Staff B, LPN revealed the care plan would be initiated and direct the staff for the care and documentation of the identified area.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interview, facility staff failed to provide planned baths to one resident (#41) and complete incontinence care to another resident (#5) of 30 residents reviewed. The facility identified a census of 42 current residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/30/18 documented diagnoses that included muscle weakness, muscular dystrophy, arthritis and peripheral vascular disease for Resident #41. The same MDS documented a BIMS (brief interview for mental status) score of 15 which indicated intact memory and cognition. Resident #41 required the assistance of one for personal for hygiene activities and bathing. The care plan focus area, initiated 4/13/16, identified the resident with lower extremity weakness as a result of muscular dystrophy. The interventions directed staff to offer resident a bath of choice/whirlpool 2 times weekly and 1 staff or more should assist the resident for personal hygiene.	F 677	Resident #41 and all similarly situated residents will receive baths as care planned. Bath Aide will be educated by 07/31/2018 regarding the importance of resident baths being given as care planned. DON or Designee will audit periodically that baths are completed and documented. Results of bath audits will be reviewed through the QAPI Committee. Resident #5 and all similarly situated residents will receive appropriate peri-care. Staff member# K and R were educated on perineal care on 6/27/18. C.N.A.'s were re-educated on peri-care on 6/29/18. DON or Designee will audit peri-care periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 677	Continued From page 24 During interview on 6/19/18 at 11:27 AM, Resident #41 stated he is upset he has not been received whirlpool baths 2 times weekly since around the first of April. The resident stated he wishes to have a whirlpool bath 2 times weekly as it loosens his muscles so he can function a little better. The resident stated he attended his care plan conference on 6/13/18 and expressed his concern about not receiving whirlpool baths. Staff at the care plan conference told him his clinical record contained documentation of frequent bath refusals; he told staff that was not true and that he had only received about 5 baths since the beginning of April. The resident stated he also told the care plan staff that CNA's (certified nursing assistants) have frequently told him he could not get a bath because he requires 2 people to transfer him in and out of the bath and the facility did not have enough staff on the hall to do so. The resident felt staff documented he refused a bath rather than documenting it had not been done; staff in attendance at the care plan conference did not reply to this statement nor did they suggest how to accomplish his whirlpool bath 2 times weekly. During interview on 6/19/18 at 9:00 AM, Staff T, CNA stated she started as a bath aide yesterday and had to be pulled to the floor. She stated there has been an issue with getting baths done for residents due to lack of staff over the last several months. 2. The MDS assessment dated 3/14/18 documented Resident #5 had diagnoses that included high blood pressure, vascular/arterial disease, high cholesterol, Alzheimer's disease, dementia, Parkinson's disease, anxiety,	F 677		

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F 677	Continued From page 25 depression, chronic lung disease, and a psychotic disorder. The MDS documented the resident had long and short term deficits as well as severely impaired cognition. Resident #5 required the assistance of 2 staff for bed mobility, transfers, dressing and personal hygiene and the assistance of one staff with walking and toilet use. Resident #5 experienced routine bowel and bladder incontinence. During observation on 6/20/18 at 9:50 a.m. Staff K, CNA and Staff R, CNA assisted Resident #5 to the bathroom and assisted him to sit on the toilet; observation revealed the resident as incontinent of urine and a large loose bowel movement. Staff R removed the soiled Depend (incontinence brief) and then used two washcloths to cleanse the resident's buttocks of stool. Staff applied a clean Depend. The staff members failed to cleanse the resident's inner groin folds and genital area. Point #7 of the facility's policy on Incontinence/Perineal Care (revised 12/3/14) instructed staff to wash all soiled skin areas and dry well, especially between the skin folds.	F 677		
F 688 SS=G	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	F 688	QAPI action plan was completed on 6/25/18. Resident #5 was evaluated by OT on 6/25/18 for potential contractures. He was placed on OT services for contractures on 6/25/18. Resident #5's care plan was updated to reflect the contracture 6/28/18. The therapy department is provided a list of ARD dates for upcoming resident assessments and they are to be screened prior to the MDS assessment. All residents care plans who have contractures were reviewed and revised on 6/28/18.	

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F 688	Continued From page 26 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: Based on clinical record review, observation and staff and family interviews, the facility failed to ensure each resident received the appropriate assessments, treatment, and services to prevent a decline in range of motion for one of one resident reviewed for rehabilitation needs (Resident #5). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/14/18 documented Resident #5 had diagnoses that included high blood pressure, vascular/arterial disease, high cholesterol, Alzheimer's disease, dementia, Parkinson's disease, anxiety, depression, chronic lung disease, and a psychotic disorder. The MDS documented the resident had long and short term deficits as well as severely impaired cognition. Resident #5 required the assistance of 2 staff for bed mobility, transfers, dressing and personal hygiene and the assistance of one staff with walking and toilet use. The MDS documented the resident had no range of motion (ROM) limitations to either the upper and lower extremities. The MDS documented the resident did not receive passive or active ROM or any restorative activities during the assessment	F 688	Care plans are reviewed and revised quarterly and prn to reflect changes in the plan of care. Staff who oversee updating care plans were educated regarding updating resident care plans to reflect contractures on 6/26/18. Therapy Department Head re-educated regarding screening process 7/19/18. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Audit findings will be brought to the monthly QAPI meetings. Ongoing Compliance Date: 7/19/18	7/19/2018

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F 688	Continued From page 27 period. The MDS assessment dated 6/13/18 documented the resident had no ROM impairment to either the upper or lower extremities. The care plan, with a target date of 7/1/18, did not document any ROM impairment. Review of the Occupational Therapy notes dated 8/10/16 to 11/7/16 revealed a fitting for compression socks to reduce edema in the lower legs. The resident had no further assessments from therapy. Observations on 6/20/18 at 8:15 a.m. and 10:20 a.m. revealed the resident kept his left hand in fisted position. Interview with the resident's daughter at 10:20 a.m. revealed Resident #5 did not keep his hand in a fist until a couple months ago. The facility had not done anything that she knew of. Further observation revealed the resident's left fingers would not extend and a strong odor of yeast. During an interview on 6/20/18 at 7:25 a.m. Staff I, Restorative Coordinator, stated the resident did not have a restorative exercise program. During an interview on 6/20/18 at 9:50 a.m. Staff K, certified nurse aide from a temporary agency, stated the resident has had his hand in a fist for the last couple months. Staff K did not recall telling anyone about it. During an interview on 6/25/18 at 9:01 a.m. Staff Q, Physical Therapy, stated no one from the staff had told her about the resident's hand. Prior to the current MDS Coordinator, there had been no	F 688		

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F 688	Continued From page 28 system in place to screen residents for a decline in function. The Certified Occupational Therapist Assistant (COTA) completed an assessment on the resident's left hand on 6/25/18. She documented a recent decline in function, the left hand had ROM impairment and requested an Occupation Therapy evaluation. During an interview on 6/25/18 at 9:01 a.m. the COTA that assessed Resident #5 stated the resident's left hand had contractures. She asked for a therapy evaluation to assess for a hand brace and education to the certified nurse aides on gentle ROM. She thought the contractures could have been prevented.	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 clinical record review, observation, facility record review and resident, family member and staff interviews, the facility failed to provide appropriate supervision to ensure each resident's individual safety for 2 of 7 residents reviewed for falls. The facility failed to supervise a resident after giving a resident a suppository to initiate the need to use the restroom that resulted in 2	F 689	Resident #194 has passed away on 03/17/2018, unrelated to the hip fracture. Resident #35 had a side rail assessment completed on 07/25/2018 and care plan updated. Staffing PPD ratio for the past month has been 5.89 hours direct care per resident per day . A side rail safety assessment was implemented on 07/26/2018. A new side rail assessment will be initiated when the resident's next MDS is due and care plan will be updated to reflect side rail usage. DON or Designee will audit periodically that side rail assessments are getting completed with the next MDS due. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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separate falls (Resident #194) and failed to provide assistance in a timely manner to reduce the risk of a fall that resulted in injury for another resident (Resident #35). The facility reported a census of 42 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/13/18 for Resident #194 revealed diagnoses that included hip fracture, Alzheimer's disease, Non-Alzheimer's dementia, limb pain and arthropathy. The assessment documented she required the assistance of 2 for bed mobility, transfer, dressing and toilet use. The assessment documented she had unsteady balance when moving from seated to standing position, moving on and off toilet, during surface-to-surface transfers and could stabilize only with staff assistance. The resident used a walker and wheelchair for mobility devices. The MDS identified the resident experienced occasional urinary and bowel incontinence. The MDS documented Resident #194 fell once without injury since the prior assessment.

The care plan focus area initiated on 12/16/14 identified a cognition focus for dementia/Alzheimer's disease. The area informed staff the resident could communicate her needs, could/did follow directions given as long as not complex and as forgetful requiring prompts, cues and reminders at times when out of her routine. The care plan directed staff to cue, reorient, and supervise as needed.

The care plan focus area initiated on 12/14/17 identified an activities of daily living concern related to dementia and the resident could forget

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things. The care plan directed staff to provide the assistance of 2 persons for transfers and toileting. The care plan informed staff the resident had full weight bearing status on the right side and TTWB (toe touch weight bearing) on the left side.

The care plan focus area dated 12/17/14 identified a concern with falls related to cognitive impairment and a history of chronic pain. The care plan informed staff Resident #194 could walk with a walker and sometimes came out of the room without the walker, she walked fast and had fallen in the past. The care plan directed staff to check on the resident for toileting/incontinent care every hour and to review information from falls to attempt to determine a cause for a fall.

The Incident Report dated 1/15/18 at 9:47 a.m. recorded an unwitnessed fall for Resident #194. The report documented staff found the resident on the floor when doing rounds, the resident complained of left hip pain and the resident transferred to the ER (Emergency Room) for further evaluation. The resident had a fracture of the left trochanter (hip) after the fall. The Predisposing Physiological Factors section documented Resident #194 as confused and with impaired memory. The Notes section of the report documented to reiterate the need to wait for assistance prior to getting up out of bed and the facility would have PT (Physical Therapy) re-evaluate whether or not the resident should have 1 or 2 person assist when transferring.

The Incident Report dated 1/29/18 at 4:49 p.m. recorded an unwitnessed fall for Resident #194. The report documented the resident found on the

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floor lying on her right side in a fetal position and stated she tried to get out at the end of the bed and didn't make it. The report documented no injuries observed post incident. The Predisposing Situation Factors of the report documented improper footwear, recent room change, side rails up, and ambulating without assist. The Other Info section recorded the resident had a left hip fracture, but did not remember that she could not walk or stand independently. The resident's call light was on, but she does not use it to call for assistance. The Certified Nurse Aide (CNA) reported being in the room 15 minutes before discovery and the resident laid in bed. Staff found the resident's foam abductor pillow (used between legs to keep from crossing after a hip fracture) and gripper socks on the floor at the end of the bed and resident had no shoes or socks. The Notes section recorded the resident should be checked on for toileting/incontinent care every hour due to frequent stools as the resident took MOM (Milk of Magnesia, a medicine used to produce bowel movements) daily. The fall did not result in injury.

The Medication Administration Record (MAR) for February 2018 revealed the resident received a PRN (as needed) bisacodyl suppository (medication used to stimulate a bowel movement) on 2/21/18 at 6:50 a.m.

The Incident Report dated 2/21/18 at 7:00 a.m. recorded an unwitnessed fall for Resident #194. The report documented staff gave the resident a suppository at 6:50 a.m., the aide just in the room and returned to recheck the resident but found her on the floor beside the bed in front of the chair in a seated position. Three staff picked the resident up and took her to the bathroom and

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then to the recliner. The resident cried out stating her left hip hurt and grabbed her hip. The report revealed the resident transferred to the ER and the facility would contact the physician about bowel regimen to prevent suppositories for the resident. The Other Info section documented the resident had a suppository and 10 minutes later tried to get up to go to the bathroom, the aide had just been in the room.

The Progress Notes dated 2/21/18 at 11:04 a.m. documented the resident returned from the hospital with new orders to discontinue PT and the resident could be up to bathroom, commode or recliner with SBA (stand by assist). The note recorded staff notified the resident's family of new orders, faxed the physician concerning her bowel regimen and X-rays showed no fracture.

The Progress Notes dated 2/21/18 at 4:04 p.m. documented the physician response with new order to discontinue senna (a laxative medication) and begin amitza (a different laxative used for irritable bowel syndrome).

The Progress Notes dated 3/9/18 at 10:11 a.m. documented since the hip surgery the resident no longer ambulated herself and required assistance from staff with all transfers and ambulation.

The MAR for March 2018 revealed Resident #194 received a PRN bisacodyl suppository on 3/10/18 at 5:01 a.m.

The Incident Report dated 3/10/18 at 5:57 a.m. recorded an unwitnessed fall for Resident #194. The report documented the resident's roommate retrieved staff to inform them the resident fell. The report recorded the call light not activated

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F 689	Continued From page 33 when the nurse arrived to the room where she found the resident lying on the floor approximately 3 feet from the bed, with 1 gripper sock on foot and the other foot bare. The resident stated she tried to get to the bathroom and the resident transferred to the hospital. The Predisposing Physiological Factors section documented gait imbalance, impaired memory, weakness/fainted and other. The Other Info section documented the resident given a suppository that morning. The Notes section recorded make sure gripper socks on both feet and no early morning suppositories. In a family interview on 6/19/18 at 2:45 p.m., the resident's daughter reported after the resident's hip fracture, she stayed in the facility for 5 days because she worried about additional falls. The family member said the facility had too many high labor patients and not enough staff to care for them. 2. The MDS assessment dated 3/21/18 for Resident #35 identified a Brief Interview for Mental Status (BIMS) score of 12 without signs/symptoms of delirium; a score of 12 indicated moderate cognitive impairment. The MDS revealed the resident required the assistance of 1 person for bed mobility, transfers, walking in room, dressing and toilet use. The MDS recorded the resident as always continent of bowel. The resident had diagnoses that included depression, chronic lung disease, generalized muscle weakness and hypoxemia (low blood oxygen levels). The MDS assessment dated 5/18/18 for Resident #35 identified a BIMS score of 10 without signs/symptoms of delirium; a score of 10	F 689		

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F 689	Continued From page 34 indicated moderate cognitive impairment. The care plan focus area dated 3/10/15 identified at times the resident could be a little forgetful but on interview, is able to state the year, month and day of the week as well as repeat the words and repeat them later without cues. The care plan focus area dated 12/17/14 identified a focus on activities of daily living due to issues with OA (osteoarthritis) and chronic pain. The care plan directed staff to provide minimal assistance of 1 for bed mobility, toileting and transfers with gait belt. The care plan focus area dated 12/17/14 identified a focus on falls due to weakness/chronic pain and use of an antidepressant medication. The care plan informed staff the resident was non-compliant with using call light for assistance and he had strong desires to be independent. The resident walked with a front wheeled walker and required oxygen as his oxygen level decreased with activities. The resident could be unsteady at times but did stabilize himself as well. The care plan directed staff to assist the resident getting in and out of bed, check on the resident frequently. The care plan lacked documentation pertaining to the use of a bed rail for boundary awareness. Review of the clinical record revealed a lack of assessment for bed rails. The Incident Report dated 5/11/18 at 1:45 a.m. documented an unwitnessed fall for Resident #35 written by Staff F, Registered Nurse (RN). The report recorded the CNA, (Staff H), reported finding the resident on the floor. Staff F wrote the	F 689		

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resident leaned against the bed on the bathroom side of the bed and the bed rail in the up position. Staff F documented the resident had a skin tear central to his forehead with approximately 10 to 15 cc (cubic centimeters) of blood on the floor. Staff F wrote the resident had 2 skin tears on the left elbows, 2 on the right elbow, some swelling and a hematoma (solid swelling of clotted blood within the tissues) on the left wrist and a smaller hematoma forming on the right elbow. Staff F recorded the resident stated he was getting up to go to the bathroom. The Immediate Action Taken section recorded staff assisted him back into bed and approximately 20 minutes afterward, he requested to be sent to the hospital to be evaluated. Staff obtained an non-emergent ambulance. The Predisposing Situation Factors section recorded the side rails as up. The Other Info section recorded the resident needed to go to the bathroom and the bed rail was up. The Notes section instructed to ensure the bed rail down and locked.

The Emergency Department (ER) Record/History and Physical dated 5/11/18 at 3:30 a.m. documented assessment revealed a laceration on the forehead and skin tears on both elbows. Resident #35 complained of pain in the left shoulder, rated at 3 on a 0 to 10 scale (10 worst pain imaginable) and ER staff completed an X-ray of the left shoulder. The record documented a left shoulder contusion, a laceration of the forehead and skin tears of both elbows.

The Progress Notes dated 5/11/18 at 5:50 a.m. documented the resident returned from the hospital.

In an interview on 6/19/18 at 2:04 p.m., Staff C,

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CNA, stated the resident slept in his bed, she thought the side rails should be put down when the resident was in bed and she did not think he could put the rails down.

Observation on 6/19/18 at 2:06 p.m. revealed Resident # 35 rested in the recliner next to the right side of his bed. The bed rail on the right side was in the down position and the controls for the bed hung on the side rail.

During an interview on 6/19/18 at 2:45 p.m., the resident's family member stated staff did not respond to call lights quickly. The family member recalled the resident's fall from bed on 5/11/18, reporting that when the side rail in the up position it was out of the way. The family member stated the resident slept hugging the side of the bed and needed the side rail in the down position to protect him from falling out of bed. The family member reported the resident went face down and got numerous skin tears and a laceration to the head.

In an interview on 6/20/18 at 9:35 a.m., Resident # 35 reported he needed help with transfers and could not get someone to help for most of the evening. Resident # 35 reported he had several falls out of bed because staff did not put down his bed rail to assist him to stay in bed. Resident # 35 recalled the fall in May 2018 when he went to the ER but could not recall the specifics. Resident # 35 stated he had a history of falls with 2 broken hips over the years. Resident # 35 stated people like his wife with dementia were not watched closely and she had falls too.

In an interview on 6/21/18 at 4:20 p.m., Staff F, Registered Nurse (RN) stated being familiar with

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F 689	Continued From page 37 Resident # 35 and recalled the night the resident fell out of bed and requested to be sent to the ER. Staff F stated Staff H requested her help. When she went to the resident's room, she found Resident #35 sitting on the floor next to the bed with blood everywhere, the side rail up (out of the way) and the bed in low position. Staff F commented the resident obviously hit his head on the floor and had a laceration to his forehead. Staff F had been told the resident could put his side rail up. Staff F stated the resident could sit on the side of the bed, could reach over to pull the small knob, and could move the side rail to the up position. Staff F said she had seen it once but not since. Staff F responded she felt staffing was an issue with the fall that night and felt she had been short a CNA. Staff F stated the overnights normally staffed 2 nurses, 2 aides B hall, 1 aide A hall and 1 aide C hall. Staff F said they now staffed with 2 nurses, 1 aide B hall, 1 aide for A, C, and F halls. Staff F reiterated she felt that staffing was a factor in Resident # 35's fall that night. The daily staffing assignment sheet for the overnight of 5/10/18 going into 5/11/18 revealed 2 nurses scheduled and 2 CNA's for the shift. The sheet reflected 1 of the CNA's responsible to float coverage of A hall and C hall and the other CNA to cover B hall, the locked unit. Resident #35 lived on the A hall.	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	F 690	See next page please	

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F 690	Continued From page 38 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore 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, observation and resident interview, the facility failed to provide catheter care in a manner to reduce the risk of urinary tract infections when staff failed to keep a catheter bag and tubing off the floor for 1 of 2 residents reviewed for catheter cares (Resident #23). The facility reported a census of 42	F 690	QAPI action plan was devised on 6/21/18. Resident #23's foley catheter bags were discarded on 6/26/18 and new catheter was implemented. Educated Nurse D regarding gloving, changing foley catheter drain bags properly, ensuring catheter drainage bag tubing not touch the floor, and general infection control practices on 6/27/18. All Nurse staff was re-educated on 6/29/18 in proper care for foley catheter down drain bags. Audits will be completed by the DON/or Designee periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 690	Continued From page 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/25/18 for Resident #23 identified a Brief Interview for Mental Status (BIMS) score of 15 without signs/symptoms of delirium; a score of 15 indicated intact cognition. The MDS recorded the resident required the extensive physical assistance of 2 with bed mobility, transfers and toilet use and that Resident #23 required an indwelling catheter for urination. The MDS documented diagnoses that included heart failure, diabetes mellitus and unspecified urinary incontinence. The care plan focus area dated 1/31/18 identified an alteration in elimination related to an indwelling catheter. The care plan informed staff the resident may utilize leg bag during the day/change to down drain bag at night. The care plan also directed staff to monitor for signs/symptoms of urinary tract infection (UTI). The Progress Notes dated 6/10/18 at 10:58 a.m. documented communication to the physician that the CNA (Certified Nurse Aide) reported confusion and loss of appetite from the resident, history of UTIs, and requested a possible UA (urinalysis) to check for UTI. The Progress Notes dated 6/11/18 at 3:16 p.m. documented staff received a new order for an antibiotic for 7 days to treat a UTI. The UA results dated 6/13/18 documented greater than 100,000 cfu/ml (colony forming units per milliliter) indicating positive for UTI.	F 690		

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F 690	Continued From page 40 The Progress Notes dated 6/18/18 at 10:22 p.m. documented the resident continued on an antibiotic for UTI. In an interview on 6/18/18 at 12:56 p.m., Resident # 23 responded the staff changed his down drain bag over to a leg bag at times. At the time of the interview, the catheter down bag hung on the side of the trash can. Observation on 6/20/18 at 8:36 a.m. revealed Resident #23's catheter down drain bag laid on the floor of the room with moderate amount of yellow urine present in the bag. Staff D, Registered Nurse (RN) attempted to put the catheter bag back on the trash can to hang but the hook broke. Resident #23 stated they broke it the night before. Staff D said she would have to get another bag because it would be better than the catheter bag lying on the floor. Staff D went to supply and obtained a new catheter down drain bag and connected it. Staff D took the old bag into the bathroom, put a urinal on a paper towel in the bathroom, emptied the bag, rinsed the bag with water, poured in toilet, and placed back into the plastic sack hanging in the shower room. Staff D hung the catheter bag on the trash can and then changed the trash bag. With the same contaminated gloves, Staff D placed the catheter down drain bag into a dignity cloth bag. Observation on 6/21/18 at 1:15 p.m. revealed Staff G, Certified Medication Aide (CMA), and Staff D assisted the resident to walk with a gait belt and front wheeled walker to the bathroom. The resident's catheter bag hung on the walker railing and the tubing under the resident's foot while walking the whole way from the recliner into the toilet, approximately 10 to 15 feet. The	F 690		

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F 690	Continued From page 41 resident stood on the tubing and staff did not move the tubing off the floor.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under 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 on a group resident interview, review of Resident Council minutes, family interview, individual resident interview, staff interview and clinical record review, the facility failed to provide	F 725	Staffing PPD's are on an average of 5.89 for the past month. Review daily staffing PPD's to ensure adequate nursing staffing. Attend resident council, if permitted, to provide them with information on daily staffing PPD's. Educated resident council on PPD's on 06/26/18. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Audit findings will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 725	Continued From page 42 sufficient staff to meet resident needs in a timely manner for 5 of 5 present during the group interview and two of two residents reviewed for sufficient staffing (Residents #35 and #41). The facility reported a census of 42 residents. Findings include: 1. During the Resident Council meeting held on 6/18/18 at 1:26 p.m., 5 out of 5 residents in attendance voiced they felt the facility was short staffed. A resident commented the answer they get is, staff is busy. One resident reported he did not get baths due to the need for 2 person assistance. Another resident commented staff left her in the bathroom for an hour when they told her she could dress and undress herself (the resident reported she needed assistance at times). A third resident reported approximately 3 weeks before, he put on the call light at 5:00 p.m. for a nurse to check his earache and at 5:50 p.m. he went out to the nurses station to find the nurse. The resident said when he asked why it took an hour to help him, staff responded they would help when they got the meds done. The resident reported the nurse never did assess his ear. The group voiced concerns for the residents who were not capable of voicing issues. The group reported staff turn off the call light and say they will be back and they don't come back. The group stated the staff used to have to go to room to push a button to turn off the call light but they learned the facility did away with that system and staff could turn the call light off without going to the room. The group reported staff miscommunication happened a lot with new staff faces on C-wing almost every day. The group voiced the staff are constantly training and they felt frustrated.	F 725		

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F 725	Continued From page 43 In an interview on 6/20/18 at 5:25 p.m. the Activities Director reported the Resident Council usually reported concerns related to staffing at every meeting. The Activities Director said the group always said there were long call lights times, call lights not getting answered, not having drinking water passed and the residents felt not listened too. In an interview on 6/20/18 at 9:13 a.m., Staff C, Certified Nurse Aide (CNA), stated within the previous week the facility tried a new way of staffing to better meet the residents' needs. Staff C reported previously they staffed 2 CNAs on each hall - A, B, C. Staff C said they now staffed: 2 CNAs on hall B; 1 CNA on the back part of hall A and 1 back of Hall C; 1 responsible for the front half of hall A and front of hall C; and 1 CNA completed baths. Staff C stated the new assignments worked much better as she felt she could be present more often to focus on the back part of the halls. 2. The Resident Council minutes dated 3/26/18 recorded the residents voiced concerns in the nursing department. The minutes recorded concerns with ice water needing passed in rooms regularly, pool aides did not know residents habits, and alarm call lights not always answered promptly. The minutes documented the DON joined the meeting to address concerns. The Resident Council minutes dated 4/30/18 recorded the residents voiced concerns in the nursing department. The minutes recorded concerns with dirty laundry not getting picked up, ice water not being passed regularly, forgetting to return after checking on the call light, and waiting	F 725		

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F 725	Continued From page 44 times the # 1 issue. The Resident Council minutes dated 5/25/18 recorded the residents voiced concerns in the nursing department. The minutes recorded concerns with laundry not always picked up, beds not made or made late in the day, residents wanted to know about appointments in advance, and ice water not always passed. 3. The Minimum Data Set (MDS) assessment dated 5/18/18 for Resident #35 identified a Brief Interview for Mental Status (BIMS) score of 10 without signs/symptoms of delirium; a score of 10 indicated moderate cognitive impairment. The MDS recorded he required the assistance of one with bed mobility, transfers, walking in room, dressing and toilet use. The MDS recorded the resident frequently experienced bowel and bladder incontinence. The MDS documented diagnoses that included depression, chronic lung disease, generalized muscle weakness and hypoxemia (low blood oxygen levels). The assessment documented Resident #35 received oxygen therapy and Hospice care. The care plan focus area dated 3/10/15 identified at times the resident could be a little forgetful but on interview, could state the year, month, and day of the week as well as repeat the words and repeat them later without cues. The care plan focus area dated 12/17/14 identified a focus on activities of daily living due to issues with OA (osteoarthritis) and chronic pain. The care plan directed staff to provide minimal assistance of 1 person for bed mobility, toileting, and transfers with gait belt.	F 725		

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F 725	Continued From page 45 The care plan focus area dated 12/17/14 identified a focus on falls due to weakness/chronic pain and the resident received an antidepressant medication. The care plan informed staff the resident non-compliant with using call light for assistance and he had strong desires to be independent. The care plan recorded the resident ambulated with a front wheeled walker and required oxygen as oxygen level decreased with activities. The care plan informed staff the resident unsteady at times but did stabilize self as well. In a family interview on 6/19/18 at 2:45 p.m., the resident's family member reported the previous week Resident #35 waited for an hour for someone to come in when his oxygen disconnected and he panicked because of shortness of breath. The family member stated she spoke with the Administrator. The family member also stated staff is not quick to respond to call lights. In an interview on 6/20/18 at 9:35 a.m., Resident #35 reported the facility did not have not enough help at night. Resident # 35 reported he needed help with transfers and could not get someone for most of the evening. Resident # 35 stated the facility did not have enough trained help that knew how to care for him; a new staff person cared for him so often he called them one night stands. Resident # 35 commented the facility had just one fourth of the staff that he felt there should be. Resident # 35 said he needed breathing treatments 4 times a day and a lot of times at night he could not get help. Resident # 35 stated he had trouble with his oxygen getting disconnected or pinched off and not able to get help in a timely manner. The concern had been	F 725		

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F 725	Continued From page 46 going on for a long time. No help comes after you wait and wait, he is instructed not to walk around, but if no one shows up what do you do? Resident # 35 stated he tried to do it himself anyway to try to keep himself going, but also to free up staff to assist other dementia residents who might need the staff's time more. He thought as long as he could motate it helped someone else to get help. Resident # 35 said he had a chair he used for support to assist him to get up but staff moved it because they didn't want him to transfer on his own. Resident # 35 knew he should wait for help but when he had to go to the bathroom he couldn't wait. At times he experienced fecal incontinence from not getting helped in time and it made him feel bad when it happened. Resident # 35 acknowledged he felt he did not have dementia as much as absence of the mind from old age and he knew he was not 100% with using the call light, but he thought sometimes the call system did not function properly. Resident # 35 stated people like his wife with dementia were not watched closely and she had falls and one of her falls resulted in a broken hip. Resident # 35 commented the residents with dementia could not speak up for themselves and he felt that was sad concluding that it's a sad thing when a senior gets to be 70/80/90 years old and can't get help. In an interview on 6/20/18 at 3:25 p.m., the Director of Nursing, (DON) acknowledged the facility working on staffing and he already was working on building staff. The DON stated he needed to rebuild. The DON stated that agency staff are trained or educated through pocket care plans. The DON stated if the agency staff member working for the first time the facility would provide orientation that day.	F 725		

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F 725	Continued From page 47 In an interview on 6/21/18 at 4:20 p.m., Staff F, Registered Nurse (RN) recalled a night Resident #35 fell out of bed and requested to be sent to the emergency room. Staff F responded she felt staffing that night an issue with the fall. Staff F said she felt she had been short a CNA that night; overnights normally staffed with 2 nurses, 2 aides B hall, 1 aide A hall, and 1 aide C hall. Staff F said now staffed with 2 nurses, 1 aide B hall, 1 aide for A, C, and F halls. Staff F responded she felt the staff could meet the residents' needs as long as the nurses helped. Occasionally, they had only 1 nurse and if the nurse couldn't help the aides it was hard to meet the residents' needs. Staff F reiterated she did feel staffing a factor in Resident # 35's fall. Staff F said when short staffed, the building so sprawled out she felt they needed 1 aide per hall or personal alarms would help. Staff F responded she had told management, unit managers, and the DON she felt they needed more staff. Staff F said there were times she worked as the only nurse in the facility starting at 6:00 p.m. The daily staffing assignment sheet for the overnight of 5/10/18 going into 5/11/18 revealed 2 nurses scheduled and 2 CNA's for the shift. The sheet reflected 1 of the CNA's as responsible to float coverage of A hall and C hall, and the other CNA to cover B hall, the locked unit. Resident #35 lived on the A hall. 4. The MDS assessment dated 5/30/18 documented diagnosis that included muscular dystrophy, arthritis and peripheral vascular disease for Resident #41. The same MDS documented a BIMS score of 15 which indicated intact memory and cognition. Resident #41 required the assistance of 2 with bed mobility,	F 725		

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F 725	Continued From page 48 transfers and toilet use and the assistance of 1 staff with personal hygiene. The care plan problem initiated 4/12/16 identified the resident with lower extremity as a result of muscular dystrophy. The care plan directed staff offer resident a bath of choice/whirlpool 2 times weekly, one staff or more should assist him with bed mobility, dressing, wheelchair locomotion on and off the unit and personal hygiene and two staff should transfer him with a mechanical sit-stand lift . The resident wished to lay down every day at 10 AM and 2 PM per his request. During interview on 6/20/18 at 1:55 PM, Resident #41 stated he consistently waits longer than 15 minutes for a response to his call light and he times it with his clock. He said staff will often respond to his call light in less than 15 minutes, ask his what he needs, turn off the call light and tell him they will be back in a few minutes. However, staff do not come back so he turns his call light on again. The resident also stated that he is often told he has to wait for transfers to bed and chair because it takes two to complete the task and there is not always two staff assigned to his area. A few days ago he sat in his chair for 11 straight hours as staff did not respond to his requests to lay down in the morning or afternoon. He stated he got upset with the charge nurse regarding this and felt no one cares that he has irritation on his buttocks from prolonged sitting. The Progress Notes entry completed by Staff A, registered nurse (RN) on 6/12/18 at 5:09 PM documented the resident has moisture-associated skin damage to his buttock which measured 11.2 centimeters (cm) x 5.2 cm. The nurse discussed incontinence management	F 725		

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F 725	Continued From page 49 and repositioning schedule with the resident. The Progress Notes entry completed by Staff A on 6/16/18 documented the resident complained to her at 3:15 PM that he had not been able to lay down all day and wanted to file a complaint. The call light response report for 5/1 to 5/31/18 documented the range of call light response for Resident #41 as between 6 minutes to one hour. The report contained handwritten notes which documented the facility ordered more call light pendants, replaced batteries, had the system repaired as it did not recognize when call lights were on from the end of May until the 1st week of June and hired more staff. The call light response report for Resident #41 dated 6/1 to 6/19/18 documented a range of call light response for Resident #41 from 55 seconds to 2 hours 47 minutes.	F 725		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and family member, resident and staff interviews, the facility failed to designate a social service designee and failed to provide social services for grieving for one of three residents reviewed for mood and behavior services (Resident #35). The facility reported a census of 42 residents.	F 745	QAPI action plan was completed on 6/21/18. Resident #35 had a PHQ-9 on 5/18/18 and scored a 1. Social Service Designee (SSD) provided a 1:1 on resident #35 6/28/18 to address his depression. SSD was assigned on 6/21/18 for the facility's residents. Residents will be assessed for depression quarterly through the MDS PHQ-9. Educated SSD on 6/21/18 regarding documentation and implementation of interventions for resident depression symptoms.	

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F 745	Continued From page 50 Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/21/18 for Resident #35 identified a Brief Interview for Mental Status (BIMS) score of 12 without signs/symptoms of delirium; a score of 12 indicates moderate cognitive impairment. The Mood section of the MDS documented on 7 to 11 days of the previous 2 weeks, Resident #35 experienced all of the following: little interest or pleasure in doing things; he felt down, depressed, or hopeless; had trouble falling or staying asleep, or sleeping too much; felt tired or had little energy; and with a poor appetite or overeating. The MDS documented diagnoses that included depression and chronic lung disease. The MDS assessment of 5/18/18 documented Resident #35 now had a BIMS score of 10 without signs/symptoms of delirium (10 indicated moderate cognitive impairment). The mood section of the MDS documented during 2 to 6 days of the previous 2 weeks, Resident #35 felt down, depressed, or hopeless. The care plan focus area dated 3/10/15 identified a focus area of mood/psychosocial as the resident had depression and voiced little interest or pleasure in doing things. The care plan focus area dated 12/11/15 identified the resident took an antidepressant medication for depression and incontinence issues. The focus area recorded the resident remained mildly depressed and during the interview, he expressed he felt depressed and lacked concentration. The care plan lacked documentation of revisions to reflect the increased mood severity score from the 3/21/18 MDS assessment. The care plan lacked updates for the resident's spouse passing away	F 745	Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 745	Continued From page 51 on 3/17/18 or interventions related to social services for the grieving process. The Progress Notes dated 3/17/18 and 3/18/18 made no mention of the resident's wife, Resident #194, passing away. Resident #194's clinical record reflected she passed away on 3/17/18 at 6:55 p.m. The progress notes documented that on 3/18/18 at 2:33 p.m., the resident's family visited the facility. The Progress Notes dated 3/21/18 at 2:47 a.m. documented the resident commented his wife passed a couple days prior and he would be going to the visitation the next day. The resident told staff he didn't know what to do now, they were married 70 years and he reminisced about memories with his wife. At 10:56 a.m. the notes documented the resident continued to be sad and stayed in his room telling the nurse he would need help all day that day. The note recorded the resident to go to wife's funeral; comforts given but not much help. The Progress Notes dated 3/26/18 at 4:48 a.m. documented the resident continued with follow up for signs/symptoms of depression and the resident was quiet that shift. Resident #35 displayed an upset mood at bedtime, stated he felt stressed and continued to express thoughts of his late wife. At 10:35 a.m. the notes documented the resident continued to be sad related to the death of his spouse and he did not want to get up that day; hospice chatted with the resident. The Bereavement notes completed on a hospice routine visit dated 4/18/18 documented hospice staff provided Bereavement Services that visit.	F 745		

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F 745	Continued From page 52	F 745		

The note recorded the team recommended a bereavement visit or 2 for Resident #35. The note documented the resident discussed his loss and reported the first few weeks were difficult but it had gotten better. The note recorded hospice left the 'When You are Grieving' booklet with the resident with plans to visit again in 2 to 4 weeks.

On 6/20/18 at 9:35 a.m., Resident # 35 stated he had trouble with depression and he tried his best to keep getting out and about. Staff encouraged him to keep active since his wife's passing. Resident # 35 stated he and his wife attended a church and the minister visited every other week or 2. Resident # 35 said he had hospice services but he had improved, so he did not have hospice services anymore.

In an interview on 6/19/18 at 10:38 a.m., Staff E, Registered Nurse (RN) stated the Resident # 35 wanted to lie down. Staff E commented the resident recently lost his wife and it was very unusual for the resident to want to lie down during the day. Staff E stated the day before the resident as up and out per normal.

In an interview on 6/19/18 at 2:01 p.m., Staff C, Certified Nurse Aide (CNA) reported to Staff E that Resident # 35 again requested to go back to bed and it's unusual for him to be that tired.

During an interview on 6/19/18 at 2:45 p.m., the resident's daughter reported she did not think the facility had a social worker. For awhile the resident had been on Hospice level of care and she thought he should go back on it. The Hospice chaplain had been good for the resident and other staff were not familiar with the residents.

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F 745	Continued From page 53 In an interview on 6/20/18 at 9:35 a.m., Resident # 35 expressed he had trouble with depression and he tried his best to keep getting out and about. Resident # 35 stated the staff encouraged him to keep active since his wife's passing. Resident # 35 stated he and his wife attended a church and the minister visited every other week or two. Resident # 35 said he did have Hospice services but he had improved so didn't have them anymore. In an interview on 6/20/18 at 5:25 p.m., the Activities Director reiterated she was not in charge of any social services. The Activities Director stated she did not know Resident #35's wife but reported she had to tell her assistant she needed to spend as much time with other residents as she did with Resident # 35. The Activities Director reported the facility had been talking about how Resident #35 had been down and declining. She had attempted to get the resident involved in going to the hospital to visit hospital residents but the resident declined. The Activities Director stated she did care plans in regards to activities only, she did not address nursing or social service issues. In an interview on 6/21/18 at 11:02 a.m., the Director of Nursing, (DON) stated to his knowledge he thought the Activities Director had been responsible for social services. The DON stated he would need to speak to the Administrator about it further. In an interview on 6/21/18 at 11:09 a.m., the Administrator stated the assignment for the Activities Director to be in charge of social services is a relatively new assignment and she would speak to her again. The Administrator said	F 745		

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F 745	Continued From page 54 as of 6/12/18, she had made that change in the Activities Director's job responsibilities. The Administrator stated she did not know who was in charge of handling social services prior to 6/12/18.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756	Resident #22 and all similarly situated residents will have a monthly pharmacy drug regimen review. Consulting pharmacist notified of monthly review expectations on 6/27/18. DON or Designee will audit that consulting pharmacist completes reviews. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 756	Continued From page 55 §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 clinical record review and staff interview, the facility failed to always perform monthly drug regimen reviews for one of 30 sampled residents (Resident #22). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment dated 4/25/18 documented Resident #22 had diagnoses including anemia, heart failure, high blood pressure, vascular disease, gastric reflux, thyroid disorder, high cholesterol, anxiety, depression and chronic lung disease. The MDS documented the resident received an antipsychotic medication 7 days a week, an antianxiety medication 7 days a week and an antidepressant medication 7 days a week. The Medication Review Report dated 6/11/18 documented an order for antianxiety Ativan, an antipsychotic Seroquel, and an antidepressant Zoloft. The care plan with a target date of 8/9/18 addressed the resident's Zoloft and listed an intervention to have a monthly medication review per consulting pharmacist. The resident's clinical record contained pharmacy	F 756		

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F 756	Continued From page 56 notes dated 8/29/17, 10/29/17 and 5/30/18. During an interview on 6/21/18 at 11:25 a.m., the Director of Nursing stated he could no locate any more monthly reviews.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, drug package insert review, staff interview and facility record review, the facility failed to adequately monitor the use of anticoagulation medication when staff administered anticoagulation medication in error on several days, missed laboratory draws,	F 757	QAPI action plan was devised on 6/8/18. Resident #8's Coumadin was held on 4/1/18. PT/INR was drawn on 4/1/18 and provider was notified on this date and held Coumadin for 3 days. Redrew on PT/INR on 4/4/18 and Coumadin was resumed at 4mg po qd. Missed dose for Coumadin on resident #8 on 5/31/18 nurse completed a medication error form notifying proper authorities. Physician ordered to administer dose of coumadin as previously ordered. Residents who take coumadin were re-evaluated to ensure their coumadin was administered per physician orders as well as PT/INR's were drawn as directed per physician orders. Agency nurse was terminated from working in the facility on 4/1/18. Educated Nurse D regarding coumadin administration, PT/INR lab draws, and medication error procedure on 6/20/18. Nurses were re-educated by 6/29/18. Audits will be completed by the DON/or Designee periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 757	Continued From page 57 administered the medication before awaiting doctor orders on days of drawn labs and omitted the medication on other days, for 1 of 3 residents reviewed who received anticoagulation therapy (Resident #8). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/25/18 for Resident #8 documented diagnoses that included peripheral vascular disease (PVD), Non-Alzheimer's dementia, and long term use of anticoagulants. The MDS identified the resident received anticoagulation medication on 4 out of 7 days of the assessment reference period. A Prothrombin time (PT) is a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder; the international normalized ratio (INR) is calculated from a PT result and is used to monitor how well the blood-thinning medication (anticoagulant) warfarin (also known as Coumadin or Jantoven) is working to prevent blood clots. The Coumadin © website, https://packageinserts.bms.com/pi/pi_coumadin.pdf, included the following instructions in the drug package insert: The dosage and administration of COUMADIN must be individualized for each patient according to the patient's INR response to the drug. Adjust the dose based on the patient's INR and the condition being treated. Consult the latest evidence based clinical practice guidelines regarding the duration and intensity of anticoagulation for the indicated conditions. Recommended Target INR Ranges and	F 757		

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F 757	Continued From page 58 Durations for Individual Indications - An INR of greater than 4.0 appears to provide no additional therapeutic benefit in most patients and is associated with a higher risk of bleeding. Venous Thromboembolism (blood clots) (including deep venous thrombosis [DVT] and PE, pulmonary embolism). Adjust the warfarin (Coumadin) dose to maintain a target INR of 2.5 (INR range, 2.0-3.0) for all treatment durations. a. The PT/INR lab results dated 3/12/18 at 1:45 p.m. documented high PT of 49.5 seconds and critical INR of 5.1. The physician wrote an order to hold the warfarin and recheck the resident's INR tomorrow (3/13/18). The fax stamp documented the order sent to the facility 3/12/18 at 2:30 p.m. The March 2018 Medication Administration Record (MAR) documented staff administered Coumadin 6 mg at 4:00 p.m. on 3/12/18. The 3/12/18 INR results faxed to the physician at 3:53 p.m. documented the resident received her warfarin on 3/12/18 and requested an order to hold warfarin tomorrow (3/13/18) and repeat an INR Wednesday 3/14/18. The fax time stamp of 4:23 p.m. indicated the physician responded and sent orders to hold the warfarin and recheck an INR tomorrow (3/13/18). Another faxed lab back to the facility at 5:52 p.m. documented the physician responded, okay to facility request to change recheck of INR to 3/14/18. The faxed communication to the physician dated 3/14/18 at 7:38 a.m. documented the resident's INR result 7.1 on the facility machine. The physician ordered the facility to discontinue Bactrim (an antibiotic; some antibiotics can cause	F 757		

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F 757	Continued From page 59 an interaction with Coumadin of increased bleeding times or higher INR values), continue to hold warfarin and recheck an INR 3/15/18. The faxed communication to the physician dated 3/15/18 at 7:14 p.m. documented a skin assessment revealed new dark purple bruise to the resident's posterior left arm. The fax documented the bruise measured 4.9 cm (centimeters) by 5.4 cm and an area to the left lateral back as improving; it measured 1.3 cm by 2.8 cm. The facility requested the physician to advise on the resident's Coumadin dose when to start and when to recheck (the INR). The physician responded to see other note and on another fax time stamped 3/15/18 at 3:34 p.m., the physician ordered the staff to hold the warfarin and recheck an INR on 3/17/18 (which measured 1.9 on that date). b. The PT/INR results 3/22/18 faxed to the physician on 3/23/18 at 11:11 a.m. documented a high PT of 35.5 seconds and a high INR of 3.6. The fax documented that due to receipt of the order this morning, staff did not hold the resident's warfarin yesterday. The fax asked if the physician would like the medication to be held this afternoon and recheck (the INR) tomorrow? The time stamp dated 3/23/18 at 12:37 p.m. documented the physician responded: yes, hold warfarin today (3/23) and recheck INR tomorrow (3/24). The March 2018 Lab Administration Report documented an INR scheduled to be drawn on 3/24/17 was not obtained until 3/25/18. The faxed communication to the physician dated 3/25/18 at 10:59 a.m. with a fax time stamp of 3/25/18 at 6:52 p.m., documented the facility rechecked the	F 757		

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F 757	Continued From page 60	F 757		

INR on 3/25 with a result of 3.4 (INR), the facility spoke to the on call physician, who ordered the facility to hold the resident's Coumadin 2 more days and recheck on Tuesday (3/27). The 3/27/18 INR measured 1.7.

c. The faxed communication to the physician dated 4/2/18 documented the resident's INR value as 3.3 on the facility machine. The physician responded with an order to reduce the dose of the warfarin to 4 mg daily and recheck the INR in 3 days.

The April 2018 MAR documented Coumadin 6 mg dose as given on 4/3, 4/4, and 4/5 and Coumadin 4 mg dose as given on 4/3, 4/4, and 4/5. (The resident received a total of 10 mg of Coumadin daily on 4/3, 4/4 and 4/5).

The Progress Notes dated 4/5/18 at 4:41 p.m. documented the resident's INR value measured 4.8 on the facility machine and the current Coumadin dose at 4 mg.

The Medication Error report dated 4/5/18 at 5:00 p.m., written by Agency Nurse 1, recorded a med error occurrence for Resident #8 . The report documented the resident had been on warfarin 6 mg (milligrams) every day but on 4/2/18, the facility received an order for warfarin to be decreased to 4 mg every day with a recheck of INR on 4/5/18. The report recorded the new warfarin ordered from the pharmacy but the nurse forgot to discontinue the 6 mg dose of warfarin when the new 4 mg dose started. The report documented the resident received warfarin 10 mg on Tuesday, Wednesday and Thursday, (4/3/18, 4/4/18, and 4/5/18, respectively). Agency Nurse 1 wrote that Staff D, Registered Nurse (RN) told

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F 757	Continued From page 61 her not to give warfarin to the resident that night due as it was on hold related to an elevated INR and the need to recheck the lab. Agency Nurse 1 she informed Staff D the resident had already received 10 mg of warfarin. Staff D realized she forgot to discontinue the warfarin 6 mg when she checked on the computer. Agency Nurse 1 documented the immediate action taken as discontinuation of the warfarin 6 mg and placing warfarin 4 mg on hold for 2 days then recheck the resident's INR. The Notes section documented the facility requested the agency nurse not return to the facility and nursing staff educated on medication change process. The faxed communication to the physician dated 4/5/18 at 7:14 p.m. documented due to a high INR value, staff planned to hold Resident # 8's warfarin 4 mg on 4/6 and 4/7, restart it on 4/8 and recheck her INR in 1 week. The PT/INR results dated 4/11/18 at 11:50 a.m. documented PT of 17.9 seconds and INR of 1.8. The results form contained orders to increase the warfarin to 4 mg on Sunday/Monday/Tuesday/Thursday/Saturday and 5 mg on Wednesday/Friday and to recheck the INR in 1 week, assuming the resident still taking 4 mg daily. The April 2018 Lab Administration Record contained an entry to check the resident's INR on 4/18/18 with the entry blank. Review of the clinical record revealed no indication the INR drawn on 4/18/18. d. The PT/INR results dated 5/17/18 documented results of PT at 15.0 seconds and INR at 1.5. The results form contained an order to change	F 757		

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F 757	Continued From page 62	F 757		

the Jantoven (warfarin) to 4 mg every other day alternating with 5 mg every other day and to recheck the INR in 2 weeks.

The May 2018 Lab Administration Record contained an entry to check the resident's INR on 5/31/18; the entry blank. Review of the clinical record revealed no documented of the INR drawn on 5/31/18.

e. The Medication Error report dated 6/7/18 at 5:03 p.m. recorded the nurse found 2 doses of Coumadin 4 mg and 5 mg due on the Tuesday the 5th and Wednesday the 6th. The report recorded the resident's INR checked at the ER (Emergency Room) for an unresponsive episode. The Immediate Action Taken section documented the resident sent to the ER for syncope (fainting) episode and the INR completed with result of 1.4; the physician ordered to redraw the INR on Monday the 11th. The Other Info section documented 2 missed doses of Coumadin were found in the med drawer from the 5th and 6th. The Notes section documented the resident sent to the ER for evaluation and new INR sheets put out for communication of results, dose and the next due date (of a lab draw).

The faxed communication to the physician dated 6/15/18 at 10:52 a.m. with a fax time stamp of 6/15/18 at 4:22 p.m., documented the resident's INR value measured 3.3 with a current order for Coumadin 5 mg daily since 6/12/18. The physician responded at 4:24 p.m., ordering to give 4 mg of Coumadin on 6/15 and 6/16, 5 mg on 6/17 and recheck (the INR) on 6/18. The facility faxed the physician back at 4:31 p.m. that staff had already given the resident 5 mg that day (6/15). The physician then changed the order to

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F 757	Continued From page 63 4 mg on 6/16 and 6/17, recheck INR 6/18 and hold the warfarin on 6/18 pending results of her INR. The faxed communication to the physician dated 6/18/18 at 10:06 a.m. documented the resident's INR result as 5.2 on the facility's machine. The physician ordered to hold the warfarin and recheck INR 6/19. In an interview on 6/20/18 at 3:25 p.m., the Director of Nursing, (DON) reported after the last medication error involving Coumadin he changed the process of how staff complete PT/INR checks. The DON stated sometime in the previous 2 weeks he initiated a flow sheet for PT/INR checks. The DON stated the nurses put the flow sheet in the hot chart to alleviate the potential for errors. The DON stated he thought the unit managers are responsible to train nurses on the use of the PT/INR machine and he thought the lab would calibrate the machine. In an interview on 6/21/18 at 12:17 p.m., the DON reported he had submitted all available PT/INR results and orders available from the clinical record.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758	Please see next page	

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F 758	Continued From page 64 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758	Resident #11 had a gradual dose reduction review addressed by their physician on 07/20/2018. Pharmacist notified of monthly GDR expectations on all residents 6/27/18. Audits will be completed by the DON/ or Designee periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 758	Continued From page 65 This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility record review and staff interview, the facility failed to attempt a gradual dose reduction (GDR) of an antidepressant medication for 1 of 5 residents reviewed for unnecessary psychotropic medication use (Resident #11). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/11/18 for Resident #11 documented diagnoses that included Non-Alzheimer's dementia and depression. The MDS recorded the resident received antidepressant medication on 7 out of 7 days of the assessment reference period. The care plan focus area dated 12/22/15 identified psychotropic drug use as evidenced by the use of antidepressant therapy, antipsychotic therapy, diagnosis of depression, and s/p (status post) CVA (cerebrovascular accident). The care plan informed staff the resident received the antidepressant medication daily called Lexapro, also known as escitalopram. The care plan directed staff to complete monthly med reviews per consulting pharmacist and GDR as recommended and approved by PCP (primary care physician). The Medication Review Report dated 4/16/18 documented an active order started 2/17/17 for escitalopram oxalate 10 mg (milligram) tablet, give 1 tablet by mouth in the morning for depression.	F 758		

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F 758	Continued From page 66 An email correspondence dated 5/30/18 at 5:03 p.m., from the facility's contracted pharmacist, sent the Director of Nursing, (DON), copies of her monthly reports. The pharmacist wrote she had several residents in mind that needed to be looked at for their diagnoses for psychotropics. The pharmacist asked the DON who/what meds he had in mind to start with. The printed email form contained an undated, unsigned, handwritten response that the facility meeting this month to go over how they were going to start getting the residents either reduced or taken off completely. In an interview on 6/21/18 at 10:48 a.m., the Director of Nursing, (DON) that since 5/30/18, they were in the process of looking at a different pharmaceutical company for more expedient service to get medications within a 2 hour period. The DON stated the current contracted pharmacist came just once a month. Review of the clinical record revealed a lack of documentation of an attempt a GDR of the escitalopram.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) 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, facility policy review, professional reference review and interviews, the facility failed to assure one resident remained free of a significant medication error of 30 total residents reviewed (Resident	F 760	Regarding Resident #38, VA medications will be ordered timely per policy. If medication is not available from VA, nurse will order from local pharmacy. Staff will administer ordered medications and if they are not available the staff will order the medications from the pharmacy if they are not in the emergency pyxis system. Educated Nurse B regarding timely medication administration 6/27/18. Nurses will be re-educated on 6/29/18. Audits will be completed by the DON/or Designee periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018.	

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F 760	Continued From page 67 #38). The facility identified a census of 42. Findings include: 1. The MDS (Minimum Data Set) assessment dated 5/23/18 documented Resident #38 had diagnoses that included chronic atrial fibrillation, anemia, chronic embolism (blood clot) and thrombosis of deep veins of the left lower extremity and Non-Alzheimer's dementia. The same MDS documented the resident has short and long term memory loss, with 2 or more falls without injury and he received daily anticoagulant medication (to prevent blood clots) during the assessment period. The resident's Medication Administration Record (MAR) documented an order dated 11/30/17 to administer Eliquis (an anticoagulant medication) 2.5 mg (milligrams) BID (two times daily). The Progress Notes Communication with the physician dated 3/16/18 documented the resident did not receive Eliquis for 5 days due to a delay in receiving the medication from the Veteran's Administration (VA) pharmacy. Staff started the medication that morning and noted no ill effects from the omission of Eliquis. The physician directed staff to call the office next time for samples. Review of the Medication Administration Record for May 2018 revealed the resident did not receive Eliquis at bedtime of 5/19 and neither of his 2 scheduled doses on 5/20/18. The resident's clinical record failed to contain physician notification of this omission.	F 760		

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F 760	Continued From page 68 During interview on 6/21/18 at 1:48 PM Staff B, Licensed Practical Nurse (LPN) stated staff need to call the VA pharmacy when refills are needed. She stated the VA sends out medication according to their records and sometimes residents run out of medications because of that. Staff should order medications from VA about a week before medications are due to run out in order to get them at the facility by the needed time. The facility's Policy & Procedure for Reorder and Deliver or Medications, revised 5/8/17, documented the following: It is the policy of Rowley Memorial Masonic Home to reorder medications for resident as needed fro the pharmacy or VA, and to ensure the medications are delivered to the facility in a timely manner. During interview on 6/21/18 at 3:43 PM the VA pharmacy representative stated the resident's Eliquis had been filled on 1/19/18, 3/15/18, 5/21/18 and 6/10/18 and another bottle to be sent 6/30/18. The representative stated the prescription sent 1/19/18 would have been eligible to have been refilled on or after 3/3/18 and the 3/15/18 prescription could have been refilled on or after 5/11/18 in order to not run out. The representative stated the 3/15 and 5/21 orders were picked up at the pharmacy window and not mailed out. During interview on 7/5/18 at 10:27 AM a VA pharmacist stated because of the resident's diagnoses of atrial fibrillation and deep vein thromboses, it would be a significant medication error to not administer Eliquis as ordered as it would increase the chance of blood clot formation	F 760		

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F 760	Continued From page 69 or to cause heart arrhythmia. Routine medications supplied by VA pharmacy are eligible to be refilled a minimum to 7 days prior to running out and the mail time for medications is 1 o 2 days maximum for the facility's location. He further stated someone can always pick up medications from their pharmacy as well. The facility's Nursing 2017 Drug Handbook directed the following Patient Teaching for Eliquis on page 149: Warn the patient not to discontinue drug without first talking to prescriber because of risk of clot formation and stroke.	F 760		
F 868 SS=B	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow regulatory requirements for Quality Assurance attendees requirements. The facility	F 868	Monthly QA meetings will have the proper amount of staff members in attendance beginning 6/26/18. Educated QA committee regarding proper number of staff members who need to attend monthly on 6/26/18. Audits will be completed by the DON/or Designee periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 868	Continued From page 70 identified a census of 42 residents. Findings include: Record review of the provided Quality Assurance information failed to show the required number of QA meeting attendees. An interview with the Administrator on 6/21/18 at 12:20 p.m. revealed the QA meetings failed to have the required number of facility attendees for 3 Quality Assurance meetings held 10/17/17, 1/22/18 and 3/20/18. The Administrator stated she knew of the need to follow regulatory requirements for attendees and the need to ensure systems are in place.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	Resident # 23's inhaler was sanitized properly 6/26/18. Educated Staff D regarding not storing inhalers or other resident medications in uniform pockets on 6/27/18. All nurses were re-educated on 6/29/18. Audits will be completed by the DON/or Designee periodically to ensure compliance. Results of audits will be reviewed through the QAPI Committee. Compliance date: 7/31/2018	

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F 880	Continued From page 71 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 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 72 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 clinical record review, observation, and staff interview, the facility failed to provide care in a manner to reduce the risk of infection for 1 of 24 residents reviewed for infection control practices (Resident #23). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment dated 4/25/18 for Resident #23 identified a Brief Interview for Mental Status (BIMS) score of 15 without signs/symptoms of delirium; a score of 15 indicates intact memory and cognition. The MDS recorded the resident required the physical assistance of 2 with bed mobility, transfers and toilet use. The MDS documented diagnoses that included heart failure, diabetes mellitus, and urinary incontinence. Observation on 6/20/18 at 8:20 a.m. revealed Staff D, Registered Nurse (RN) prepared Resident #23's medications. Staff D entered the resident's room with his morning pills, eye drops and inhalation medication. Staff D put the Ziploc labeled bags of the 2 eye drop medications and the inhalation medication container into her uniform scrub pocket. Staff D gave the Simbrinza drop (a medicated eye drop), 1 drop in each eye, then gave the oral inhalation medication, had the resident inhale (without wiping of the container)	F 880		

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F 880	Continued From page 73 and placed the medications back in her scrub pocket. Staff D completed a treatment to the resident's toe then obtained another medicated eye drop (lantanoprost) from her scrub pocket, administered the eye drop and put the medication back in her scrub pocket. Staff D returned to the med cart, removed the 2 eye drop medications and inhalation medications from her pocket and placed the medications back into the med cart without sanitizing the items. In an interview on 6/20/18 at 3:25 p.m., the Director of Nursing, (DON) acknowledged the pocket of the staff uniform would be considered dirty. The DON expected staff not to put medications that would come in contact with the residents' mouth into their pockets.	F 880		