STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK RAPIDS HEALTH CENTRE	703 SOUTH UNION ROCK RAPIDS, IA 51246

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction 10-5-18 The following deficiencies are the result of the recertification survey completed 9/4-6/18. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582	F582 Medicaid/Medicare coverage/liability notice No immediate action possible for residents number 27 and 40 due to is historical On 10/5/18 ,the Regional Nurse Consultant provided in service/education to the management team, including Administrator, Director of Nursing, Social Services, Dietary Supervisor, Activities Coordinator related to the requirements for A notice of Medicare non coverage letter Prior to discontinuation of Medicare part A services. The Administrator will add to the morning team meeting, 5 days weekly, discussion of any residents who will be discontinued from the Medicare part A services and verify that the notice of Medicare non coverage has been provided to the resident within the regulatory required time frame. This will continue on an ongoing basis to ensure that residents' number 27, 40 and other like residents of	

			the facility receive the appropriate notification of Medicare non-coverage when being discontinued from Medicare part A services. That administrator or designee will report findings of the above monitoring system monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.		

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

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

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F 582	Continued From page 1 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to provide Notice of Medicare Non-Coverage (NOMNC) for Skilled Nursing Facility (SNF) Beneficiary Notification 2 of 3 residents reviewed (Resident #27 and #40). The facility reported a census of 39 residents. Findings include: The facility completed and provided the Beneficiary Notice form for residents discharged within the last six months, and who were discharged from Medicare covered Part A stay with benefit days remaining, which included Resident #27 and Resident 40. The form	F 582		

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F 582	Continued From page 2 indicated Resident #27 remained in facility, and Resident #40 discharged to home. The facility completed SNF Beneficiary Protection Notification Review form which indicated Resident #27 started Medicare Part A Skilled services on 6/26/18 with the last covered day 7/19/18. However, the form showed that the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) to Resident #27, and indicated the reason for not giving the notice was the facility did not know they had to provide one. The facility also completed SNF Beneficiary Protection Notification Review form for Resident #40 that showed start date on 5/7/18 for Medicare Part A Skilled services with the last covered day on 7/25/18. The form also showed that facility did not provide a NOMNC to Resident # 40, because facility "Didn't know to provide" notice. On 9/5/18 at 10:57 AM, the Social Worker verified that Residents #27 and #40 were not given NOMNC when they were discharged from Medicare covered Part A stay with days remaining.	F 582	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583	F583 Personal Privacy/Confidentiality of Records On 9/07/2018 the window blinds in the rooms for resident number 23 and 29 were corrected to provide privacy. On 9/7/2017, The administrator completed an audit to identify Any other resident rooms that are in need of corrections to the window blinds and any identified needs have been corrected. The Administrator will in-service staff on 10/5/18, related to the need to report any breaks or needs for replacement of window blinds in resident rooms immediately to ensure continued privacy for residents 23, 29 and other current residents of the facility. The Administrator will complete routine facility walking rounds on a weekly basis for 8 weeks, then, at least monthly on an ongoing basis to ensure that window coverings are appropriate and providing privacy. The Administrator or designee will report findings of the above monitoring system

			monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 583	Continued From page 3	F 583		

this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to assure personal privacy for 2 of 12 resident's reviewed (Resident #23 and #29). The facility reported a census of 39 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 7/13/18, Resident #23 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive

F 583		F 583		
	Continued From page 4 assistance with activities of daily living (ADL's) including toileting and personal hygiene. The resident's diagnoses included dementia, anxiety disorder, and depression. During observation on 9/5/18 at 7:22 a.m. Staff C, Certified Nursing Assistant (CNA) and Staff D, CNA provided personal care including incontinent care. The vertical blinds (to the window to the outside) had approximately 3 missing segments leaving a 9 inch gap one end and 1 missing on the other end leaving a small gap to outside. During an interview on 9/6/18 at 7 a.m. the Administrator stated they ordered new blinds and they didn't fit, and have reordered. She didn't realize there was such a big gap, and agreed it was a privacy concern. 2. According to the MDS assessment dated 7/27/18, Resident #29 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living (ADL's) including toileting and personal hygiene. The resident's diagnoses included Alzheimer's disease. During observation on 9/5/18 at 8:44 a.m. Staff B, CNA and Staff A, CNA provided incontinency care. During the provision of incontinency care Staff B left the resident uncovered from the waist to the lower legs 2 times as she went to the bathroom to wash her hands. During an interview on 9/6/18 at 7:15 a.m. the Director of Nursing (DON) stated she expected staff to keep residents covered except when necessary to provide care.			

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F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623	F623 notice requirements before transfer/discharge No immediate action possible for residents number 33 and 41 due to is historical. On 9/7/2018 The Social Service Director provided a list of resident transfers/discharge to the office of the state long term care ombudsman for the month of August 2018. Any Residents of the facility can be affected. On 9/6/18 the Regional Clinical Nurse Consultant provided in-service/education to the facility Department Supervisors, related to the requirements and expectations of providing notice of resident transfers to the office of the State Long Term Care Ombudsman on a monthly basis and notice to the same office immediately upon a 30-day notice for discharge. The Social Service designee will be responsible for notification of resident transfers and discharges to the Ombudsman office monthly. The Administrator will monitor monthly to ensure continued compliance for resident number 41, 33 and other residents of the facility. The Social Service Director or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 623	Continued From page 6 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623		F 623		

Continued From page 7

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to send a copy of a Notice to Transfer to a representative of the Office of the State Long Term Care Ombudsman for 2 residents, (Resident #41 and #33). The facility reported a census of 39 residents.

Findings include:

1. Review of Resident #41's record showed entries on 7/29/18 at 9:06 am the resident remains lethargic and unresponsive. Oxygen remains via mask at 4 liters. Abdominal breathing noted with approximately 10 seconds of apnea. No signs and symptoms of pain/discomfort or shortness of breath noted. Family remains at bedside. Per family request the Doctor on call was paged requesting orders to be sent to ER for evaluation. The on call Doctor returned call and did a phone consult with family at this time. Family to again decided whether or not to send

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F 623	Continued From page 8 resident to ER vs. comfort. At 9:19 am Resident #41's family consulted, they wish to send to ER for evaluation. The Doctor was notified and gave verbal okay to send him in. Family notified. Non-emergency transport notified. During interview on 9/5/18 at 4:45 p.m. the Social Service Designee (SSD) stated she had not notified the Ombudsman of Resident #41's transfer. 2. According to the Minimum Data Set (MDS) assessment dated 8/10/18, Resident #33 scored 11 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident's diagnoses included septicemia and other fracture (ribs). The Progress Notes dated 7/17/18 at 5:07 p.m. documented the resident transferred to the hospital for further testing, hospitalization related to possible sepsis. The Progress Notes dated 8/21/18 4:31 a.m. documented the resident red and warm from right lower extremity to abdomen with a fever at 100.5 degrees. The family okayed transfer to the hospital. During an interview on 9/5/18 at 2:16 p.m. the SSD stated she did not know until last week that she had to notify the Ombudsman of transfers and discharges and had not started doing it yet.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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F 625	Continued From page 9 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify a resident and/or the residents representative of the facility policy for bed hold prior to transfer to the hospital for 2 of 2 residents reviewed, (Resident #41 and #33). The facility reported a census of 39 residents. Findings include: 1. Review of Resident #41's record showed entries on 7/29/18 at 9:06 a.m. the resident	F 625	F625 notice of bed hold policy before/upon transfer No immediate action possible for residents' number 33 and 41 due to is historical. Current residents of the facility can be affected. On 9/6/18 the Regional Clinical Nurse Consultant provided in-service/education to the facility Department Supervisors, related to the requirements and expectations of providing Bed hold notice policy to the resident or residents representative upon transfer to the hospital. The Director of Nursing will in-service the facility licensed nurses related to the requirements and expectations of providing bed hold notice to the resident or resident representative upon transferred to the hospital. The Director of Nursing will review hospital transfers at least 5 days a week to ensure that the bed hold policy was provided to the resident and/or residents representative upon transfer. If it is identified by the Director of Nursing that the bed hold was not provided due to unforeseen circumstances, she will ensure the bed hold notice is provided within 24 hours. The Director of Nursing and/or designee will report findings of the above monitoring system monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 625	Continued From page 10 remains lethargic and unresponsive. Oxygen remains via mask at 4 liters. Abdominal breathing noted with approximately 10 seconds of apnea. No signs and symptoms of pain/discomfort or shortness of breath noted . Family remains at bedside. Per family request the Doctor on call was paged requesting orders to be sent to ER for evaluation. The on call Doctor returned call and did a phone consult with family at this time. Family to again decide whether or not to send resident to ER vs. comfort. At 9:19 am Resident #41's family consulted, they wish to send to ER for evaluation. The Doctor was notified and gave verbal okay to send him in. Family notified. Non-emergency transport notified. The resident's record did not include documentation of the bed hold policy given to the residents family. During interview on 9/5/18 at 4:53 p.m. the Director of Nursing stated if the family was here at the time of the transfer staff would have them sign it at time of the transfer. During interview on 9/6/18 at 9:00 a.m. the Facility Consultant stated they were unable to find that a bed hold notice had been given to Resident #41's family. 2. According to the Minimum Data Set (MDS) assessment dated 8/10/18, Resident #33 scored 11 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident's diagnoses included septicemia and other fracture (ribs). The Progress Notes dated 7/17/18 at 5:07 p.m.	F 625		

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F 625	Continued From page 11 documented the resident transferred to the hospital for further testing et hospitalization related to possible sepsis. The Progress Notes dated 8/21/18 4:31 a.m. documented the resident red and warm from right lower extremity to abdomen with a fever at 100.5 degrees. The family okayed transfer to the hospital. The clinical record lacked documentation of resident or resident representative notification of the facility bed hold policy. During an interview on 9/5/18 at 2:15 p.m. the Business Office Manager stated she talked to the daughter at the last hospitalization but did not document it and did not do a written bed hold.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facilty failed to complete the appropriate	F 637	F637 Comprehensive Assessment after Significant Change Resident number 19 now has a Significant Change Assessment completed. Current residents of the facility can be affected. On 9/6/18 the Regional Nurse Consultant provided in service to the Director of Nursing, Administrator and department supervisors related to the requirements and expectations of completing a full assessment when there is a significant change in condition for a resident as defined by the RAI manual. The Director of Nursing will review the 24 hour summary	

			in PCC (facility clinical software) of the current residents, daily times 5 days a week and will also review the 24 hour summary with the MDS coordinator each day to determine if there is a significant change identified for current residents for 8 weeks to ensure continuous compliance. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 637	Continued From page 12 comprehensive assessment for a significant change in condition for 1 of 12 active residents reviewed (Resident #19). The facility reported a census of 39 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 4/6/18 Resident #19 scored 6 on the Brief Interview for Mental Status indicating severe cognitive impairment. The resident required supervision with bed mobility, and was independent with transfers, ambulation, and toilet use. According to the quarterly MDS assessment dated 7/6/18, Resident #19 scored 3 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers, ambulation, and toilet use. The resident's diagnoses included diabetes and dementia. The clinical record lacked a comprehensive assessment related to the significant change in the resident's ADL status (bed mobility, transfers, ambulation,and toilet use). During an interview on 9/6/18 at 7:15 a.m. the Director of Nursing (DON) stated the resident did have a significant change.	F 637		
F 655 SS=C	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		

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F 655		F 655	F655 Baseline Care Plan	
	Continued From page 13 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details		Immediate action not possible due to it is historical New admission residents could be affected. On 9/6/18, the Regional Nurse Consultant provided in service to the Director of Nursing, Administrator and department supervisors related to the requirements and expectations of providing the resident and their representative with a summary of the baseline care plan. The Director of Nursing will educate/explain the requirements and expectations of providing the resident and/or their representative with a summary of the baseline care plan within 72 hours of admit. The Director of Nursing or designee will follow up 48 hours after each new admission to verify that the baseline care plan is completed and that the summary is scheduled to be provided to the resident and/or their representative within 72 hours of admission. This will continue on and ongoing basis to ensure that resident 42 and other newly admitted residents receive the baseline care plan summary timely. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as	

			indicated in staff will be reeducated as needed.	

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F 655	Continued From page 14 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide the resident and their representative with a summary of the baseline care plan for Resident #42. The facility reported a census of 39 residents. Findings include: Review of a 48 Hour Plan of Care for Resident #42 showed the resident had been admitted to the facility on 4/24/18. The form included a space to document the date it was reviewed with the resident/representative. There was no documentation the review had been completed. During interview on 9/5/18 at 9:20 am the Facility Consultant stated there was no documentation that the baseline care plan had been reviewed with the resident or the representative.	F 655		
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	F 656		

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F 656		F 656	F656 Develop/Implement Comprehensive Care Plan.	
	Continued From page 15 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to care plan psychotropic medications and potential adverse side effects for one resident receiving psychotropic medications (Residents #30). The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) assessment with		Resident number 30, care plan has now been reviewed and revised to include psychotropic medications and the potential adverse side effects. Residents who receive Anti-psychotic medication can be affected. The Director of Nursing will audit current residents of the facility to identify those receiving anti-psychotic medications and will revise their care plan appropriately to include anti-psychotic medications and the potential adverse side effects. The Director of Nursing or designee will review care plans weekly on an ongoing basis, of those that are scheduled that week to ensure that resident number 30 and other like residents of the facility who receive anti-psychotic medications, have it identified on their care plan and that it includes potential adverse side effects. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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F 656	Continued From page 16 assessment reference date 5/4/18 identified Resident #30 with BIMS of 4, severely impaired cognitive skills for daily decision making. Review of History and Physical dated 2/14/18 showed the resident was admitted to the hospital for out of control behaviors, anxious, pacing hallways and attempting to exit building. Resident #30 was delusional and having hallucinations, yelling at imaginary staff, was paranoid- thinking people are out to get her. She heard people talking to her over speakers, the nursing home does not have overhead speakers. She is difficult to redirect. The resident was discharged back to the facility on 3/7/18. The September 2018 Medication Administration Record revealed the resident received Sertraline (antidepressant) 100 milligrams daily, Trazodone (antidepressant) 50 milligrams every day and Risperdal (antipsychotic) 1 milligram. twice daily. All three medications had order date of 3/7/18. Resident #30's current care plan with target date of 11/1/18 lacked documentation the resident received Sertraline, Trazodone and Risperdal and potential adverse side effects related to the use of the medications. During an interview 9/6/18 at 11:25 a.m., the Facility Consultant stated it would be expected the use of the medications and potential adverse side effects be on the residents care plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		

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F 658	Continued From page 17 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on records review, observation, and staff interview, the facility failed to follow physician's order for 1 of 6 residents (Resident # 32) sampled for medication administration, and failed to follow physician orders and notify the physician of a significant weight change for 2 of 12 residents reviewed (Resident #10 & #30). The facility reported a census of 39 residents. Findings include: 1. The Medical Diagnosis list indicated Resident #32 had diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia, and unspecified asthma. The physician's orders for Resident #32 included treatment with Sodium Chloride Nebulization Solution 7% 1 unit inhale orally via nebulizer two times a day, give with budesonide, and Budesonide Suspension 0.5 milligram (mg)/2 milliliters (ml), 2 ml inhale orally two times a day. The order for Budesonide included instructions to rinse mouth with water after use and not to swallow. Resident #32's care plan dated 6/13/18, indicated Resident #32 had a diagnosis of COPD, and interventions included administration of medications per physician's orders, as outlined in the Medication Administration Record (MAR). On 9/05/18 at 7:55 a.m., Staff G, Certified	F 658	F656 Develop/Implement Comprehensive Care Plan. Resident number 30, care plan has now been reviewed and revised to include psychotropic medications and the potential adverse side effects. Residents who receive Anti-psychotic medication can be affected. The Director of Nursing will audit current residents of the facility to identify those receiving anti-psychotic medications and will revise their care plan appropriately to include anti-psychotic medications and the potential adverse side effects. The Director of Nursing or designee will review care plans weekly on an ongoing basis, of those that are scheduled that week to ensure that resident number 30 and other like residents of the facility who receive anti-psychotic medications, have it identified on their care plan and that it includes potential adverse side effects. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality	

			Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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F 658		F 658		

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Medication Aide (CMA) administered Resident # 32's nebulization treatment using the Sodium Chloride Nebulization Solution 7% and Budesonide Suspension 0.5 mg/2 ml via nebulizer mask. Staff G told the resident that she would be back in 20 minutes to turn off the nebulization treatment. Staff G left the resident's room at 7:59 a.m.

On 9/05/18 at 8:24 a.m., the Director Of Nursing (DON) entered the resident's room and turned off the nebulization treatment. The DON did not rinse the resident's mouth after the treatment as directed by the physician's orders.

The MAR for September 2018, showed that the medications, Sodium Chloride Nebulization Solution 7% and Budesonide were administered, as marked for 9/5/18 at 8:00 a.m., even though instruction for mouth rinse after medication administration was not followed.

2. The Minimum Data Set (MDS) assessment for Resident #10 dated 6/22/18, included diagnoses of congestive heart failure, hypertension, diabetes and osteoarthritis. The MDS documented the resident required extensive assistance of one for bed mobility, toilet use, transfer, dressing and personal hygiene. The MDS documented the resident was frequently incontinent of urine and always continent of bowel. The resident's Brief Interview for Mental Status (BIMS) score was a 15 which indicated no cognitive impairment.

A Rock Rapids Health Centre Doctor/Nursing Home Communication Sheet dated 7/12/18 sent with resident to the physicians clinic documented resident had increase in weight, shortness of breath, and increased pain in legs. The physician

F 658		F 658		
	Continued From page 19 ordered 2 new medications and 2 new treatments. Treatments included: 1). Keep feet elevated when seated. 2). Muscle rub to legs for pain two times per day as needed. Review of the resident's treatment record for July 2018, August 2018 and September 2018 failed to include the above treatment orders to; 1). Elevate feet when seated. 2). Muscle rub to legs for pain two times per day as needed. The Residents treatment record showed an order for daily weight. The residents weight on 8/20/18 - 8/24/18 was 282 pounds (lbs), on 8/25/18 the weight was 283 lbs, on 8/26/18 the weight was 286.2 lbs, on 8/27/18 weight was 289 lbs and on 8/28/18 the weight was 291 lbs. In an interview on 9/5/18 at 10:30 a.m., the Director of Nursing stated she was unsure of what parameters would require the physician be notified for a resident's weight gain that was on daily weight. She would need to look back in the resident's orders to find the directive. The Director of Nursing provided a hospital discharge dated 2/10/18, and noted by the facility on 2/11/18 that directed to call your doctor or health coach if you have weight gain of more than 2 lbs overnight or 5 lbs in one week. 3. The Minimum Data Set (MDS) assessment for Resident #30 dated 8/03/18, included diagnoses of atrial fibrillation, coronary artery disease, hypertension, arthritis, and non-Alzheimer's Dementia. The MDS documented the resident required extensive assistance of two for bed			

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F 658	Continued From page 20 mobility, toilet use, transfer, dressing and personal hygiene. The MDS documented the resident was frequently incontinent of urine and occasionally incontinent of bowel. The MDS indicated the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3. A review of the resident's monthly weight record documented resident's weight on 8/1/18 as 173 lbs and on 9/1/18 as 152 lbs. The resident's weight loss was 21 lbs, which equaled 11% weight loss in one month. A nursing Home Resident Report sent to the physician on 8/31/18 was returned with ordered calazime cream two times per day and as needed for treatment of a wound to the residents left buttock. A review of the residents August and September treatment record show the treatment failed to be placed on the record for administration. In an interview on 9/05/18 at 5:32 p.m., the DON stated she would expect new orders to be transcribed on to the MAR or TAR. In an interview on 9/06/18 at 7:48 a.m., the Director of Nursing stated she would have expected notification to alert the physician that weight loss had been significant example 21 lbs in one month.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to	F 676		

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F 676		F 676	F656 Develop/Implement Comprehensive Care Plan. Resident number 30, care plan has now been reviewed and revised to include psychotropic medications and the potential adverse side effects. Residents who receive Anti-psychotic medication can be affected. The Director of Nursing will audit current residents of the facility to identify those receiving anti-psychotic medications and will revise their care plan appropriately to include anti-psychotic medications and the potential adverse side effects. The Director of Nursing or designee will review care plans weekly on an ongoing basis, of those that are scheduled that week to ensure that resident number 30 and other like residents of the facility who receive anti-psychotic medications, have it identified on their care plan and that it includes potential adverse side effects. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure 1 of 12 resident received services to maintain, improve or prevent avoidable decline activities of daily living. The facility census was 39 residents.

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Findings include:

The Minimum Data Set (MDS) assessment for Resident #30 dated 8/03/18, included diagnoses of atrial fibrillation, coronary artery disease, hypertension, arthritis, and non-Alzheimer's Dementia. The MDS documented the resident required extensive assistance of two for bed mobility, toilet use, transfer, dressing, personal hygiene walk in room and walk in corridor. The resident also needed extensive assist of one for locomotion on and off unit. It showed the resident used a wheelchair and walker. The MDS documented the resident was frequently incontinent of urine and occasionally incontinent of bowel. The resident's Brief Interview for Mental Status (BIMS) score of 3 indicated severe cognitive impairment.

The prior MDS dated 5/04/18 documented the resident needed supervision (oversight, encouragement or cueing) for transfer, walk in room, walk in corridor, locomotion on and off unit and used a walker. It documented the resident was steady at all times with moving from seated to standing position, walking, turning around, moving on and off toilet, and surface to surface transfer.

The resident's care plan dated 1/5/16 included a potential for falls with an intervention of resident is on restorative program. It also documented a revision on 5/31/18 that resident ambulated independently with a walker.

When interviewed on 9/05/18 at 4:31 p.m., Staff B, Certified Nurse Aide, (CNA) reported that the resident spends most of her time in the recliner

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Continued From page 23 except for sleeping. She stated the resident continued to decline following a fall in June and eventually needed a wheelchair to get to the dining room and activities.

When interviewed on 9/05/18 at 5:00 p.m., the Director of Nursing reported she was not sure why the resident had the decline in ambulation. She thought it may have been related to a fall the resident had suffered in June. She remembered the fall had occurred and they had requested Physical Therapy to do a screen. She stated Physical Therapy Assistant (PTA) had not directed any further service from therapy. She stated the resident continued to decline and used a wheelchair for transportation to and from meals and activities. She reports she had been medical leave in July and is not exactly sure what happened. She reported she was aware that the resident had been picked up for physical therapy in July. She would have expected the nursing department to have done assessments or nursing notes on the resident related to her decline in ADL's.
The DON failed to provide any restorative therapy notes that had occurred between June and July when the resident declined.

When interviewed on 9/06/18 at 9:01 AM the PTA stated that the staff had asked him to do a screen on the resident 6/11/18 as she had a fall. He felt she did not need any therapy at that time. He stated he did a physical therapy screen July 20, 2018, as it was time for the resident's annual screen. He noted at that time the resident had declined enough to warrant physical therapy to get involved. Physical therapy added the resident to service and she remains on service at this time. He reported she is not back to baseline but

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ROCK RAPIDS HEALTH CENTRE	703 SOUTH UNION ROCK RAPIDS, IA 51246

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F 676	Continued From page 24 Is improving. A Therapy Screening Form dated 6/11/18 documented: Resident found in her bathroom on the floor no shoes or gripper socks on and incontinent of BM. The document failed to include documentation to reflect if a therapy evaluation was recommended or not or if any change in condition or deficit had been noted. A Therapy Screening Form dated 7/20/18 completed for annual screen documented a therapy evaluation recommendation of yes. The Director of Nursing failed to provide documentation, nurse notes or restorative notes related to the resident's change in condition from 6/11/18 to 7/20/18.	F 676		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Deters, Angela	F 686	F686 treatment/services to prevent/heal pressure ulcer Residents who have physician orders In their records and pressure ulcers can be affected. On 9/6/2018 pressure relieving cushion was added to the recliner chair that is used by resident number 30. On 9/6/2018 the director of nursing reviewed resident number 30 treatment orders and verified that they were noted appropriately and transcribed onto the treatment documentation record. On 9/21/2018 the Director of Nursing provided in-servicing to current nursing staff related to but not limited to: following physician orders, transcribing physician orders, staff awareness of pressure sores, pressure relieving devices, prevention and treatment of pressure sores, prevention and treatment of pressure sores.	

			The Director of Nursing or designee will complete an audit that identifies residents with skin breakdown or at high risk. The Director of Nursing or designee will complete an audit to verify that identified residents have pressure relieving cushions in their wheel chairs and in their recliner chairs or room chair. The Director of Nursing or designee will review physician orders at least 5 days per week for the previous 24 hours and follow up for correct follow through, on an ongoing basis to ensure continuous compliance for resident number 30 and other like residents of the facility. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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F 686		F 686		
	Continued From page 25 Based on observation, clinical record review and staff interview the facility failed to ensure interventions were completed to prevent or promote healing of areas of altered skin integrity for 1 of 1 resident reviewed (Resident #30). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #30 dated 8/03/18, included diagnoses of atrial fibrillation, coronary artery disease, hypertension, arthritis, and non-Alzheimer's Dementia. The MDS documented the resident required extensive assistance of two for bed mobility, toilet use, transfer, dressing and personal hygiene. The MDS documented the resident was frequently incontinent of urine and occasionally incontinent of bowel. The resident's Brief Interview for Mental Status (BIMS) score was a 3 which indicated severe cognitive impairment. The care plan dated 1/5/2016 included a problem of potential for impaired skin integrity related to incontinence of urine and age related skin changes. The goal was resident's skin will remain intact with interventions placed should problems be identified. Interventions included medications and treatments per physician's orders, treat as needed and ordered, and pressure relieving mattress on bed. A Braden Scale for predicting pressure sore risk dated 8/05/18 documented the resident scored a 14, which identified the resident to be at risk for developing a pressure sore. A Nursing Home Resident Report document dated 8/31/18 that had been faxed to the			

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F 686		F 686		
	Continued From page 26 residents physician noted that the resident had an open area to left buttock that measured 0.5 centimeters (cm) by 1.5 cm. The fax was returned dated 9/1/18 with a physician's order for Calazime cream (a skin protective cream) two times per day and as needed until healed. A review on 9/5/18 of the resident's August and September treatment and medication administration records showed the physician ordered treatment had not been placed on the record and the resident had not received the treatment. A Nursing Home Resident Report document dated 9/03/18 that had been faxed to the resident's physician requested an order for 2 oz of med pass (high protein liquid supplement) two times a day related to skin impairment and increased weight loss. It was returned dated 9/04/18 with the physician note "OK". A Skin Grid for Pressure Ulcers was started on 9/03/18. It documented a facility acquired pressure ulcer on residents coccyx, stage 2 (Partial thickness skin loss presenting as a shallow open ulcer) 3 cm by 3 cm with blood drainage and a purple wound bed. The resident's treatment record documented that an order was added on 9/04/18 for Optifoam AG (a foam wound dressing) one time a day every three days for pressure ulcer, apply at bedtime. During an observation of care on 9/05/18 at 10:00 AM Staff D, Certified Nurse's Aide (CNA) assisted the resident to the toilet. The CNA stated she was unable to visualize pressure area at this time she was unsure where it was and thought it			

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F 686		F 686		
	Continued From page 27 may be resolved. When she wiped the resident buttock she reported there was blood on the wipe and she stated the pressure area was at the top of the resident's buttock crease. The area was open with no wound treatment in place. The CNA then assisted the resident to sit in her recliner chair. She stated the resident only lies down at night to go to bed; she prefers to sit in her recliner chair. There was no pressure relieving cushion in the recliner chair. During an observation on 9/05/18 at 2:30 PM the Registered Nurse Wound Care Certified (RNWCC) measured the areas on the resident's coccyx and buttocks. The coccyx wound was now a stage 3 (Full thickness skin loss involving damage of subcutaneous tissue, presenting as a deeper open ulcer) and the measurement was 4.5 cm by 4.5 cm that included the outer skin area involved with the open area 1.4 cm by 1.5 cm and a depth of 0.4 cm. The wound on the left buttock, stage 2, measured 1.0 cm by 1.5 cm and less than .5 cm deep. The RNWCC stated she had just started at this facility one week ago. She would be doing skin rounds one time a week. She would expect the charge nurses to be able to accurately assess wounds when she is not here. She stated a dressing had been ordered for the area but it was not completed on the date it should have been applied and she does not know why as the supplies were here and there was no documented rationale for it not being applied and no nurse notes were found. She would expect that a chair cushion would have been added to the resident's recliner. A review of the resident's treatment record showed no signature to document completion of the treatment ordered to start on 9/4/18 for the pressure area.			

F 686	Continued From page 28 On 9/05/18 at 3:58 PM, the RNWCC reported she had ordered a cushion for the resident's chair, notified the resident's son and the physician of the skin issues, and set up an in-service with a wound care specialist to educate the staff on wound care and treatment. During an interview on 9/05/18 at 5:32 PM the Director of Nursing stated she would expect new orders to be transcribed on to the medication record or treatment record. She would expect a resident with pressure skin condition to be provided with a pressure reducing cushion for relief while up in a chair, especially for resident that spends majority of time in her recliner chair. She would also expect orders on the treatment record to be followed or a documented entry to say why it wasn't completed to be found in the record.	F 686		
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 record review and staff interview, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents with falls	F 689	CNA involved with resident #19 was educated at the time of incident. Residents who require assistance with transfers have potential to be affected. The DON or designee with have training with nursing staff on October 5th, 2018 regarding gait belt usage. to ensure continuous compliance for resident number 19 as well as other like residents in the facility. DON/Designee will complete 5 random competence checks weekly for 8 weeks. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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F 689		F 689		

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(Resident #19). The facility reported a census of 39 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 7/6/18, Resident #19 scored 3 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, and toilet use. The resident's diagnoses included diabetes and dementia.

The Care Plan identified the resident had the potential for falls. Interventions included:
a. Be sure the call light within reach and encourage her to use it for assistance as needed. The resident able to verbalize her wants/needs and demonstrated proper use of her call light.
b. Monitor for safety techniques and provide prompts/cues and assist as needed.

The Progress Notes dated 9/3/2018 at 11:00 a.m. documented a Certified Nursing Assistant (CNA) requested assistance in the resident's room. Upon entering the room, observed the resident laying on her right side between her recliner and couch. The CNA in the room stated she went to assist the resident from her recliner to get into her wheelchair when the resident stood up and her legs gave out and she fell over. The CNA stated she did not use a gait belt. The resident had a skin tear to her right elbow measuring 0.3 x 0.5 cm. The CNA states the resident did not hit her head. Staff educated on use of gait belts.

During an interview on 9/6/18 at 7:15 a.m. the Director of Nursing (DON) stated all staff are

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F 689	Continued From page 30 expected to use a gait belt when assisting residents with transfers.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one 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	F 690	Immediate education provided to CNAs regarding resident number 12 and 19. Resident who require assistance with personal hygiene have the potential to be affected. DON or designee will have training with nursing staff regarding facility policies, requirements, and expectations to peri-care, catheter care, and appropriate glove procedures while providing cares on October 5th, 2018, to ensure continuous compliance for resident number 12, and 19 as well as other like residents in the facility. DON or designee will randomly observe 5 CNAs per week for 8 weeks during personal hygiene cares. The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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F 690		F 690		

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possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interview, the facility failed to provide appropriate care to prevent urinary tract infection (UTI) for 2 of 2 residents reviewed (Resident #12 and #19). The facility reported a census of 39 residents. Findings include:

1. According to the Minimum Data Set (MDS) dated 6/29/18 Resident #12 had diagnoses that included neurogenic bladder and dementia. The Brief Interview for Mental Status (BIMS) score of 6 indicated the resident had severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including toilet use, personal hygiene and had an indwelling urinary catheter.

The Care Plan revised 6/12/15 with a goal target date of 10/3/18 identified the resident with an alteration in elimination related to bowel incontinence, a suprapubic catheter, and cerebral palsy. Interventions included:

a. Assist in changing incontinent pads when soiled.

b. Monitor for signs and symptoms (s/s) of UTI such as low back/flank pain, dark, odorous urine, sediment in urine, fever, et.

c. Report to the physician as needed. Treatment as ordered.

d. Monitor catheter patency.

e. Keep tubing free of kinks, and keep drainage bag below bladder level.

f. Secure catheter to leg with catheter strap as needed to avoid pulling

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F 690		F 690		

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and tension.

g. Change catheter monthly and as needed (prn) and attach to straight drainage. h. May wear leg bag when up.

i. Change drain bags twice a month and prn.

j. Provide peri/cath care each shift and with each incontinent episode and as needed.

k. Be alert to any discoloration, redness, swelling, open areas, drainage or s/s infection and report to physician as needed.

A Urine Culture dated 7/13/18 showed the resident had a UTI with the organism Escherichia coli and Enterococcus Faecalis (found in the bowel). The physician ordered Ertapenem 1 gram intramuscular daily for 7 days, and Nitrofurantoin 100 mg every 6 hours for 7 days.

A Urine Culture dated 8/3/18 showed the resident had a UTI with the organisms E-coli and Enterococcus Faecalis. The physician ordered Macrobid 100 mg 2 times a day for 2 weeks.

A Urine Culture dated 8/24/18 showed the resident had a UTI with the organisms E-coli, Enterococcus facalis, and Klebsiella pneumoniae. The physician ordered Cipro 250 mg 2 times a day for 10 days along with Macrobid 100 mg 2 times a day for 10 days.

During an observation on 9/5/18 at 8:16 a.m. Staff C, Certified Nursing Assistant (CNA) and Staff E, CNA provided care. Staff C provided pericare in the front, then the resident rolled to the right and Staff C wiped the anal and buttock areas multiple times. Staff rolled the resident to her back and Staff C wiped the catheter insertion site and catheter tubing without changing her gloves.

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F 690	Continued From page 33 During an interview on 9/6/18 at 7:20 a.m. the Director of Nursing (DON) stated gloves should be changed after perirectal care, before doing other tasks, and acknowledged the resident had UTI's with e-coli. 2. According to the MDS assessment dated 7/6/18, Resident #19 scored 3 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, and toilet use. The resident's diagnoses included diabetes and dementia. The Care Plan identified the resident with the potential for urinary tract infection (UTI). Revised on 11/9/2016 with a goal target date of 10/10/18. Interventions included: a. Encourage fluids with cares and offer a variety of fluids with meals/activities. Water pitcher kept in room. b. Ensure pericare is being performed every shift and as needed (prn) per resident or staff. c. Provide increased assist as needed. d. Medications per physician orders. See MAR. Resident is on prophylactic antibiotic and cranberry supplement daily at this time. e. Monitor for sign/symptoms of UTI such as low back/flank pain, dysuria, hematuria, increased frequency/urgency, fever, dark, odorous, cloudy urine, sediment in urine, ect. f. Resident wears disposable pullups. A Urine Culture dated 8/23/18 showed the resident had a UTI with the organism Escherichia coli (found in the bowel). The physician ordered Rocephin (antibiotic) 1 gram intramuscularly every day for 5 days.	F 690		

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F 690	Continued From page 34 The Progress Notes dated 8/29/18 at 2:59 p.m. documented the resident completed round of Rocephin IM fort UTI with no adverse reactions noted. During an observation on 9/5/18 at 7:00 a.m. Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA assisted the resident with a.m. cares. Staff removed the resident's incontinent pad. After toileting, with the resident standing, Staff A wiped the anal area with a wet washcloth, then with the same cloth wiped from the pubic area over the genital/urinary meatus area without turning the cloth to a clean area. During an interview on 9/6/18 at 7:15 a.m. the Director of Nursing (DON) stated wiping the genital area with the same cloth after wiping the anal area was not appropriate incontinent care for preventing UTI.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692	No immediate actions were required. Current residents have potential to be affected. CDM/RD or designee provided education to staff regarding the facilities weight process on October 5th 2018. to ensure continuous compliance for resident number 19 and other like residents in the facility. CDM or designee audits will be conducted weekly on current nutrition at risk residents for 8 weeks including resident 19 for significant weight changes. The Certified Dietary Manager will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to assure resident's maintained acceptable parameters of nutrition, notify the physician and family of significant weight loss, and initiate interventions timely for 1 of 3 resident's reviewed (Resident #19). The facility reported a census of 39 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 7/6/18, Resident #19 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, and toilet use. The resident's diagnoses included diabetes and dementia.

A Nutrition Data Collection Tool summary dated 4/16/18 documented the resident had no significant weight changes in 6 months, and she consumed 50-100% of her meals.

The Care Plan identified the resident's BMI was over ideal range, initiated 04/17/18. At the time the resident had no plans for aggressive weight loss however had an unplanned significant weight loss. The interventions

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F 692	Continued From page 36 included to offer the diet the doctor ordered, and weigh per facility protocol and document significant changes. The Weight Summary record documented the resident had the following weights: 1/7/2018, 154.6 Lbs 2/1/2018, 156.0 Lbs 3/13/2018, 154.0 Lbs 4/2/2018, 156.0 Lbs 6/2/2018, 160.0 Lbs. The Meal Intake records showed the resident consumed less than 50% of her meals 12 out of 45 meals or 26% of the time 6/1-15/18. The meal records showed the resident consumed less than 50% of her meals 24 out of 45 meals or 50% of the time from 6/16-30/18. The Weight Summary record showed the resident weighed 137# on 7/1/2018, a 23# or 14.38% loss in 1 month, with 5% in 1 month being significant. Other than the recorded weight, the clinical record failed to address the significant change. The Weight Summary documented weights: 7/7/2018 13:29 135.0 Lbs 7/8/2018 09:28 135.0 Lbs 7/9/2018 09:28 136.8 Lbs A Nutrition Progress Note dated 7/10/18 documented the resident had a significant weight loss. The registered dietician was aware and a referral sent. The resident was not on any type of supplement. They would start tracking in Nutrition at Risk. The note did not assess the resident's intake status. A Significant Weight Loss/Gain sheet dated	F 692		

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7/10/18 documented the resident had a 16.7% weight loss in 1 month. The dietician recommended a supplement, and the MDS coordinator to notify the family.

The clinical record lacked documentation of physician or family notification, or initiation of a supplement.

The Care Plan initiated 7/10/18 identified the resident had a significant weight loss, with interventions to offer the diet the doctor order and monitor intake, initiated 7/10/18.

The Dietary Progress Notes dated 7/16/18 at 7:56 a.m. documented the resident's weight noted to be down 30 pounds. A re-weight confirmed the loss. The registered dietician aware. Resident added to Nutrition At Risk. A Registered Nurse stated at care conference they would discuss adding a supplement to diet for weight loss.

The Progress Notes dated 7/23/18 at 10:01 a.m. documented the resident's are conference held on 7/20/18 with the resident's children. Resident's weight decline discussed with the family. Dietary and the family agreed to send a facsimile (fax) for an order for Boost (dietary supplement) 240 cc 2 times a day for added calories for the resident. They would continue to encourage the resident to eat what she could at meals.

A facsimile (fax) dated 7/23/18 notified the physician the resident had a weight decline of 10% over 180 days with a current weight of 136#, and questioned if they could add Boost 240 cc 2 times a day for added calorie intake. The physician responded yes.

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

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	165181	A. BUILDING _____ B. WING _____	09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 38 During an interview on 9/5/18 at 9 a.m. the Dietary Supervisor (DS) stated the dietician was aware of the resident's weight loss and recommended dietary supplements. She did not know when the weight loss was discovered. At 9:38 a.m. the DS She stated she checked weights for the Nutrition at Risk meeting on 7/10/18 and found the resident's loss. She confirmed the dietician recommended supplements on 7/10/18, and stated not knowing why the supplement not started for nearly 2 weeks after the dietician recommended it. During an interview on 9/6/18 at 7:15 a.m. the Director of Nursing (DON) stated she expected staff to notify the physician and family right away of significant weight losses, and initiate interventions right away.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility failed to provide pain management and assessment for 1 of 2 residents with identified pain. (Resident #10) The facility census was 39 residents. Finding include::	F 697	DON assessed resident number 10 immediately and provided pain management and added current order to the Treatment Record. Current residents have the potential to be affected. The DON or designee will provide education related to facility pain management policy, requirements, and expectations on October 5th, 2018. The DON or designee will complete an audit to identify residents who receive routine pain medications and will verify pain management is appropriately addressed on plan of care. The DON or designee will add pain evaluation to the residents treatment record of current residents, each shift to assess pain level of resident number 10 and other current residents of the facility on an ongoing basis.	

			The Director of Nursing will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated in staff will be reeducated as needed.	

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F 697		F 697		

Continued From page 39

The Minimum Data Set (MDS) assessment for Resident #10 dated 6/22/18, included diagnoses of congestive heart failure, hypertension, diabetes and osteoarthritis. The MDS documented the resident required extensive assistance of one for bed mobility, toilet use, transfer, dressing and personal hygiene. The MDS documented the resident was frequently incontinent of urine and always continent of bowel. The resident's Brief Interview for Mental Status (BIMS) score was a 15 which indicated no cognitive impairment.

The care plan for Resident #10 included a potential for alteration in comfort with a goal of resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain.

The interventions included evaluate the effectiveness of pain interventions as needed and monitor and report to nurse any signs or symptoms of non-verbal pain.

Observation on 9/04/18 at 1:37 p.m., revealed Resident #10 seated in her recliner, with her feet flat on the floor. She reported her leg pain at a 10, and her legs more swollen than usual. She stated she felt like crying and it had been painful for about a month. She reported she had not gone out to the dining room for lunch today because of her pain. She stated she had let the staff know that was why she had not gone out to the dining room for lunch. She reported staff had not assessed her legs or her pain at this time.

Observation on 9/05/18 at 10:10 a.m., showed Resident #10 seated in her easy chair with TED hose on and feet on the floor. She stated she felt better and went out to the dining room for breakfast. She reported the pain a 6 in her legs

F 697		F 697		
	Continued From page 40 and that she had told staff that she had discomfort. Review of resident's record showed she had been seen in the physician's clinic on 7/12/18 for assessment of severe bilateral leg pain. Review of resident's Physician Orders from the 7/12/18 office visit showed that an order for muscle rub two times per day as needed for pain to her lower legs had been ordered by physician. Record review revealed these orders had not been transcribed onto the Treatment Record and had not been provided or offered to the resident. The Director of Nursing failed to provide any further documentation that assessed the resident's pain in the Nurses Notes or Nurses Assessments. In an interview with the Director of Nursing on 9/05/18 at 5:32 p.m., she stated she would expect the new orders to be transcribed on to the MAR or TAR. She would also have expected the nursing staff to do an assessment and document after the resident had been sent to clinic for Edema and Pain control. On 9/06/18 at 9:11 a.m., observation revealed the resident in her room seated in her recliner with her legs in a dependent position. The resident reported her leg pain at a 6 and that she had let the staff know again today.			
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.	F 758		

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F 758	Continued From page 41 §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; (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	F 758	Resident number 23, PRN psychotropic medication discontinued on 9/25/2018. Current residents receiving PRN antipsychotic medications have the potential to be affected. On October 5th, 2018, DON or designee to provide in-services training to license nurses related to PRN psychotropic medications and the requirements and expectations they will not be ordered for greater than 14 days without physician rational. DON or designee will audit current residents who are receiving psychotropic medications to ensure appropriate rational for continuous use beyond 14 days, for resident number 23 and other current residents all of the facility who have physician orders for PRN psychotropic medications. The DON or designee will review physician orders daily (5 days week) on a going basis and verify psychotropic medication have a 14 day stop or appropriate physician rational to continue. DON or designee will report findings of the above to QAPI monthly times 3 months then review and assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 758		F 758		

Continued From page 42 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. This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to assure psychotropic medications were not ordered on an as needed (PRN) basis for more than 14 days without a rationale for 1 of 5 residents (Resident #23). The facility reported a census of 39 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 7/13/18, Resident #23 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living (ADL's) including toileting and personal hygiene. The resident's diagnoses included dementia, anxiety disorder, and depression.

A Consultation Report dated 1/31/18 notified the physician the resident had a PRN order for an anxiolytic (Lorazepam) in place for greater than 14 days without a stop date. The recommendations were to discontinue the PRN, and if it could not be discontinued, current regulations required the prescriber document the indication for use, the intented duration of therapy, and the rationale for the extended time period. The physician declined the recommendation but failed to document a

F 758	Continued From page 43 rationale. A Consultation Report dated 3/27/18 notified the physician the resident had a PRN order for an anxiolytic (Lorazepam) in place for greater than 14 days without a stop date. The recommendations were to discontinue the PRN, and if it could not be discontinued, current regulations required the prescriber document the indication for use, the intented duration of therapy, and the rationale for the extended time period. The physician declined the recommendation but failed to document a rationale. A Consultation Report dated 7/1/18 notified the physician the resident had not used the PRN Lorazepam for 90 days and recommended consideration of discontinuing due to lack of use. The physician declined with no rationale provided. The September 2018 Medication Administration Record (MAR) showed the resident continued with the order for Lorazepam (anxiolytic) 0.5 mg every 8 hours PRN for anxiousness. During an interview on 9/6/18 at 7:15 a.m. the Director of Nursing (DON) stated the physician who is their medical director didn't think it necessary to provide a rationale for continuing the PRN order for Lorazepam for more than 14 days.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		

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F 842	Continued From page 44 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;(iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	No immediately action possible. Current residents of the facility have the potential to be affected. On October 5th, 2018, DON or designee will provide inservice education related to maintaining complete resident records. DON or designee with complete a record audit of current residents to verify that they include H&P, admission orders, recertification orders and are otherwise complete. DON or designee will complete record review within 72 hours of admission to ensure that medical records for resident #23 and other current residents of the facility are maintained and complete. This will be completed on an ongoing basis. DON or designee will report findings of the above to QAPI monthly times 3 months then review and assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 842		F 842		
	Continued From page 45 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a complete record for 1 of 12 active residents reviewed (Resident #23). The facility reported a census of 39 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 7/13/18, Resident #23 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living (ADL's) including toileting and personal hygiene. The resident's diagnoses included dementia, anxiety disorder, and depression.			

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F 842	Continued From page 46 The clinical record lacked the resident's History and Physical (H&P), Admission orders, and Recertification orders. During an interview on 9/5/18 at 11:50 a.m. Staff H, Medical Records stated she had looked and was unable to find the H&P, Admission orders or Recertification orders for the resident.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of facility policy, QAPI (Quality Assessment and Performance Improvement) documentation, and staff interview, the facility failed to identify, analyze, and prioritize problems regarding quality indicators, under the QAPI program. The facility also failed to include specific, measurable, attainable, reasonable and time-bound goals, to develop and implement action plans to reach set goals, and to evaluate whether or not goals were met. At the time of the survey, the facility reported a census of 39, that could potentially be affected by this deficient practice. The facility reported a census of 39 residents. Findings include: The facility's policy titled, Risk	F 867	On 9/6/18, The Regional Nurse Consultant provided in-service/education to the facility management team related to the QAPI program including discussing, measurable, reasonable, and time bound goals. to identify, analyze, and prioritize problems regarding quality indicators, under the QAPI program. Also discussed development, action plans and to evaluate whether or not goals were met. The Regional Clinical Consultant will attend at least one facility QAPI meeting in next 3 months to assist in continuing education of the process if needed. The Administrator will review the QAPI meeting agenda with the Regional Nurse Consultant monthly times 3 months. The Administrator will report findings of the above to QAPI monthly times 3 months then review and assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 867		F 867		

Continued From page 47

Management/Quality Assurance Process Improvement (QAPI) Program, dated 9/14, indicated that program is focused on minimizing risk and improving residents' cares by implementing process for root cause analysis and the utilization of quality improvement teams. The procedure indicated to identify, review and address quality indicators through implementation of action plans, including goals, outcome indicators, and monitoring plan. The policy also directed the QAPI committee to meet monthly.

The QAPI documentation for the last 6 months, from 3/18 to 8/8/18 revealed that the QAPI committee did not consistently meet on a monthly basis, which was in violation of it's own policy. There were no QAPI committee meetings for the months of 4/18 and 7/18.

In addition, the QAPI committee meeting documentation showed the following:

March 2018:
1. Quality Standards
a. Antipsychotics - 2
b. Falls - 17
c. Pressure Ulcers (In-house Acquired) - 11
d. Unplanned Weight Loss
- in 30 days - 0
- in 90 days - 1
- in 180 days - 3

2. Reportable Events
a. Hospital Admission or ER visits - 4

3. Infection Control
a. Infection Rate -
b. Nosocomial Infection Rate -
c. # of Nosocomial UTI (Urinary Tract Infection) in

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F 867	Continued From page 48 past 30 days - 2 Review revealed a lack of evidence to show root cause analysis of the above data. There lacked proof of discussions to show analysis to identify existence of problems, and in order to identify priorities to be addressed. There lacked goals set and plan of actions that geared toward addressing identified priority problems. During the survey, concerns were identified with failure to implement measures to ensure resident safety, and failure to provide necessary treatments to prevent/heal pressure ulcers. April 2018 There was no QAPI committee meeting conducted. May 2018 1. Quality Standards a. Antipsychotics - 3 b. Falls - 17 c. Pressure Ulcers (In-House Acquired) - 8 d. Unplanned Weight Loss - 2. Infection Control a. Infection Rate - 3 b. Nosocomial Infection Rate - c. # of Nosocomial UTI (Urinary Tract Infection) in past 30 days - 2 There was lack of evidence to show analysis of the above-data, in order to understand the increase in the use of antipsychotics, the appropriateness of antipsychotic medication usage including indications, and dose reductions. There was also lack of evidence to show analysis	F 867		

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F 867	Continued From page 49 to know why the number of fall occurrences was unchanged and what interventions (if any) did not work and needed revision. The data-related concerns identified during the survey, included failure to address the as needed (PRN) use of antipsychotic medication, failure to develop a comprehensive care plan for the use of psychotropic medications, and failure to implement plan of actions to prevent accidents/falls. June 2018 1. Quality Standards a. Antipsychotics - 1 b. Falls - 8 c. Pressure Ulcers (In-House Acquired) - 7 d. Unplanned Weight Loss - in 30 days - 1 - in 90 days - 7 - in 180 days - 4 2. Infection Control a. Infection Rate - 7 b. Nosocomial Infection Rate - c. # of Nosocomial UTI (Urinary Tract Infection) in past 30 days - 5 There was lack of evidence to show root cause analysis of the above-data, in order to identify priority problems such as the increased rates for unplanned weight loss, infection, and UTI in past 30 days. There lacked specific, attainable and time-bound goals and action plans on how to address the problems. The concerns identified during the survey that were related to facility's failure to address these data/problems, included; failure to complete	F 867		

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F 867	Continued From page 50 comprehensive assessment for significant change in nutritional status, failure to implement measures to prevent decline in resident's nutrition/hydration status, failure to implement interventions to prevent UTI, failure to maintain and implement actions to prevent the acquisition and spread of infections, and failure to develop and implement an antibiotic stewardship program. July 2018 There was no QAPI committee meeting conducted. August 2018 1. Quality Standards a. Antipsychotics - 1 b. Falls - 8, 1 with major injury c. Pressure Ulcers - 3 = In-House Acquired - 2, Admitted - 1 d. Unplanned Weight Loss - in 30 days - 4 - in 90 days - 3 - in 180 days - 3 2. Reportable Events a. Hospital Admission or ER visits - 1 (hip fracture) 3. Infection Control a. Infection Rate - 13.8% (4.6) b. Nosocomial Infection Rate - 13.8% c. # of Nosocomial UTI (Urinary Tract Infection) in past 30 days - 5 4. Contractures a. # of Residents with Contractures - 1	F 867		

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F 867	Continued From page 51 b. # of In-House Acquired - 1 5. Nursing Services - Indicated a concern regarding physician and nursing follow-through on recommendations. There was lack of evidence that the QAPI committee conducted analysis of the data reported, especially regarding the increased rate of unplanned weight loss, hospital admission with major injury, and the unchanged number for UTI. The documentation also showed an issue concerning physician and nursing follow-through on recommendations, however, there was lack of evidence to show discussions of planned actions in order to solve the problem. Related concerns identified during the survey included, Assessment for significant weight loss, Interventions to maintain nutrition/hydration, Interventions to prevent Accidents/Hazards, Interventions to prevent UTI), and failure to address resident's decline in activities of daily living. On 9/6/18 at 10:25 a.m., the Administrator and the Director of Nursing (DON) verified lack of thorough data analysis, and identification of priority problems were not evident in the QAPI documentation. They further verified the lack of planned interventions or actions to address issues as reported in QAPI committee meetings.	F 867		
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	F 880		

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F 880	Continued From page 52 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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	F 880	On 9/5/18 Education was provided to staff F and staff G related to nebulizer cleanliness, proper handling procedures of nebulizer, single alcohol swabs, and hand washing between cares and residents. Current resident of the facility have the potential of being affected. On October 5th, 2018, DON or designee will provide inservice related to the infection prevention control program which will include, nebulizer cleanliness, proper handling procedures of nebulizer, single alcohol swabs, and hand washing between cares and residents. DON or designee will observe nebulizer treatment competency to 5 random nurses' weekly times 8 weeks to ensure continuous compliance for resident number 32, 9, and current residents of the facility. DON or designee will observe 5 staff members a week to ensure competency compliance related to hand washing for resident number 2, 4, and current resident of facility. DON or designee will observe 5 staff members a week to ensure competency compliance with single use alcohol swabs for resident number 2, 4, and current resident of the facility. DON or designee will observe 5 staff members a week to ensure competency compliance with handwashing to assure continuous compliance for resident number 2, 4, and current resident of the facility. DON or designee will observe 5 staff members a week to ensure competency compliance with peri-care for resident number 12, 19, and current residents of the facility. DON or designee will observe 5 staff members a week to ensure competency compliance with pressure ulcer cares for resident number 30 and other residents of the facility who has pressure ulcers. DON or designee to report findings of the above to QAPI monthly times 3 months then review and assess for need to continue. The plan will be reviewed and	

			revised as indicated and staff will be reeducated as needed.	

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	165181	A. BUILDING _____ B. WING _____	09/06/2018

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F 880		F 880		
	Continued From page 53 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, records review, and staff interview the facility failed to implement consistent infection prevention practices in the care and treatments of 4 of 6 residents (Resident # 32, # 9, #2, and #4) observed for medication administration, 2 of 2 residents (Resident #12, and #19) observed for perineal cares, and 1 of 1 resident (Resident #30) observed for care of pressure ulcer. At the time of the survey, the facility reported a census of 39 residents. Findings include: The facility's policy and procedure #1.1 and 1.1.1 titled, Infection Prevention & Control Program,			

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F 880	Continued From page 54	F 880		
	dated 3/15, provided that facility strives to prevent transmission of infections and communicable diseases, development of nosocomial infection, and effectively treat and manage nosocomial and community acquired infections. The procedure indicated monitoring of staff compliance to standard and transmission based precautions and other infection control procedures. The facility's Infection Prevention policy #7.3, sub-titled, Handwashing, dated 3/15, indicated acknowledgement that handwashing is the single most important procedure for preventing nosocomial infections. The policy directed staff to perform handwashing between resident contacts, and to wash hands after performing tasks including, contact with blood/body fluids, contact with contaminated items or surfaces, contact with resident/patient, initiating clean procedure, and removal of gloves. During observations for medication administration, there were multiple breaches in infection prevention (using dirty nebulizer masks, re-using alcohol swabs, and not performing hand hygiene), as follows: 1. On 9/5/18 at 7:55 a.m., Staff G, Certified Medication Aide (CMA) entered Resident #32's room to administer nebulization treatment with Budesonide Suspension 0.5 milligrams (mg)/2 milliliters(ml)+ Sodium Chloride Nebulization Solution 7%. Staff G used Resident #32's nebulizer mask which was heavily soiled with a whitish substances. 2. On 9/5/18 at 8:03 a.m., Staff G, CMA took out Resident #9's Albuterol 2.5 mg/3 ml from medication cart and entered Resident #9's room			

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F 880	Continued From page 55 to administer the nebulization treatment. Staff G looked for Resident #9's nebulizer system and found the tubing, mask, and cup (all attached together/intact) but lying on the floor with papers scattered in between Resident # 9's chair and bedside table. Staff G picked up the device, put the medication in the cup, and administered the nebulization treatment. 3. On 9/5/18 at 11:43 a.m., Staff F, Registered Nurse (RN) entered Resident #2's room to do blood sugar check. Staff F donned a pair of gloves and wiped Resident 2's left small finger with an alcohol swab, then put it on top of the bedside table without a barrier present. However, Resident #2 voiced not wanting left small finger to be used and suggested to use right middle finger instead. Staff F then picked up the used alcohol swab on top of bedside table, wiped Resident #2's middle finger and obtained the blood sample. Staff F removed her gloves, prepared insulin, donned another pair of gloves, administered the resident's insulin. Staff F then removed the gloves, and went to document in the computer. Staff F failed to perform hand hygiene before, during, and after the entire duration of the tasks performed. 4. On 9/5/18 at 11:57 a.m., Staff F proceeded straight to the 200 Hallway. Staff F donned gloves, wiped Insulin Aspart flex pen hub with alcohol swab, prepared 3 units of insulin, and wiped Resident #4's abdominal skin for injection with the same alcohol swab used to wipe the insulin flex pen. Staff F then removed gloves and touched the computer to document medication administration. Staff F failed to perform hand hygiene between residents (Resident #2 and #4), and failed to perform hand hygiene before,	F 880		

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F 880		F 880		
	Continued From page 56 during, and after preparation and administration of Resident #4's medication. During interview on 9/5/18 at 12:04 p.m., Staff F stated she thought she did not re-use the alcohol swab, and then acknowledged that she did not perform hand hygiene in between tasks, and between residents. During interview on 9/5/18 at 2:25 p.m., the Director of Nursing (DON) stated expectation that staff should observe infection control practices at all times, including medication administration. 5. The Minimum Data Set (MDS) assessment for Resident #30 dated 8/03/18, included diagnoses of atrial fibrillation, coronary artery disease, hypertension, arthritis, and non-Alzheimer's Dementia. The MDS documented the resident required extensive assistance of two for bed mobility, toilet use, transfer, dressing and personal hygiene. The MDS documented the resident was frequently incontinent of urine and occasionally incontinent of bowel. The resident's Brief Interview for Mental Status (BIMS) score was a 3 which indicated severe cognitive impairment. The resident record also documented a pressure ulcer to left buttock and a pressure ulcer to resident's coccyx. During observation on 9/05/18 at 10:00 a.m., Staff D, Certified Nurse's Aide (CNA) assisted the resident into the bathroom and onto the toilet, CNA then washed hands and donned gloves. She removed the residents wet brief, threw it into the trash can, and left the bathroom to get a clean brief from the resident's closet. The CNA returned to the bathroom, removed gloves and donned a new pair. She assisted the resident to a standing			

F 880	Continued From page 57 position, pulled a wet wipe from the package and wiped the resident's leg creases and buttocks turning to a new side with each wipe. She tossed this wipe and reached into package to get another which she used to wipe front to back on the resident's peri area, she tossed this wipe toward garbage and it missed and landed on the floor. The CNA picked the wipe up off the floor and placed it into the garbage can, she then took another wipe and wiped the resident buttock area. She then picked up a tube of barrier cream with one soiled gloved hand, squeezed the cream onto the other soiled gloved hand and wiped it onto the resident's buttocks. Observation revealed the resident had an open area on the coccyx. The CNA removed the glove from her left hand and without hand sanitation continued to assist the resident pulled up brief and pants, and helped resident to her recliner. Staff D proceeded to touch the resident's pants, shirt, gait belt, walker, recliner, privacy curtain, recliner lift controller, call light, bathroom door knob and bathroom sink handles to turn on the water with the same soiled gloves used to provide incontinency care and apply barrier cream. She then removed and discarded the glove in the trash, removed the trash liner tied it shut and turned and washed her hands. When interview on 9/05/18 at 5:32 p.m., the Director of Nursing stated she would expect a staff to remove dirty gloves and do hand sanitation prior to applying barrier cream to a residents bottom especially on a resident with an open wound.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		

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F 881	Continued From page 58 §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to establish an infection prevention and control program that must include an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The facility reported a census of 39 residents. Findings include: Based on facility record review, and staff interview, the facility failed to ensure infection control program included commitments toward responsible use of antibiotics through implementation of an antibiotic stewardship program. This deficient practice could potentially affect the facility's census of 39 residents, as reported at the time of the survey. Findings include: Review of the facility Infection Prevention & Control Program, dated 3/15 revealed the policy lacked information regarding antibiotic stewardship program, and protocols and system for monitoring antibiotic use. On 9/5/18 at 2:25 p.m., the Director of Nursing (DON) verified that the facility did not have written guidelines for antibiotic stewardship. The DON	F 881	Nurse Consultant in-serviced department supervisory team related to antibiotic stewardship program as part the infection control program. Current resident of the facility have the potential of being affected. October 5th 2018, DON or designee will provide inservice education related to antibiotic use, which will include the McGeers criteria and communication with the physician. DON or designee review physician orders, 5 days a week, to review any new antibiotic orders and antibiotic logs, to verify the antibiotic has been logged appropriately and will verify appropriate criteria has been met. DON or designee to report findings of the above to QAPI monthly times 3 months then review and assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.	

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F 881	Continued From page 59 stated the facility relied on consultant pharmacist's education for staff on how to use antibiotics. The DON further stated that "corporate" was still working to provide facility written guidelines for antibiotic stewardship. On 9/5/18 at 4:06 p.m., the Nurse Consultant verified that the facility did not implement antibiotic stewardship. She stated she talked to the DON on 9/4/18 and discovered that the facility did not have one, despite corporate expectation that antibiotic stewardship program be in place in all buildings.	F 881		