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	165310	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Correction Date_____ The following deficiencies are related to the facility's annual health survey and the Incident # 82845-I completed on 4/22- 25/2019. The facility reported incident is substantiated. See code of Federal Regulations (42CFR) Part 482, Subpart B-C.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		

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

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to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by

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anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation and interviews the facility failed to ensure the residents received the required information regarding their right to file a grievance and to ensure their grievance policy included the required information. The facility identified a census of 128.

Findings include:

During the Resident Council meeting on 4/23/19, beginning at 1:30 p.m., 6 of 6 residents reported they did not know the name of the grievance

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F 585	Continued From page 3 officer or the process to file a grievance. Observations throughout the facility revealed no postings to identify the grievance officer or information on how to file a grievance. During an interview on 4/24/19, at 9:15 a.m., an administrator from a sister facility acknowledged the facility does not have any information posted to identify the grievance officer or how to file a grievance. Review of the resident admission packet revealed a document titled "Agencies Available to Assist Residents, Tenants and/or Family Members:", lacked information regarding the grievance policy and the only information identified regarding the grievance process, included the facility name, administrator and facility phone number. Review of a policy title "Grievances and Concerns", dated 8/2017, revealed it failed to identify a resident has the right to file a grievance anonymously, the contact information of the grievance official and their right to obtain a written decision .	F 585		
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- §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	F 625		

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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 staff interview, record review, and facility policy the facility failed to provide 5 of 9 sampled residents with bed hold information upon transfer out of the facility. (Resident #3, 14, 88, 90, 97)The facility reported a resident census 128.

Findings include:

1. The Admission Record for Resident #3 had diagnoses which included chronic respiratory failure, depression, dementia, and anxiety.

The Nurses Progress Note dated 11/27/18 documented the resident had wheezes and shortness of breath in both lungs. The resident requested to be transferred to a local hospital and staff sent the resident per their request.

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The Nurses Notes dated 12/9/18 at 12:42 p.m. documented the resident returned to the facility.

Review of the Nurses Notes dated 11/27/18 to 12/9/18 lacked documentation the staff provided a bed hold to the resident/family upon transfer.

2. The Admission Record for Resident #97 had diagnoses including chronic obstructive pulmonary disease, anxiety disorder, and high blood pressure.

The Nurses Notes dated 2/23/19 at 9:03 p.m. documented the resident had an admission to the hospital for pneumonia and returned to the facility on 3/1/19, the clinical record lacked documentation the staff provided the resident with a bed hold.

During an interview on 4/23/19 at 2:40 p.m. Staff K, Registered Nurse reported she has a folder for bed hold forms at the nurses station and the staff are expected to provide one to the resident/family upon transfer to the hospital.

During an interview on 4/24/19 at 10:39 a.m. Staff E, Registered Nurse reported when a resident is sent to the hospital the nurse needs to send the code status, medication list, and bed hold policy with the resident/family.

3.) Record review of Resident # 90 revealed a nurse progress report with admission date to the hospital on 3/3/19. The resident returned to the facility on 3/6/19 per readmission progress note.

Interview with Staff N, Registered Nurse Consultant on 4/3/19 at 11:00 a.m. stated she

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could not find a bed hold or documentation for Resident #90's hospitalization on March 3rd.

4. Resident #14's Minimum Data Set (MDS) assessment dated 1/17/19 showed the resident had severe memory loss, required extensive staff assistance with daily cares, had diagnoses including neurogenic bladder and Schizophrenia.

A Hospital Discharge Summary showed the resident admitted 1/3/19 and discharged 1/8/19. The discharge diagnoses included, septic shock, secondary to right lobe pneumonia and urinary tract infection.

The residents record failed to show any Nurse's notes, discharge or transfer notes regarding a bed hold form given to the resident/family.

5. Resident #88's minimum Data Set (MDS) assessment dated 3/14/19 showed the resident had good memory skills, required 1 staff for limited assistance with daily cares, and had diagnoses of heart failure, chronic lung disease, syncope (dizziness) and collapse, and a seizure disorder.

A Hospitalist History and Physical dated 4/8/19 revealed the resident had a fall while working with therapies and taken to the hospital for further evaluation.

The resident's clinical record failed to reveal the staff gave a bed hold form to the resident upon transfer.

The Admission Agreement with revision date 2/15/17 documented the following: If the Resident has a temporary absence from the facility for

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F 625	Continued From page 7 medical treatment, the facility will provide written information to the resident specifying the duration of the bed hold policy under the applicable governmental regulations, and the facility's policies regarding bed hold periods. The facility will then ask the resident or the resident's legal representative, family member or responsible party if he/she wishes the bed held open. This shall be documented in the resident's record including the response. Upon request of the resident or the residents' legal representative, family member or responsible party the facility will hold the bed open for at least tem days during the resident's absence and the facility shall receive payment for the absence period in accordance with provisions of the agreement.	F 625		
F 644 SS=B	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644		

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This REQUIREMENT is not met as evidenced by:
Based on interviews and record review the facility failed re-assess 1 of 2 residents reviewed for Preadmission Screening and Resident Review (PASRR) (Resident # 60). The facility reported a census of 128 resident.

Findings included:

The Minimum Data Set (MDS) assessment for Resident # 60 dated 2/20/19, listed a diagnosis of psychotic disorder (other than schizophrenia).

Resident # 60's PASRR dated 6/14/17, identified a negative level one screen. The PASRR documented major depression and anxiety and lacked a diagnosis of psychotic disorder (other than schizophrenia)
Staff V-Social Services completed the PASRR review dated 6/12/17.

Review of the Diagnosis/ History sheet dated 3/6/2014, listed diagnosis of psychosis not otherwise specified (NOS).

During an interview 4/24/19 at 10:16 a.m., Staff Y Registered Nurse (RN) reported getting the resident's diagnosis from History and Physical (H&P) and Physician's progress notes.

During an interview on 4/24/19 at 10:30 a.m., Staff V-Social Services (S.S.) reported when completing the PASRR paper work she obtains the information from the H&P and family interviews.

During an interview on 4/24/19 at 10:47 a.m.,

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F 644	Continued From page 9 Staff V-SS stated the resident had a psychiatric evaluation in 2017 without a diagnosis at that time. She reported she did not see the psychosis not other wise specified (NOS) diagnosis on the H&P but she did mark anxiety and depression on the PASRR dated 6/4/17. During an interview on 4/24/19 at 02:53 p.m., the Acting Administrator RN reported staff are expected to fill out the PASRR information as accurately as they can.	F 644		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and resident interviews the facility failed to ensure a residents safety for 1 of 3 residents reviewed for a fall (Resident #88). The resident obtained a fracture from a fall, when a staff person turned away from the resident, requiring hospitalization. The facility identified a census of 128 residents. Findings include: 1. Resident #88's Minimum Data Set (MDS) assessment dated 3/14/19 showed the resident had a score of 14 out of 15, indicating good memory skills. The resident required 1 staff for	F 689		

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limited assistance with ambulation in the room and in the facility. The MDS showed the resident had unsteadiness with walking but able to stabilize without staff assistance. The MDS also showed the resident had heart failure, chronic lung disease, syncope (dizziness) and collapse, and diabetes.

The Care Plan revised on 3/28/19 showed the resident required staff assistance with mobility related to impaired mobility, shortness of breath, weakness and fatigue post hospitalization for pneumonia with respiratory failure, congestive heart failure, and a history of syncope episodes with falls. An intervention included to provide assistance of 1 staff with transfers and ambulation and to use a walker while ambulating.

The Physician Order Statement (POS) dated 12/19/18 directed staff to administer 1 liter per minute by nasal cannula to keep the resident's oxygen saturations above 90 percent (%) as needed (oxygen saturation testing is a method to check oxygen levels in a person's bloodstream. The normal range of oxygen saturation for adults is 94 to 99 percent. Low blood oxygen levels can result in abnormal circulation and cause the following symptoms: shortness of breath, headache, restlessness, dizziness, rapid breathing, chest pain, confusion, and high blood pressure.)

A Physical Therapy Evaluation and Plan of Treatment dated 3/20/19 identified the resident will have therapy for 3 times a week for 4 weeks. A long term goal identified for the resident is to ambulate safely on level surfaces for 150 feet, using a wheeled walker.

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Observation on 4/22/19 at 11:16 a.m. (initial tour) revealed the resident in her recliner with the oxygen running at 1 liter per minute per nasal cannula. The resident reported she fell while at home and had no falls since being here. The resident reported having fractured some bones in the back and had pain in her right shoulder. She reported she is receiving pain medications and felt her pain was under control.

A Hospitalist History and Physical report dated 4/8/19 revealed the resident had a fall while working with therapy while at the care facility. According to the resident and family the therapist left her to grab a chair and in the meantime the resident lost her balance and fell backwards, landing on the buttocks. The resident started to have severe pain in the right hip and hit her head. The fall resulted in the resident being transferred to a local hospital for evaluation. The report revealed the resident had a CT (computerized tomography) scan without contrast of the pelvis which revealed an oblique nondisplaced fracture through the right ilium and nondisplaced right superior and inferior pubic rami fracture (fractured pelvis). The Orthopedic surgeon on call was consulted and recommended non-operative management with pain control, PT and OT therapy and weight bearing as tolerated. The resident admitted to the hospital for further management and evaluation.

Review of an x-ray report of both hips dated 4/8/19 revealed the resident had an oblique nondisplaced fracture through the right ilium/iliac wing and a non displaced right superior and inferior pubic rami fractures.

A Nurses Note dated 4/8/19 showed the resident

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walked with therapy to the dining room with use of a walker and gait belt. The therapist left the resident's side, walked over to get a chair for her to sit in and the resident fell, hitting her head on the wall near the nurse's station. A nurse's assessment revealed the resident responded appropriately and had full range of motion without pain but sustained a skin tear to the right forearm. The physician ordered the resident to be sent to the hospital for evaluation due to hitting her head and currently receiving anticoagulant medication.

An Online Abuse or Incident Reporting form dated 4/9/19 sent to Department of Inspections and Appeals reported an incident resulting in hospitalization for Resident #88. The incident summary showed the resident had diagnoses which included osteoporosis, low back pain, syncope (dizziness) and collapse, orthostatic hypotension (where the blood pressure drops with a change of position), diabetes, congestive heart failure, ischemic cardiomyopathy (a weakened heart from damage) and hypertension. The resident has a BIMS of 14 out of 15 BIMS (Brief Interview for Memory Skills) and an assist of one with a front wheeled walker for transfers and ambulation. On 4/8/19 at 2:30 p.m. therapy worked with the resident for ambulation to see if the resident could safely be independent with ambulation in the facility. The resident walked 130 feet with a gait belt, needed stand by assist and occasional contact assist (holding on to the gait belt). The resident then walked 20 feet and 56 feet, with minimal contact assist. The therapist noted the resident's pace going slower. The therapist asked the resident if she wanted to sit down. The therapist turned to get a chair and as the therapist turned back, she saw the resident falling away from her. The resident fell against

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the wall with the shoulder, hit her head on the wall, and slid down onto the floor, landing on the buttocks.

The Corrective Action Description of the Online Report 4/12/19 showed the resident went to the emergency room. The resident received an anticoagulant (blood thinner) and had hit the head which required an evaluation. The hospital reported a nondisplaced fracture of the right iliac wing superior and inferior pubic rami which required hospitalization. The resident had an extensive history of dizziness and collapse of unknown injury. The resident wore Ted hose (compression stockings) and an abdominal binder while ambulating and denied dizziness at the time of the fall. The initial post fall nursing assessment and the initial Emergency Medical Service assessment identified an oxygen saturation of 85 % to 92%, indication the resident likely de-saturated (low oxygen) due to exertion while ambulation with therapy. The facility believed a combination of muscle fatigue and mild hypoxia (low oxygen) played a significant role in the resident's fall. The resident's care plan was updated to include the use of oxygen with ambulation.

A witnessed Fall Report by the facility dated 4/8/19 showed while the resident walked with therapy staff to the dining area using a walker and gait belt, the resident became tired, the therapist walked over to get a chair for the resident to sit down. The resident fell, hitting her head on the wall near the nurse's station. After staff completed an assessment, the resident went by ambulance to the hospital. The resident received a skin tear to the right forearm. The Report showed the resident ambulated with assistance,

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was alert and orientated, used a walker. The resident ambulated long distance with Physical Therapy and became overly tired. The fall occurred as the therapist went to get a chair for the resident to rest. The Physical Therapist Assistant (PTA), Staff B wrote a statement: I was walking the resident to practice longer distances. While walking the resident to Station 1's dining room, turned away to get a chair for the resident to sit in and the resident fell back hitting the head on the wall near the nurse's station. Additional Notes on 4/9/19 on this Witnessed Fall Report included the resident assessment revealed a lower oxygen saturation after ambulation.

The Patient Incident Reporting Form (by Rehabilitation) dated 4/8/19 showed the PTA (Physical Therapist Aide-Staff B), account of the fall: The patient participated in therapy. The patient met goal of walking to the nurse's station with the front wheeled walker and stand by assist (SBA-walking next to the resident). This therapist turned to pull a chair up for the resident and the resident fell to the right and could not reach the resident to recover the resident's balance. The resident hit the shoulder and her head on the wall and continued to fall onto the floor.

A Physical Therapy Treatment Encounter Note dated 4/3/19 showed the resident with precautions and a fall risk. The therapist set up an oxygen bag on the walker to support an oxygen tank for the resident while ambulating. Gait training performed with contact guard and/or close stand by assist with a wheelchair to follow. The resident's oxygen level monitored throughout ambulation. The note indicated the resident's oxygen level dropped to 82 % with the resident on 2 liters of oxygen. The resident instructed to slow

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the pace for safety and ambulated up to 150 feet prior to rest break.

A Physical Therapy Treatment Encounter Note dated 4/4/19 showed the resident ambulated 150 feet plus 100 feet. The resident's oxygen level dropped as low as 85% but increased to 95% while sitting and cued to use pursed lip breathing.

A second interview with the resident on 4/23/19 at 11:27 a.m. the resident reported she did have a fall here at the facility. The resident reported not remembering if a gait belt around her waist at that time, or if oxygen applied. The resident reported walking with a therapist down to station 1.

An interview on 4/23/18 at 12:15 p.m. Staff B, Physical Therapist Aide (PTA) reported walking the resident from Station 3 dining room to the resident's room, after a rest period, walked 130 feet and then another 20 feet. The resident's walker had a large oxygen tank in a bag on the resident's front wheeled walker which distributed oxygen to the resident during ambulation. Returning to the resident's room, Staff B switched the oxygen tank to the oxygen concentrator in the room. Staff B requested the resident to walk down the hall to Station 1, to get medication. When they got outside the resident's room, the PTA noted the oxygen tubing didn't go any further, so she removed the oxygen from the resident. The PTA walked with the resident down the hall, approximately 45 to 56 feet without oxygen. At the station, the PTA, noted the resident slower in pace and turned to get a chair for the resident. As the PTA turned back towards the resident she fell. The PTA reported Occupational Services (OT) were ready to determine the resident as independent that day and said she did not agree

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or disagree. The PTA reported the resident had on the gait belt, compression socks and abdominal binder. The PTA reported she did not hold onto the gait belt and used stand by assist the entire last walk. The PTA stated by using stand by assistance this would help determine if the resident's functions could be deemed independent. The PTA thought therapy services were going to make the resident independent that day, but then the fall occurred. The PTA also noted she did not check the resident's oxygen level during the entire session that day.

An interview on 4/23/19 at 1:50 p.m. Staff C, Physical Therapist (PT) reported PT usually determines if a resident is deemed independent. All services will get together to discuss the matter. The PT replied they usually do a few sessions with the resident to determine if the resident is safe. The PT reported it was this Rehabilitation's Policy to always have a gait belt on a resident when working with the resident, whether they require one or not. The PTA noted staff usually use contact guard (CGA) in testing the resident, which means we hold onto the resident's gait belt while ambulating. A person can get the feeling of the residents balance, gait, and steadiness with the use of the gait belt. He noted stand by assist (SBA) means we just stand by them as they ambulate.

An interview on 4/23/19 at 2:15 p.m. the Director of Rehabilitation Services reported all services will meet and discuss the determination to declare a resident independent with ambulation. The Director agreed the PT and TO notes did not report they were planning on making the resident independent on 4/8/19.

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An interview on 4/2319 at 2:35 p.m. Staff E, Licensed Practical Nurse (LPN) reported she saw the PTA walking the resident down the hall towards Station 1. The resident had on a gait belt, compression stockings, abdominal binder, using a walker. Staff E saw the PTA holding onto the gait belt. When they got to the entrance of the dining room, Staff E heard the PTA say to the resident it looked like she needed to rest. The PTA let go of the gait belt and stepped over to the opposite side of the resident to retrieve a chair. The resident fell into the wall. Staff E noted there were other staff persons in the dining room that the PTA could have asked for assistance to get the chair. Staff E commented staff do not let go of the gait belt until the resident was in a safe place.

An interview on 4/25/19 at 8:23 a.m. Staff AA, LPN, reported working the day the resident fell. It occurred between 2 p.m. and 2:30 p.m., at shift change. Staff AA entered the dining room and found the resident on the floor by the wall, by the entrance to the dining room next to the medication carts. Staff AA asked the PTA what happened, the PTA told Staff AA, she ambulated the resident on a longer distance to see if the resident could be independent with ambulation. The PTA said she let go of the resident to get a chair and the resident fell. Staff AA reported there were 4 or 5 people in the same area and the PTA could have asked for some help. Staff AA assessed the resident, noted a skin tear, asked if the resident had pain, which the resident answered no. The resident covered her face and began to cry. Due to the resident hitting the head and being on an anticoagulant, the staff transferred the resident to a local hospital for evaluation. The resident stated twice to the

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medics that she had pain.

An interview on 4/25/19 at 11:30 a.m., Staff C reported they usually make resident's independent in the room first and then independent in the halls. He noted the PTA may have been trying to determine if the resident could be independent in the hall on the day the resident fell.

An interview on 4/15/19 at 12:10 p.m. the Acting Administrator (former Director of Nursing) reported all she knew of the resident's fall was second hand. She commented not knowing how the gait belt should be used for the resident that day, stand by assist or contact guard, because the Therapy Department have their own scope of practice.

The facility's Falls Protocol Quick Reference dated 1/2015 reported identifying residents at risk which included:
- completed a fall risk assessment for each resident at the time of admission and quarterly.
- for those residents identified at risk of falls initiate/implement preventive interventions via care plan.

The Facility's Policy for Functional Assist Level Scale dated 9/5/17 showed the Policy for Rehabilitation Services that all therapy personnel will document following an uniform system of measurement for disability by using the functional assist level scales within the clinical documentation systems. These scales indicate how much assistance is required for this individual to carry out a task.

The Procedure for this Policy showed the

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following scales included:
- Standby Assist (SBA) = No physical contact needed however close enough to reach if help is needed.
- Contact Guard (CGA)= Occasional contact is needed-protective safeguarding.

Based on observation, record review, staff, and resident interviews the facility failed to ensure a residents safety for 1 of 3 residents reviewed for a fall (Resident #88). The resident obtained a fracture with the fall while a staff person turned away from the resident, and required hospitalization. The facility identified a census of 128 residents.

Findings include:

1. Resident #88's Minimum Data Set (MDS) assessment dated 3/14/19 showed the resident had a score of 14 out of 15, indicating good memory skills. The resident required 1 staff for limited assistance with ambulation in the room and in the facility. The MDS showed the resident had unsteadiness with walking but able to stabilize without staff assistance. The MDS also showed the resident had heart failure, chronic lung disease, syncope (dizziness) and collapse, and diabetes.

The Care Plan revised on 3/28/19 showed the resident required staff assistance with mobility related to impaired mobility, shortness of breath, weakness and fatigue post hospitalization for pneumonia with respiratory failure, congestive heart failure, and a history of syncope episodes with falls. An intervention included to provide assistance of 1 staff with transfers and ambulation and to use a walker while ambulating.

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The Physician Order Statement (POS) dated 12/19/18 directed staff to administer 1 liter per minute by nasal cannula to keep the residents oxygen saturations above 90 percent (%) as needed (oxygen saturation testing is a method to check oxygen levels in a person's bloodstream. The normal range of oxygen saturation for adults is 94 to 99 percent. Low blood oxygen levels can result in abnormal circulation and cause the following symptoms:shortness of breath, headache, restlessness, dizziness, rapid breathing, chest pain, confusion, and high blood pressure.)

A Physical Therapy Evaluation and Plan of Treatment dated 3/20/19 identified the resident will have therapy for 3 times a week for 4 weeks. A long term goal identified for the resident is to ambulate safely on level surfaces for 150 feet, using a wheeled walker.

Observation on 4/22/19 at 11:16 a.m. (initial tour) revealed the resident in her recliner with the oxygen running at 1 liter per minute per nasal cannula. The resident reported she fell while at home and had no falls since being here. The resident reported having fractured some bones in the back and had pain in her right shoulder. She reported she is receiving pain medications and felt her pain under control.

A Hospitalist History and Physical report dated 4/8/19 revealed the resident had a fall while working with therapies while at the care facility. According to the resident and family the therapist left her to grab a chair and in the meantime the resident lost her balance and fell backwards, landing on the buttocks. The resident started to have severe pain in the right hip and hit her head,

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the fall resulted in a transfer to a local hospital for evaluation. The report revealed the resident had a CT (computerized tomography) scan without contrast of the pelvis which revealed an oblique nondisplaced fracture through the right ilium and nondisplaced right superior and inferior pubic rami fracture (fractured pelvis). The Orthopedic surgeon on call was consulted and recommended non-operative management with pain control, PT and OT therapy and weight bearing as tolerated. The resident admitted to the hospital for further management and evaluation.

Review of an x-ray report of both hips dated 4/8/19 revealed the resident had a an oblique nondisplaced fracture through the right ilium/iliac wing and a non displaced right superior and inferior pubic rami fractures.

A Nurses Note dated 4/8/19 showed the resident walked with therapy to the dining room with use of a walker and gait belt. The therapist left the resident's side, walked over to get a chair for her to sit in and the resident fell, hitting her head on the wall near the nurse's station. A nurse's assessment revealed the resident responded appropriately and had full range of motion without pain but sustained a skin tear to the right forearm. The physician ordered the resident to be sent to the hospital for evaluation due to hitting her head and currently receiving anticoagulant medication.

An Online Abuse or Incident Reporting form dated 4/9/19 sent to Department of Inspections and Appeals reported an incident resulting in hospitalization for Resident #88. The incident summary showed the resident had diagnoses which included osteoporosis, low back pain, syncope (dizziness) and collapse, orthostatic

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hypotension (where the blood pressure drops with a change of position), diabetes, congestive heart failure, ischemic cardiomyopathy (a weakened heart from damage) and hypertension. The resident has a BIMS of 14 out of 15 BIMS (Brief Interview for Memory Skills) and an assist of one with a front wheeled walker for transfers and ambulation. On 4/8/19 at 2:30 p.m. therapy worked with the resident for ambulation to see if the resident could safely be independent with ambulation in the facility. The resident walked 130 feet with a gait belt, needed stand by assist and occasional contact assist (holding on to the gait belt). The resident then walked 20 feet and 56 feet, with minimal contact assist. The therapist noted the resident's pace going slower. The therapist asked the resident if she wanted to sit down. The therapist turned to get a chair and as the therapist turned back, she saw the resident falling away from her. The resident fell against the wall with the shoulder, hit her head on the wall, and slid down onto the floor, landing on the buttocks.

The Corrective Action Description of the Online Report 4/12/19 showed the resident went to the emergency room. The resident received an anticoagulant (blood thinner) and had hit the head which required an evaluation. The hospital reported a nondisplaced fracture of the right iliac wing superior and inferior pubic rami which required hospitalization. The resident had an extensive history of dizziness and collapse of unknown injury. The resident wore Ted hose (compression stockings) and an abdominal binder while ambulating and denied dizziness at the time of the fall. The initial post fall nursing assessment and the initial Emergency Medical Service assessment identified an oxygen

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saturation of 85 % to 92%, indication the resident likely de-saturated (low oxygen) due to exertion while ambulation with therapy. The facility believed a combination of muscle fatigue and mild hypoxia (low oxygen) played a significant role in the resident's fall. The resident's care plan was updated to include the use of oxygen with ambulation.

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patient met goal of walking to the nurse's station with the front wheeled walker and stand by assist (SBA-walking next to the resident). This therapist turned to pull a chair up for the resident and the resident fell to the right and could not reach the resident to recover the resident's balance. The resident hit the shoulder and her head on the wall and continued to fall onto the floor.

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resident's room, after a rest period, walked 130 feet and then another 20 feet. The resident's walker had a large oxygen tank in a bag on the resident's front wheeled walker which distributed oxygen to the resident during ambulation. Returning to the resident's room, Staff B switched the oxygen tank to the oxygen concentrator in the room. Staff B requested the resident to walk down the hall to Station 1, to get medication. When they got outside the resident's room, the PTA noted the oxygen tubing didn't go any further, so she removed the oxygen from the resident. The PTA walked with the resident down the hall, approximately 45 to 56 feet without oxygen. At the station, the PTA, noted the resident slower in pace and turned to get a chair for the resident. As the PTA turned back towards the resident she fell. The PTA reported Occupational Services (OT) were ready to determine the resident as independent that day and said she did not agree or disagree. The PTA reported the resident had on the gait belt, compression socks and abdominal binder. The PTA reported she did not hold onto the gait belt and used stand by assist the entire last walk. The PTA stated by using stand by assistance this would help determine if the resident's functions could be deemed independent. The PTA thought therapy services were going to make the resident independent that day, but then the fall occurred. The PTA also noted she did not check the resident's oxygen level during the entire session that day.

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resident is safe. The PT reported it is this Rehabilitation's Policy to always have a gait belt on a resident when working with the resident, whether they require one or not. The PTA noted staff usually use contact guard (CGA) in testing the resident, which means we hold onto the resident's gait belt while ambulating. A person can get the feeling of the residents balance, gait, and steadiness with the use of the gait belt. He noted stand by assist (SBA) means we just stand by them as they ambulate.

An interview on 4/23/19 at 2:15 p.m. the Director of Rehabilitation Services reported all services will meet and discuss the determination to declare a resident independent with ambulation. The Director agreed the PT and TO notes did not report they were planning on making the resident independent on 4/8/19.

An interview on 4/2319 at 2:35 p.m. Staff E, Licensed Practical Nurse (LPN) reported she saw the PTA walking the resident down the hall towards Station 1. The resident had on a gait belt, compression stockings, abdominal binder, using a walker. Staff E saw the PTA holding onto the gait belt. When they got to the entrance of the dining room, Staff E heard the PTA say to the resident it looked like she needed to rest. The PTA let go of the gait belt and stepped over to the opposite side of the resident to retrieve a chair. The resident fell into the wall. Staff E noted there were other staff persons in the dining room that the PTA could have asked for assistance to get the chair. Staff E commented staff do not let go of the gait belt until the resident is in a safe place.

An interview on 4/25/19 at 8:23 a.m. Staff AA, LPN, reported working the day the resident fell. It

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occurred between 2 p.m. and 2:30 p.m., at shift change. Staff AA entered the dining room and found the resident on the floor by the wall, by the entrance to the dining room next to the medication carts. Staff AA asked the PTA what happened, the PTA told Staff AA, she ambulated the resident on a longer distance to see if the resident could be independent with ambulation. The PTA said she let go of the resident to get a chair and the resident fell. Staff AA reported there were 4 or 5 people in the same area and the PTA could have asked for some help. Staff AA assessed the resident, noted a skin tear, asked if the resident had pain, which the resident answered no. The resident covered her face and began to cry. Due to the resident hitting the head and being on an anticoagulant, the staff transferred the resident to a local hospital for evaluation. The resident stated twice to the medics that she had pain.

An interview on 4/25/19 at 11:30 a.m., Staff C reported they usually make resident's independent in the room first and then independent in the halls. He noted the PTA may have been trying to determine if the resident could be independent in the hall on the day the resident fell.

An interview on 4/15/19 at 12:10 p.m. the Acting Administrator (former Director of Nursing) reported all she knew of the resident's fall was second hand. She commented not knowing how the gait belt should be used for the resident that day, stand by assist or contact guard, because the Therapy Department have their own scope of practice.

The facility's Falls Protocol Quick Reference

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F 689	Continued From page 28 dated 1/2015 reported identifying residents at risk which included: - completed a fall risk assessment for each resident at the time of admission and quarterly. - for those residents identified at risk of falls initiate/implement preventive interventions via care plan. The Facility's Policy for Functional Assist Level Scale dated 9/5/17 showed the Policy for Rehabilitation Services that all therapy personnel will document following an uniform system of measurement for disability by using the functional assist level scales within the clinical documentation systems. These scales indicate how much assistance is required for this individual to carry out a task. The Procedure for this Policy showed the following scales included: - Standby Assist (SBA) = No physical contact needed however close enough to reach if help is needed. - Contact Guard (CGA)= Occasional contact is needed-protective safeguarding.	F 689		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		

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F 732	Continued From page 29 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to post current daily worksheets for 4 of 4 days. The facility reported a census of 128 residents. Findings included: During an observation on 4/22/19 at 9:59 a.m., the daily staffing worksheets dated 4/19/2019 posted in station 1A hallway.	F 732		

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F 732	Continued From page 30 During an observation on 4/23/19 at 7:21 a.m. and 8:05 a.m. the daily staffing worksheets dated 4/19/2019 posted in station 1A hallway. During an observation on 4/24/19 at 8:28 a.m., the daily staffing worksheets dated 4/23/19 posted in station 1A hallway. During an observation on 4/25/19 at 7:30 a.m. the daily staffing worksheets dated 4/24/19 posted in station 1A hallway. During an interview on 4/25/19 at 7:10 a.m., the Provisional Administrator stated daily nurse staffing is posted daily by the receptionist when they arrive, usually around 7:30 a.m. The Provisional Administrator stated the floor nurses take staff call ins but they do not make changes to the staffing sheet to reflect the changes.	F 732		
F 741 SS=B	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental	F 741		

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and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
[as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].

§483.40(a)(2) Implementing non-pharmacological interventions.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review the facility failed to provide 6 hours of dementia education for 1 of 9 employee files reviewed. The facility reported a census of 128 residents.

Findings included:

During record review on 4/23/19 at 1:44 p.m., Relias (computer program that tracks employee training) records indicated Staff M Registered Nurse (RN) attended 3 hours of dementia training.

During an interview on 4/23/19 at 4:33 p.m., Staff K-Assistant Director of Nursing (ADON) stated the facility has staff who exclusively work the Chronic Confusion and Dementia unit (CDDI) as well as staff who float to the CCDI unit. Staff K further stated staff should attend 6 hours of dementia training through Relias if they work the CCDI unit.

During record review on 4/24/19 09:28 a.m., Daily Staffing Worksheet indicated Staff M worked

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F 741	Continued From page 32 Station 2, the CCDI unit on 4/6/19, 4/7/19, 4/13/19, 4/20/19 and 4/21/19. During an interview on 4/25/19 at 7:10 a.m., the Provisional Administrator stated all nursing staff attend 6 hours of dementia education within 30 days of hire. During an interview on 4/25/19 at 8:51 a.m., Staff Z Human Resources Coordinator stated the facility uses the Relias training system. When staff are hired all their information is entered in the Relias system and the training is automatically assigned based on what corporate designates in the system. Staff Z further stated they do not assign the education but assured what was assigned was completed before staff started working on the floor. Staff Z stated they didn't have access to look into what staff should complete until they were entered into the computer and were not aware, prior to today, that 6 hours of dementia education was required prior to working the dementia unit.	F 741		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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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 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.

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F 880	Continued From page 34 §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 observations, interviews, and record review the facility failed to deliver clothes while maintaining infection control for 2 of 5 halls observed on 3 of 3 days and failed to maintain infection control with 2 of 4 resident with catheters observed (Resident # 14 and # 65). The facility reported a census of 128 residents. Findings included: 1. During an observation on 4/22/19 at 12:09 p.m., the laundry cart in the Station I B hall contained clean, hanging laundry, 1/2 covered by a sheet on the top, the sides of the clothing exposed. Staff W-Housekeeping/Laundry removed clothing from the hanging cart letting a long garment drag across the floor as she walked down the hall . During an observation on 4/22/19 at 12:12 p.m., Staff W took a hand full of clothing into a residents room, came out of that room with some clothes on hangers, and went in another resident	F 880		

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room across the hall. Staff W removed clothes from the hanging laundry cart and threw them over her shoulder and took them down the hall to a residents room.

During an observation on 4/22/19 at 12:35 p.m., the hanging laundry cart parked in Station 1 B Hall with the sheet over the top, leaving the sides of the clothes exposed.

During an observation on 4/22/19 at 1:26 p.m. noted the hanging laundry cart 1/2 way down on Station 1 C Hall with a sheet 1/2 covering the top of the clothing cart, leaving the other 1/2 exposed and 100% of the sides exposed. The 3 shelf folded laundry cart with blue bins of personal clothes lacked a cover. Staff X Housekeeping/ Laundry removed clothing from the hanging rack and threw them over his shoulder and carried into a residents room.

During an observation on 4/23/19 at 2:00 p.m. noted the hanging laundry cart located at station 1 C hall with a sheet over 1/2 of the hanging laundry, leaving the side of the clothing exposed. The 3 shelf cart with blue bins lacked a cover on the bottom 2 shelves. Staff X removed a handful of clothes placed them over his shoulder and went down the hall to deliver to a resident..

During an observation on 4/24/19 at 1:21 p.m. noted the hanging laundry cart in the Station 1 B Hall contained a sheet over the top, with the 1/3 of the sides exposed to residents passing in the hall.

During an observation on 4/24/19 at 1:26 p.m., the 3 shelf folded laundry cart with blue bins, contained a white cover over the top shelf and the

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lower 2 shelves contained folded socks and under clothes exposed.

During an observation on 4/24/19 at 1:46 p.m., the clean hanging laundry cart located in Station 1 C Hall with a sheet covering over ¾ of the top of the cart leaving the sides exposed while Staff W delivered clothing to residents rooms. The 3 shelf folded laundry cart with blue bin contained socks and underclothes, ½ covered on the top shelf with the remaining 2 1/2 shelves of clothing exposed.

During an interview on 4/24/19 at 2:29 p.m., the Housekeeping/Laundry Supervisor reported they expect the staff to keep clean laundry covered during the delivery process. The Housekeeping/Laundry Supervisor continued to state expecting staff to keep clean laundry off the floor, take the clean laundry into one resident room only, and to keep clean laundry off their uniforms.

During an interview on 4/24/19 at 2:37 p.m., the Acting Administrator Registered Nurse (RN) reported the expectation is clean laundry is covered for delivery, not acceptable to drag laundry on the floor or carry over the shoulder.

The policy titled Delivery of Clean Linens dated 2013, directed staff to keep laundry carts completely covered to prevent contamination.

2. Resident #14's Minimum Data Set (MDS) assessment dated 1/17/19 showed the resident had severe memory loss, required extensive staff assistance with daily cares and had a Foley catheter for bladder control.

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The Care Plan dated 9/28/15 showed the resident had an indwelling catheter with history of urinary tract infections, urinary retention and had a neurogenic bladder.

Observation 4/22/19 at 10:35 a.m.-2:35 p.m. revealed the resident sitting in a wheelchair in the dining room, the Foley catheter tubing laid directly on the floor.

Observation on 4/22/19 at 2:35 p.m. a staff member took the resident outside, while assisting the resident outside via their wheelchair the catheter tubing dragged on the floor.

A Hospital Discharge Summary showed the resident admitted 1/3/19 and discharged on 1/8/19. The discharge diagnoses included, septic shock, secondary to right lobe pneumonia and urinary tract infection.

An interview on 4/24/19 at 5:43 a.m. Staff Q, Certified Nursing Aide (CNA) reported a catheter bag and catheter tubing should not be on the floor.

An interview on 4/24/19 at 5:49 a.m. Staff H, CNA, reported a resident's catheter and tubing are not suppose to be touching the floor.

An interview on 4/24/19 at 6:05 a.m. Staff G, CNA, reported staff are to keep a resident's urinary bag in a personal cover and place it under the wheelchair. The catheter tubing or bag do not drag on the floor. Staff G noted the bag and tubing are to be kept high enough under the wheelchair so it does not drag on the floor.

An interview on 4/23/19 at 6:55 a.m. Staff F,

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Licensed Practical Nurse (LPN), reported a resident's catheter bag and tubing are not to touch the floor.

3. Resident #65's MDS assessment dated 2/26/19 showed the resident with memory intact, required extensive staff assistance with daily cares, and had a Foley catheter for bladder control. The MDS also showed the resident had diagnoses of multiple sclerosis, diabetes, and a neurogenic bladder.

The Care Plan, revised on 12/26/18, showed the resident at risk for infection related to frequent episodes of urinary incontinence due to urinary tract infections. The care plan revealed the resident had a suprapubic catheter.

Observation on 4/22/19 at 11:25 a.m. revealed the resident transferred by Staff T, Occupational Therapist (OT) and Staff U, Physical Therapist (PT) in the wheelchair, through the hall and into the shower room. The resident's urinary bag, dragged on the carpet floor, approximately 8 to 10 feet.

Observation on 4/24/19 at 6:50 a.m. revealed Staff J, CNA, rolling the resident out of the shower room via a wheelchair. The resident's personal catheter bag, dragged on the floor.

An interview on 4/24/19 at 11:05 a.m. the Director of Therapy Services (Staff D) reported the Therapy staff know a resident's catheter bag and tubing are not to be touching the floor.