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ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

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F 000	INITIAL COMMENTS Correction date 11/13/2019 The following deficiencies result from the facility's recertification survey and investigation of Complaint #86227-C; #86244-C; and #86245-C. Complaint #86227-C was substantiated. Complaint #86244-C was substantiated. Complaint #86245-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	F 606		

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 606	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff interview, and facility policy review, the facility failed to assure an Iowa criminal background and abuse registry check completed with approval obtained from DHS (Department of Human Services) for 3 of 7 current employees sampled, (Staff C, Staff E, Staff J), prior to them working in the facility. The facility reported a census of 41 residents. Findings include: 1. The personnel file for Staff C, Licensed Practical Nurse (LPN), documented a hire date of 6/25/19. The file contained a criminal background and abuse registry check completed on 6/4/19 that documented further research required. The file lacked documentation of a May Work letter/approval from Iowa DHS prior to hire. 2. The personnel file for Staff E, Certified Nurse Aide (CNA), documented a hire date of 7/21/19. The file contained a criminal background and abuse registry check completed on 7/21/19 that documented further research required. The file lacked documentation of a May Work letter/approval from Iowa DHS prior to hire. 3. The personnel file for Staff J, CNA, documented a rehire date of 3/19/19. The file reflected Staff J severed previous employment with the facility 03/2018 and therefore had a gap in employment. The file contained a criminal background and abuse registry check completed on 3/4/19 that documented further research required. The file lacked documentation of a May Work letter/approval from Iowa DHS prior to hire 3/19/19.	F 606		

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F 606	Continued From page 2 On 10/8/19 at 10:45 a.m., Staff M, Clinical Nurse Manager, and Staff L, Director of Operations, reported they identified issues with the hiring process in June 2019. They both said the management company made the decision to move the hiring process to the Central Office so they could ensure the proper completion of background checks as the facility did not do it correctly. On 10/8/19 at 2:39 p.m., the Human Resources (HR) Manager, stated she started in March 2019. The HR Manager reported Staff J a rehire. The HR Manager stated since the change in hiring process, someone else did the recruiting to ensure facility compliance. The HR Manager stated after running a background check the facility received a rap sheet; if it contained the comment "Waiver Signature on File", she was told it was not necessary to receive the May Work approval letter from DHS since already on file. The HR Manager stated the facility only had the DCI (Division of Criminal Investigation) Iowa Record Check Request Form S with the documented results and Waiver Signature on File marked for Staff C, Staff E, and Staff J. The HR Manager stated the Waiver Signature on file showed an employee eligible to work and DHS kept on file. The HR Manager said if a background check came back with a new hit, then the facility got a letter. The HR Manager clarified DCI the department to tell her they did not need the letter. On 10/9/19 at 10:39 a.m., a representative for Iowa DCI stated DHS provided facilities the May Work approval letter; DCI only provided the record check.	F 606		

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F 606	Continued From page 3 On 10/9/19 at 10:42 a.m., a representative for DHS stated a facility is required to have a May Work approval letter from DHS, not DCI, prior to hiring an employee to work in a healthcare facility. The representative said the DCI waiver on file just meant an applicant had a previous waiver on file. The facility's Abuse Prevention, Identification, Investigation, and Reporting Policy revised 11/28/16 directed the following: Employee Screening: 1. The facility will conducted and Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3).	F 606		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		

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F 609	Continued From page 4 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, staff interview and facility policy review the facility failed to report 3 instances of resident to resident altercations (Resident #20 for 2 incidents involving Resident #4 and Resident #31) and one misappropriation of resident property (Resident #34) to the Iowa Department of Inspections & Appeals (DIA) within 24 hours. The facility reported a census of 41 residents. Findings include: 1. A Minimum Data Set (MDS) assessment for Resident #4 dated 7/24/19, identified a Brief Interview for Mental Status (BIMS) score of 7 (severe cognitive impairment). The MDS documented diagnosis of Alzheimer's disease, edema, diabetes mellitus, restlessness and agitation, macular degeneration and vascular dementia with behavioral disturbance. The MDS identified the resident with limited assist with bed mobility, extensive assistance with transfers and total dependence with locomotion on the unit. Mobility devices include walker and wheelchair.	F 609		

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F 609	Continued From page 5 The care plan for Resident #4, last updated on 7/27/19, revealed the resident had altered thought processes, delayed cognitive functioning and behaviors related to vascular dementia and Alzheimer's disease. The care plan also indicated impaired mobility and a potential for verbal aggression. A care plan focus area dated 4/16/19 for Resident #4 identified the resident with a potential to threaten to hit or bite staff. Nursing notes revealed on 9/5/19 the resident yelled and attempted to stand on her own. The resident also went into other residents' rooms. On 9/15/19 the resident had increased exit seeing behaviors, appeared agitated and required 1 on 1 supervision. Nursing notes, dated 9/21/19, revealed Resident #4 yelled and attempted to hit and kick staff. Resident #31's MDS dated 9/18/19 identified a BIMS score of 6 indicating severe cognitive deficit. The MDS indicated diagnoses that included: dementia without behavioral disturbance, anxiety disorder, glaucoma, osteoarthritis and Alzheimer's. The MDS revealed Resident #31 was independent with bed mobility, transfers and walking. Resident #31's care plan revealed a potential/actual impairment skin integrity with a goal to maintain clean and intact skin with direction to staff to encourage good nutrition and hydration in order to promote healthy skin. A progress note dated 10/4/19 for Resident #31 documented Resident #4 went into the Resident #31's room. Resident #31 got up from bed and attempted to get Resident #4 out of the room. Resident #4 then grabbed the arms of Resident	F 609		

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#31 and scratched her. Resident #31 sustained skin tears on both arms. The right forearm skin tear measured 1 centimeter (cm) x 1 cm and the left forearm skin tear measured 2 cm x 0.5 cm. Staff cleansed the skin tears and applied steri-strips. Nursing notes dated 10/4/19 revealed staff notified the doctor, a family member and the director of nursing (DON).

A facility Online Abuse Reporting document for the facility revealed the facility failed to report the resident to resident physical altercation between Resident # 4 and Resident # 31 to the Department of Inspections and Appeals (DIA).

On 10/8/19 at 2:30 p.m. the DON on 10/8/19 at 2:30 PM stated she did not report the incident (which occurred on a weekend) as she was home sick. She stated when she arrived to work on Monday, she didn't remember staff called her about it on the weekend so she did not report to the State agency. The DON stated she reported the incident 10/8/19 after she consulted with the nurse consultants for the facility.

Facility abuse policy/procedure revised 11/28/16 defined resident abuse as: "resident to resident physical contact that occurs which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm, pain or mental anguish is considered resident to resident abuse".

2 The Minimum Data Set (MDS) dated 9/27/2019 revealed Resident #20's diagnoses included: fracture, Alzheimer's disease and age related osteoporosis. A Brief Interview for Mental Status (BIMS) documented a score of 3 out of 15 indicating severe cognitive impairment. The

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F 609	Continued From page 7 resident required limited assist of one staff for bed mobility, transfers and toilet use. A progress note dated 8/20/2019 at 4:01 PM, documented Resident #20 had her feet up in a recliner when another resident pushed her feet off of the recliner and threw a blanket at her. An interview on 10/14/2019 at 5:12 PM, the Director of Nursing DON) confirmed the facility did not report the incident to DIA. The facility failed to report a witnessed resident to resident altercation no later than 24 hours of the altercation. A progress note dated 8/20/2019 at 9:47 PM, documented Resident #20 approached another resident and pinched her neck. An interview on 10/14/2019 at 5:12 PM, the Director of Nursing DON) confirmed the facility did not report the incident to DIA. The facility failed to report a witnessed resident to resident altercation no later than 24 hours of the altercation. 4. The Minimum Data Set (MDS) dated 10/1/2019, showed diagnosis for Resident #34 included cancer, restless leg syndrome, and pain in right hip. The Brief Interview for Mental Status (BIMS), documented a score of 8 out of 15 indicating moderate cognitive impairment. The resident was dependent on 1 staff for bed mobility and toilet use. The resident required assistance of 2 for transfers. . On 10/7/2019 at 1:08 PM, Resident #34's	F 609		

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daughter stated about a week and a half prior she had noticed a music box missing out of Resident #34's room. Furthermore the daughter said she reported the missing music box to administration the day before.

On 10/9/2019 at 12:52 PM, the Director of Nursing (DON), acknowledged Resident #34's daughter reported the music box missing. The DON said the Social Services Director (SSD) was looking into the missing item.

On 10/09/2019, the SSD stated she received a report of the missing music box. The SSD started a grievance form with the daughter after she received the report from the daughter of the missing music box on 10/8/2019 at 10:00 AM. The SSD searched through other resident's rooms to see if it had been misplaced. SSD reported there was no inventory sheet filled out upon admission.

On 10/9/2019 at 3:00 PM, the SSD reported she developed a questionnaire per corporate direction to give to the heads of each department for staff questioning.

On 10/9/2019 at 3:40 PM, the SSD found that staff confirmed the music box was in Resident #34's room. The facility could not pinpoint which day the music box was brought in or which day the music box went missing.

An interview on 10/10/2019 at 7:47 AM, the DON revealed she did not report the incident to DIA.

On 10/10/19 at 8:38 AM, a discussion with the Nursing Home Administrator (NHA) revealed she submitted a report of the missing music box to

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F 609	Continued From page 9 DIA on 10/9/2019 at 4:55 PM. An interview on 10/10/2019 at 12:05 PM, Staff H, MDS Coordinator reported the BIMS score of 13 no longer applied to Resident #34 as the resident is no longer capable of completing most of the BIMS assessment. In her opinion, it is due to metastasis of cancer to the brain. A progress note dated 10/6/2019 at 3:49 AM, documented the daughter reported Resident #34's music box missing. A Grievance Form dated 10/8/2019 showed the report of the missing music box with a picture of the music box attached. A fax titled Online Abuse or Incident Reporting sent on 10/9/2019 at 4:55 PM, documented a music box went missing in a resident's room on 10/6/2019 and the date the facility became aware was on 10/9/2019. The facility failed to report misappropriation of Resident #34's music box within 24 hours of obtaining knowledge of the missing item to DIA. 3. Staff interviews related to lack of reporting resident to resident contact between Resident #4 and Resident #31: On 10/7/19 at 9:48 a.m., Staff C , Licensed Practical Nurse (LPN), reported the day before yesterday 2 lady residents in the unit got into a fight. Staff C stated Resident #4 went into Resident #31's room and Resident #31 did not want her in there as it was late, approximately 9:20 p.m. Staff C stated she reported the incident to the DON. She asked the DON if she should do	F 609		

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something and the DON said no. Staff C commented, however, Staff I, Registered Nurse (RN), told her staff should report it. Staff C clarified the DON knew about the resident to resident altercation and said it was just fine. Staff C stated Staff I had her just write up something about the aggressive residents because the DON said it was okay.

On 10/7/19 at 12:39 p.m., Staff D, Environmental Aide (EA), reported he started "sitting shifts" in nursing approximately 2 months prior. Staff D clarified the facility had someone like activity or dietary departments sit with residents in case of an emergency. Staff D reported he did not have CNA (certified nurse aide) certification. Staff D identified himself as the only staff member on the CCDI (Chronic Confusion and Dementing Illness) unit when Resident #4 made the resident to resident contact. Staff D reported he wrote a statement for Staff C that same night, 10/4/19. Staff D responded the resident to resident contact occurred after dinner, 2:00 p.m. to 10:00 p.m. shift when he was assigned B Hall (CCDI unit) that night. Staff D stated as he walked with another resident back to his room, he saw Resident #4 sitting at the table talking to herself. Staff D saw Resident #31 in her room when Staff D walked down the hall to another resident's room. Staff D stated while he talked to Resident #13, Resident #31 came down the hall to report Resident #4 tried to get into her room. When Resident #31 said "Stop", Resident #4 went in Resident #31's room and attacked her. Staff D commented the contact happened in the 2 minutes he was in Resident #13's room. Staff D recalled Resident #4 stood in Resident #31's doorway and tried to get into the room. Staff D said he had Resident #4 put her feet on the foot

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pedals of her wheelchair and he pushed Resident #4 down to her room to separate the residents. He then asked Resident #31 what happened. Staff D reported Resident #31 said Resident #4 tried to get in her room and when Resident #31 said she exited her room to say stop it, Resident #4 clawed her arm. Staff D said Resident #31 showed him her arm which bled. Staff D ran out to the phone and called the nurse who picked up immediately. Staff D said Staff C came in the next minute and sorted it out and talked with Resident #31 while Staff D went into Resident #4's room. Staff D commented he couldn't leave Resident #4 alone as she wandered. Staff D stated Staff C wrapped up the cut on Resident #31's arm and asked him to write a statement before he left, which he did. Staff D commented he kept the residents separated the rest of the night. Staff D thought Resident #4 forgot about the interaction immediately as she denied attacking Resident #31 calling Staff D a liar. Staff D stated no other facility staff asked him for a statement.

On 10/7/19 at 11:30 a.m., the DON reviewed the online abuse or incident reporting list and identified it as accurate to the best of her knowledge. The list did not contain a facility self-report for the resident to resident altercation that occurred between Resident #4 and Resident #31 from 10/4/19.

On 10/8/19 at 11:00 a.m., the surveyor heard the DON tell the Administrator that no immediate separation of Resident #4 and Resident #31 needed for resident to resident contact. The DON confirmed to the Administrator staff initiated frequent checks as soon as they became aware of the incident the other day.

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F 609	Continued From page 12 On 10/8/19 at 2:12 p.m., the DON responded to a question about when she received facility training on abuse. The DON responded she provided the abuse policy to others several times, but she did not have training from the facility specifically. When asked what the facility abuse policy said about resident to resident abuse, the DON responded, apparently she did not know what the abuse policy said. The facility's Abuse Prevention, Identification, Investigation, and Reporting Policy revised 11/28/16 informed and directed the following: Key Definitions: "Resident Abuse" under the Federal Certification Guidelines 42 C.F.R. 483.12 is defined as follows - Point 13. Resident-to-resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm, pain or mental anguish is considered resident-to-resident abuse. Reporting: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections & Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse and result in serious bodily injury,	F 609		

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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 609	Continued From page 13 or not later than twenty-four (24) hours if the events that cause the allegation involve abuse but do not result in serious bodily injury.	F 609		
F 623 SS=B	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	F 623		

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	165149	A. BUILDING _____ B. WING _____	10/15/2019

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F 623	Continued From page 14 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 (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	F 623		

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F 623	Continued From page 15 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. 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 interview the facility failed to notify the ombudsman of transfer or discharge for two of two residents reviewed (Resident #35, Resident #37). The facility reported a census of 41 residents. Findings include: 1. The Census tab for Resident #35 revealed she transferred to the hospital on unpaid hospital leave 7/20/19 and returned 7/26/19 and again on 8/25/19 and returned 8/29/19. 2. The Census tab for Resident #37, revealed the resident transferred to the hospital on unpaid hospital leave 5/18/19 and returned 5/2/19, again	F 623		

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F 623	Continued From page 16 on 7/14/19 and returned 7/17/19, and again on 9/9/19 and returned 9/16/19. The admit/discharge report for August, September, and October 2019 failed to identify Resident #35 and #37 transferred to the hospital. On 10/9/19 at 9:28 a.m., the Director of Nursing (DON) verified the facility only notified the ombudsman of discharges for the last three months. On 10/9/19 at 2:57 p.m. the social service director revealed she worked at the facility for 4 months. She verified the facility notified the Ombudsmen of admits and discharges for the last 3 months. The list only contained admits/discharges and not transfers to the hospital.	F 623		
F 625 SS=B	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 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	F 625		

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F 625	Continued From page 17 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 interview the facility failed to provide a bed hold policy and ensure it was signed and returned within 48 hours for two of two residents reviewed (Resident #35, Resident #37). The facility reported a census of 41 residents. Findings include: 1. The Census tab for Resident #35 revealed she transferred to the hospital on unpaid hospital leave 7/20/19 and returned 7/26/19 and again on 8/25/19 and returned 8/29/19. The chart lacked bed hold notices on 7/20/19 and 8/25/19. 2. The Census tab for Resident #37 revealed he transferred to the hospital on unpaid hospital leave 5/18/19 and returned 5/2/19, again on 7/14/19 and returned 7/17/19, and again on 9/9/19 and returned 9/16/19. The chart lacked bed hold notices on 5/18/19, 7/14/19, and 7/17/19.	F 625		

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F 625	Continued From page 18 An undated policy titled Notice of Bed Hold indicated the facility should notify all residents regarding bed hold policy and notices when a resident transferred out of the facility. On 10/9/19 at 9:28 a.m., the Director of Nursing (DON) verified the facility did not provide bed holds to residents or the resident's representative and verified Resident #35's record and Resident #37's record failed to contain a bed hold notice.	F 625		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to resubmit a level 1 PASRR (Preadmission Screening and Resident Review) when additional mental health diagnoses	F 644		

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F 644	Continued From page 19 were added for 1 of 1 resident identified for review of PASRR. (Resident #27). The facility reported a census of 41 residents. Findings include: Resident #27's PASRR dated 10/12/15 documented the resident did not have any mental illnesses. The PASRR identified no further screening required unless the resident received diagnoses of an actual or suspected major mental illness. A list of Resident #27's diagnoses included delusional disorders added 11/16/17 and major depressive disorder added 6/5/17. The facility failed to resubmit a PASRR level 1 when Resident #27 received diagnosis of a major mental illness (major depressive disorder)	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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F 656	Continued From page 20 (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 observation, staff interview and record review, the facility failed to implement a comprehensive person-centered care plan by furnishing the services to maintain the resident's highest practicable physical well being in 2 of 16 (Residents #24 and #34). Staff did not utilize a walker when transferring Resident #34 as the care plan directed. Resident #24's side rails did not contain padding as directed on the care plan. Facility census was forty-one (41) residents. Findings include:	F 656		

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F 656	Continued From page 21	F 656		

1. The Minimum Data Set (MDS) dated 10/1/2019, showed diagnosis for Resident #34 included cancer, restless leg syndrome, and pain in right hip. The Brief Interview for Mental Status (BIMS), documented a score of 8 out of 15 indicating moderate cognitive impairment. The resident was dependent on 1 staff for bed mobility and toilet use. The resident required assistance of 2 for transfers.

A care plan with initiation date of 9/30/19 contained a problem of ADL (activities of daily living) self care performance deficit related to confusion and fatigue. The care plan directed staff to utilize a walker when transferring and ambulating the resident.

Observation on 10/9/2019 at 9:17 AM, showed Staff T, Certified Medication Aide (CMA), Restorative, transfer Resident #34 from her wheelchair to the toilet with a gait belt and from the toilet to the wheelchair and then from the wheelchair to the bed with stand by assist from a Hospice aide. Staff T did not utilize a walker during any of the transfers. Observation revealed the walker in the shower stall.

Observation on 10/9/2019 at 9:50 AM, showed Staff U, Certified Nursing Assistant (CNA), transfer the resident from the bed and into the wheelchair using a gait belt. Staff U did not use the walker to aide with the transfer. Walker was noted to be in the shower stall.

On 10/10/2019 at 9:15 AM, the Director of Nursing (DON), stated she expected staff to follow the care plan when transferring residents..

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F 656	Continued From page 22 On 10/10/2019 at 11:35 AM, Staff U CNA stated she did not know staff should use a walker when transferring Resident #34. Staff U said she looked at the Kardex to determine the resident's transfer needs. Staff U pulled up the Kardex and pointed to the heading of mobility devices. The Kardex did not contain the directive to use a walker when transferring the resident. On 10/10/19 at 11:45, the DON stated the Karex should correspond to the care plan. The DON made copies and showed the surveyor the direction to use a walker with transfers was on the Kardex. The DON repeated staff should have used the walker with the transfers as directed on the Kardex. A Kardex report printed on 10/10/19 directly following the 11:45 interview with DON, directed staff under Resident Care section that res uses a walker for transfer and ambulation. Under the Mobility section it was blank after mobility devices. 2. The MDS dated 9/6/19 identified Resident #24 with diagnoses that included Alzheimer's Disease. A BIMS score of "5" revealed the resident with severe cognitive deficit. The resident required extensive assist of two staff with bed mobility, transfers and toilet use. The resident required extensive assist and assist of one staff for personal hygiene. A care focus area dated 3/17/16 revealed the resident at risk for falls related to dementia. The care plan contained an intervention dated 11/30/18 for padded siderails to decrease risk for bruising.	F 656		

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F 656	Continued From page 23 Observation on 10/9/19 at 1:17pm showed the resident assisterd to be with two staff. Observation rvealed the side rails did not contain padding as care planned. Observation on 10/10/19 at 7:47am irevealed no padding on the side rails as care planned. On 10/9/19 at 1:17pm, Staff A, CMA (certified medication aide) stated she did not know the resident's care plan directed staff needed to pad the side rails and also stated she never knew the resident to use padding on her side rails. On 10/9/19 at 1:17pm, Staff H, RN stated she did not know the resident's care plan contained the directive of padded siderails.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		

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F 657	Continued From page 24	F 657		

not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to review and revise 1 out of 16 residents plan of care (Resident #20). The facility failed to revise Resident #20's comprehensive care plan so the care plan included physical therapy recommendations following a fall with fracture. The facility reported a census of 41 residents.

Findings include:

A Minimum Data Set (MDS) dated 9/27/2019, showed Resident #20's diagnoses included fracture, Alzheimer's disease and age related osteoporosis. The Brief Interview for Mental Status (BIMS) documented a score of 3 out of 15 indicating severe cognitive impairment. The resident required limited assist of one staff for bed mobility, transfers and toilet use.

A care plan with initiation date of 4/3/19 directed staff to provide the assistance of one staff for mobility while healing from a 8/11/19 left humerus fracture.

Observation on 10/7/2019 at 11:43 AM, revealed the resident stood up from their chair on their own. Staff T, Certified Medication Aide

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F 657	Continued From page 25 (CMA)/Restorative, directed the resident to walk to the facility dining room. The resident did not have a walker at the time and ambulated independently without a walker. Observation on 10/7/2019 at 2:37 PM, showed the resident seated in the common area with a walker in front of her. Observation on 10/9/2019 at 8:17 AM, showed the resident ambulated in the hallway with a walker. On 10/7/2019 at 2:42 PM, Staff T stated she did not know Resident #20 needed to use a walker with ambulation. Staff T said she received clarification earlier that day from the Physical Therapist (PT) that the resident should use a walker. Staff T concurred that she directed the resident to ambulate to the dining room earlier that day without a walker. On 10/9/2019 at 2:00 PM, the PT stated she made the recommendation to encourage Resident #20 to use a wheeled walker. The PT said the process is to hand the recommendation to the MDS Registered Nurse (RN). The PT said she did not know what happened after she handed the recommendation to the MDS RN. On 10/9/19 at 2:05 PM, Staff H, MDS Coordinator, RN,stated she did not receive the therapy recommendation from PT for this resident. She added that she did not updated Resident #20's care plan since the resident's fall with fracture on 8/11/19. Staff H conceded the care plan did not to reflect the resident's current status and required updating.	F 657		

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F 657	Continued From page 26 On 10/9/2019 at 2:06 PM, the DON concurred that the resident's care plan should reflect the resident's current status and required updating. On a form titles Therapy Recommendations and dated 10/4/2019, the PT recommended to encourage Resident #20 to use the wheeled walker with ambulation at all times. The most current care plan dated 3/29/2019 provided by the facility did not include an intervention directing staff to encourage resident to use a wheeled walker at all times.	F 657		
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, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, medication admin audit reports, family interview, and staff interview, the facility failed to administer medications within scheduled time frames or to ensure adequate amount of time passed before administering additional doses of medications for 3 of 4 residents reviewed for late medications (Resident #21, #34). Resident #25 received a breathing treatment from Staff G CMA (certified medication aide) at approximately 9:30 p.m. on 10/6/19. The medication administration record (MAR) revealed Staff C LPN (licensed practical nurse) signed that she administered the medication at 7:16 p.m. on that date. The facility reported a census of 41 residents.	F 658		

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	165149	A. BUILDING _____ B. WING _____	10/15/2019

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

(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 658	Continued From page 27 Findings include: 1. Resident #21's Minimum Data Set (MDS) assessment dated 8/22/19 identified a Brief Interview for Mental Status (BIMS) score of 15 without signs/symptoms of delirium. A score of 15 indicated intact cognition. The MDS documented diagnoses that included: heart failure and urge (urinary) incontinence. On 10/8/19 at 9:23 a.m., Resident #21 reported there were times when he received his medications late. Resident #21 stated the other week he didn't get his medications because of staffing. The Medication Admin Audit Report printed 10/9/19 revealed Resident #21 received the following medications scheduled for 10/6/19 at 6:00 p.m. late when administered at 11:55 p.m.: a. Finasteride (used to treat enlarged prostate to reduce symptoms) tablet 5 milligrams (mg); give 1 tablet by mouth at bedtime for urinary retention b. Baza (antifungal cream) 2% (miconazole nitrate), apply to testicle/groin area topically 2 times a day for fungal treatment c. Tamsulosin (used to make urination easier) capsule 0.4 mg, give 1 capsule by mouth at bedtime for urinary retention d. Clotrimazole cream (antifungal medication) 1%, apply to neck topically 2 times a day for flare up prevention 2. Resident #34's MDS assessment dated 10/1/19 identified a BIMS score of 08 with sign/symptom of delirium of inattentive behavior that fluctuated. A score of 08 indicated moderate	F 658		

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F 658	Continued From page 28	F 658		

cognitive impairment. The MDS documented diagnoses that included: cancer, chronic lung disease, right hip pain, and restless leg syndrome. The MDS recorded the resident received hospice level of care services.

On 10/7/19 at 1:22 p.m., Resident #34's family member reported the resident cried in pain and there was a day the resident received pain medications late.

The Medication Admin Audit Report showed the actual times when Resident #34 received the pain medication Gabapentin, which was scheduled to be given 3 times a day, from 9/25/19 thru 10/9/19. The report recorded the resident received Gabapentin late on the following dates and times:
a. Gabapentin capsule 100 mg, give 2 capsules by mouth at 6:00 a.m. administered -
9/25 at 9:41 a.m.; 9/26 at 8:26 a.m.; 9/27 at 8:24 a.m.; 9/28 at 7:59 a.m.; 9/29 at 8:10 a.m.; 9/30 at 9:35 a.m.; 10/1 at 11:27 a.m.; 10/3 at 9:30 a.m.; 10/4 at 7:55 a.m.; 10/5 at 7:23 a.m.; 10/7 at 8:46 a.m.; 10/8 at 8:42 a.m.
b. Gabapentin capsule 100 mg, give 2 capsules by mouth at 2:00 p.m. administered -
9/25 at 4:39 p.m.; 9/26 at 4:42 p.m.; 9/28 at 3:35 p.m.; 9/29 at 3:31 p.m.; 9/30 at 3:35 p.m.; 10/1 at 3:50 p.m.; 10/3 at 6:53 p.m.; 10/4 at 7:31 p.m.; 10/5 at 3:26 p.m.; 10/6 at 4:35 p.m.; 10/7 at 8:11 p.m.; 10/8 at 4:28 p.m.; 10/9 at 3:46 p.m.
c. Gabapentin capsule 100 mg, give 2 capsules by mouth at 6:00 p.m. administered -
9/25 at 7:21 p.m.; 9/26 at 8:03 p.m.; 9/28 at 7:50 p.m.; 9/29 at 8:47 p.m.; 9/30 at 7:20 p.m.; 10/1 at 7:41 p.m.; 10/2 at 10:10 p.m.; 10/3 at 6:53 p.m. (given at same time as 2 p.m. dose); 10/4 at 7:30 p.m. (given at same time as 2 p.m.

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F 658	Continued From page 29 dose); 10/5 at 8:00 p.m.; 10/6 at 7:12 p.m.; 10/7 at 9:29 p.m. (only an hour 20 minutes after 2 p.m. dose); 10/8 at 7:25 p.m. The report showed the resident received Methadone (narcotic) late on the following dates and times: d. Methadone 10 mg, give 1 tablet by mouth at 10:00 p.m. for pain - 9/30 not given; 10/2 at 2:13 a.m.; 10/4 at 6:49 a.m.; 10/5 at 12:30 a.m.; 10/6 at 2:08 a.m.; 10/7 at 12:10 a.m.; 10/9 at 2:20 a.m. In addition, the report recorded the resident received 2 doses of the pain medication methadone 10 mg on 10/4/19 within 1 hour of each other: e. Methadone 10 mg, give 1 tablet by mouth at 10:00 p.m. for pain; scheduled 10/3/19 at 10:00 p.m. but given late at 6:49 a.m. on 10/4/19. f. Methadone 10 mg, give 1 tablet by mouth in the morning for pain; scheduled 10/4/19 at 6:00 a.m., given at 7:52 a.m. on 10/4/19. On 10/7/19 at 9:48 a.m., Staff C, Licensed Practical Nurse (LPN), stated the facility used to have 2 nurses work during the day and 2 nurses work during the night with 3 CNAs (Certified Nurse Aides) on the overnight shift. Staff C said the work load way too much right now and she worked 4 nights in a row. Staff C commented the Director of Nursing (DON) yelled at her and said, "what do you want me to do?" (regarding staffing). Staff C reported the night before the 10/7/19 interview that she administered all the medications late as not done until 11:00 p.m. Staff C identified the medications as late because Staff N, CNA, worked all by herself on A and C Halls until Staff O, CNA, came in from 2:00 p.m. to 10:00 p.m. Staff C revealed an environmental aide (Staff D) worked in the dementia unit. Staff	F 658		

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F 658	Continued From page 30 C reported Staff N asked the DON for help and the DON said, "what do you want me to do?". Staff C stated at 2:00 p.m., Staff G, Certified Medication Aide (CMA), arrived to administer medications on A and C Halls. Staff C reported she told Staff G to help get the residents into bed and Staff C would pass the medications. Staff C stated the medications were not administered until 10 p.m. Staff C stated Staff E, CNA, was supposed to arrive at 6:00 p.m. but did not arrive to work until 9:45 p.m. On 10/8/19 at 1:10 p.m., Staff G, Certified Medication Aide (CMA), stated there were times she had to help the aides so there were times residents received medications late; anywhere from 30 minutes to an hour late. On 10/9/19 at 10:00 a.m., the DON responded she would expect staff to administer medications within an hour before or hour after the scheduled time frame. The DON acknowledged medications scheduled 3 times a day would definitely be expected to be administered within an hour before or hour after each scheduled time. The DON reviewed the Medication Admin Audit Report for Resident #34 and confirmed she would consider the Gabapentin medication administered late on several days. The DON stated she agreed the Gabapentin mediation times scheduled too close together as well with 6:00 a.m., 2:00 p.m., and 6:00 p.m. The DON stated she would take a look at the order and likely change the 6:00 p.m. time to 8:00 p.m. 3. On 10/7/2019 at 10:04 AM, Resident #25 stated he activated his call light on at 9 PM. Resident stated he felt short of breath and needed a breathing treatment. He further	F 658		

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F 658	Continued From page 31	F 658		

reported the nurse did not come until 10:00 PM. He felt this was unacceptable and said he mentioned the lack of staff issues on several different occasions but nothing changed. The resident stated all shifts are short of staff. He felt it may have something to do with administration changing 4 times in 2 years. The resident shared the desire to move to a different place.

The call light report showed Resident #25 activated his call light 4 times between 9:00 PM and 10:00 PM. The following are the times the call light came on and the amount of time before the call light was turned off on 10/6/19.

a. 9:14:03 PM 3 minutes and 12 seconds
b. 9:22:38 PM 18 minutes and 19 seconds
c. 9:42:18 PM 9 minutes and 23 seconds
d. 9:52:37 PM 2 minutes and 22 seconds

On 10/08/19 at 10:54 AM Resident #25 reported he had to wait for a breathing treatment again last night until after 10:00 PM. The resident stated he found the nurse in C hall. The resident reported he was short of breath all evening and he did not see anyone all evening.

In a phone interview on 10/8/2019 at 1:35 PM, Staff G, CMA confirmed she worked the evening of 10/6/2019. Staff G reported answering Resident #25's call light around 9:30 PM. Staff G said the resident requested a breathing treatment. Staff G found Staff C, LPN and relayed resident's request and Staff C, LPN gave Staff G, CMA the supplies and medication for the treatment. Staff G stated she then returned to the Resident #25's room and administered the breathing treatment.

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F 658	Continued From page 32 In a phone interview on 10/9/19 at 5:16 PM, Staff C, LPN stated if she signed she gave Resident #25 a breathing treatment a little after 7 PM on Sunday 10/6/19 then she did. Staff C added that she would not document she administered the breathing treatment without giving it first just to be in compliance. Staff C worked the floor and administered medications. She said the breathing treatment for Resident #25 is due at 9 PM. Staff C did not remember answering resident's light. Staff C was told that Staff G reported getting the breathing treatment supplies and medicine from Staff C, then Staff G reported administering the breathing treatment around 9:30 PM that evening. Staff C replied that she must have thought she was going to administer the treatment at 7:16 PM but got too busy to give it. She must have meant to administer it but forgot. Staff C added that this was another example of not having enough help. In an interview on 10/10/19 at 9:16 AM, the DON stated it is not acceptable to document a medication as administered when it was not. Furthermore, she said if the staff signed that they administered it and were unable to administer the medication, the staff could could go back into the system and document they did not administer it with rationale. A Medication Administration Record dated 10/1/2019-10/31/2019 for Resident #25, directed staff to give Ipratropium-Albuterol Solution 3 milliliters four times a day (breathing treatment). The times set up for the breathing treatment are 8 AM, 12 PM, 4 PM, and 8 PM. A Medication Audit Report for Resident #25 revealed that the 8:00 PM dose for the	F 658		

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F 658	Continued From page 33 Ipratropium-Albuterol was documented as administered at 7:16 PM by Staff C even though Staff G CMA administered the medication at 9:30 p.m..	F 658		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and chart review the facility	F 661		

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F 661	Continued From page 34 failed to communicate necessary discharge information to resident or continuing care provider for 1 of 1 residents (#39). Facility reported a census of 41 residents. Findings include: Chart review revealed Resident #39 admitted to the facility on 6/21/19 for physical therapy (PT) and occupational therapy (OT) services. Resident #39 discharged to the community on 7/9/19. According to the admission orders, the resident had a diagnosis of acute chronic respiratory failure, acute pulmonary edema and ambulated with the assistance of a walker. The chart for Resident #39 lacked documentation of a recapitulation of the stay to provide continuing care information, or documentation of how the resident's medications were dispensed upon discharge. The facility policy for discharge with a revision date of November 2016, included the expectation that the interdisciplinary team prepared a discharge summary upon anticipated discharge and included a recapitulation of the residents stay and a post-discharge plan of care. On 10/10/19 at 10:30 a.m. the Director of Nursing (DON) acknowledged the discharge summary, a recapitulation of the stay, and documentation of disposition of medications are all missing for Resident #39. She said she understood this previously was an area of concern and a past compliance issue. The DON stated that she could not locate a physician's order set for Resident #39.	F 661		

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F 689	Continued From page 35	F 689		
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 observations, interviews and clinical record review, the facility failed to adequately supervise 2 of 3 (Residents #34 and #35) to prevent falls. Resident #34 admitted to the facility 9/13/19 with a high fall risk and history of falls. The resident also required assistance of staff for transfers and ambulation The resident was often up by self. The care plan failed to identify Resident #34 as a high risk for falls and resident frequently gettung up without staff assist. On 9/20/19 the resident fell sustaining a fracture. The resident fell 5 more times from 9/20/19 to 10/9/19 without adequate investigation with root cause analysis and no interventions implemented until 10/7-9/19 during the survey. Resident #35 exhibited anxiety and confusion 8/25/19 at 9:33 p.m.An hour before falling and sustaining a fracture the resident attempted to self transfer.The resident required surgical revision arthroplasty. There was no evidence the facility implemented interventions knowing the resident attempted to self transfer. A majority of the resident falls occurred on the least staffed shift. There were staff interviews expressing there was not enough staff to answer call lights and to	F 689		

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F 689	Continued From page 36 prevent falls. The facility reported a census of 41 residents. Findings include: 1. An admission Minimum Data Set (MDS) dated 9/20/2019, showed diagnosis for Resident #34 included cancer, Chronic Pulmonary Obstructive Disorder (COPD), and pain in the right hip. The Brief Interview for Mental Status (BIMS), documented a 13 out of 15 indicating intact cognition. The resident was dependent on 2 staff for bed mobility, transfers, and toilet use. The MDS indicated resident had 2 falls with injury prior to admission. A Fall Risk Assessment dated 9/13/2019 indicated resident was at high risk for falling. A Baseline Care Plan dated 9/13/2019, revealed Resident #34 required 1 person physical assist for bed mobility, transfer, toilet use and ambulation in room and corridor. Mobility devices were listed as a wheel chair and walker. The baseline care plan contained the question asking if the resident had a history of falls. Staff checked "no". The baseline care plan failed to identify the resident at high risk for falls. An incident report (IR) dated 9/20/19 at 7:33 a.m. revealed an unwitnessed fall in the resident room. A CMA (certified medication aide) found the resident on the floor at the foot of her bed at 6:35 a.m.. Staff noted a skin tear to the left elbow (no size listed). The report documented staff observed no injuries post incident. The IR identified the following predisposing fall factors: confusion, recent change in cognition, impaired	F 689		

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memory and recent medication changes and "other". In the "other info" area staff documented the resident was a new admission (9/13/19) and restless with increased complaints of pain. The IR failed to fully investigate the incident by failing to document they asked the resident where she was going and when staff last toileted the resident or last saw the resident. There were no interventions listed following the incident.

A Progress Note dated 9/20/2019 at 6:41 AM, identified the resident as very confused that morning, yelling out for police and a lawyer. The resident pulled her catheter out. Staff administered PRN (as needed) Lorazepam (antianxiety).

A September 2019 medication administration record identified staff administered lorazepam 0.5 milligrams (mg) at 6:26 a.m. The MAR also identified that staff administered morphine (narcotic) 20 mg. at 5:23 a.m. Staff documented the morphine as ineffective.

A Progress Note dated 9/20/2019 at 7:33 AM, documented staff observed the resident on the floor. The resident denied pain but yelled out. The resident transported to the hospital emergency room (ER) for examination.

A Progress Note dated 9/20/2019 at 9:55 AM, revealed the resident returned to the facility with a diagnosis of non-displaced vertical fracture of the left iliac wing with no new orders. The resident received Fentanyl (narcotic) in the ER.

A Progress Note on 9/22/2019 at 11:34 AM, documented resident continued to have pelvic pain, a 1.3 diameter bruise on resident's buttock

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F 689	Continued From page 38 and paranoid delusions. The resident spit out PRN medications. A Progress Note on 9/22/2019 at 8:19 PM, revealed the resident with increased paranoia 1.5 to 2 hours after receiving PRN Morphine (narcotic). A Progress Note on 9/23/2019 at 6:45 AM, documented the resident yelled and screamed during the night. Staff administered pain and anti-anxiety medications. A Progress Note on 9/24/2019 at 9:34 PM, revealed the resident appeared upset, anxious, and confused with visual hallucinations. The physician ordered a one time order for Haldol (antipsychotic) and staff administered the medication. A Progress Note on 9/25/2019 at 9:10 PM, revealed the resident admitted to Hospice (end of life care). A Progress Note on 9/26/2019 at 11:45 PM, revealed staff found the resident on the bathroom floor. The resident stated she fell. Staff documented they educated the resident and encouraged the resident to use the call light. An incident report dated 9/26/19 at 11:45 p.m. revealed an unwitnessed fall in the resident bathroom. Following the fall, staff encouraged the resident to use the call light. The IR identified factors contributing to the fall as the resident not calling for help and ambulating without assistance. The IR failed to investigate the incident by asking the resident where she was going and when staff last assisted the resident to	F 689		

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the toilet or last saw the resident. The intervention following the incident was dated 9/26/19: toilet upon arising, before and after meals and PRN. The care plan revealed the intervention was not added to the care plan until 10/9/19 (during the survey). The intervention did not address the situation of the fall occurring in the night and night time toileting.

A call light report print out identified the resident activated the call light 9/26/19 at 11:23 p.m. and staff answered 11:33 p.m. It is not known if staff assisted the resident at 11:33 p.m. or with what.

A Fall Risk Assessment dated 9/27/2019 identified the resident with 1 to 3 falls in the last 3 months which revealed the resident at risk for falls.

A care plan created 9/30/2019 contained a focus area: actual fall on 9/20/2019 that resulted in a vertical non displaced fracture of the left iliac wing. Interventions included a Physical Therapy (PT) consult for strength and mobility dated 9/30/2019. Interventions dated 10/4/2019 included to offer resident to get up at 8:30 AM and move closer to nurses station. Another focus area created 9/30/2019 identified Activities of Daily Living/ self care deficit. An intervention included the use of a walker for transfers and ambulation.

An MDS 10/1/2019, showed diagnosis for Resident #34 included cancer, restless leg syndrome, and pain in right hip. The Brief Interview for Mental Status (BIMS), documented a score of 8 out of 15 indicating moderate cognitive impairment. The resident was dependent on 1 staff for bed mobility and toilet

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F 689	Continued From page 40 use. The resident required assistance of 2 for transfers. A Fall Risk Assessment dated 10/4/2019, identified the resident as a high fall risk. A Progress Note dated 10/4/2019 at 2:30 AM, documented staff found the resident on the floor against the recliner. The resident received skin tears to the upper extremities. An IR dated 10/4/19 at 2:15 a.m. revealed an unwitnessed fall in the resident room. Staff found the resident on the floor with her back against the recliner. The resident received 2 skin tears. The right arm skin tear measured 1 centimeter (cm) by 1 cm. and the left arm upper arm skin tear measured 2.5 cm. by 5 cm. Despite the 2 skin tears received during the fall, the IR documented "no injuries observed post incident". The IR listed the factors that contributed to the fall as: confusion, incontinence, weakness, gait imbalance, impaired memory and ambulating without assistance. In the other info area documentation revealed the resident attempted to get up per self and staff should encourage the resident to use the call light. The resident exhibits restlessness at times. The IR identified the intervention following the incident, dated 10/4/19 as to encourage/attempt to put resident in bed, instead of recliner. Review of the care plan revealed the intervention not added to the care plan until 10/8/19 (during the investigation). The IR failed to investigate the incident by asking the resident where she was going and when staff last assisted the resident to the toilet or last saw the resident. There was no record of the resident using the call light on 10/4/19.	F 689		

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A Progress Note dated 10/4/2019 at 9:08, documented staff found the resident on the floor on her back. The resident stated she wanted to get up and fell.

An IR dated 10/4/19 at 9:04 a.m. revealed an unwitnessed fall in the resident room. Staff found the resident laying on her back next to the bed. Staff did not observe injury. The IR identified the following factors as contributing to the fall: confusion, recent illness, weakness, gait imbalance and ambulating without assistance. The IR identified the resident as restless. The IR did not identify they asked the resident where she was going or what happened when the fall occurred or when staff last toileted the resident or last saw the resident. The intervention following the incident dated 10/4/19 was the facility discussed falls with the Hospice nurse. The facility reviewed medications. The report documented the resident had a call light and uses the call light. Monitor and check resident frequently and move closer to the nurses station when bed available. Offer to get resident up at 8:30 a.m. Review of the care plan identified the offer to get up at 8:30 a.m. and move closer to the nurses station not added to the care plan until 10/8/19 (during the investigation). The care plan did not contain the directive to monitor and check resident frequently. There was no record of the resident using the call light on 10/4/19.

A Progress Note dated 10/7/2019 at 6:42, revealed staff found the resident lying on the floor in her bedroom. The resident laid on her right side and stated she hit her head.

An IR dated 10/7/19 at 6:08 a.m. revealed an unwitnessed fall in the resident room. A nurse

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F 689	Continued From page 42 aide reported the resident was on the floor on her right side. The resident stated she hit her head. Following this incident, staff moved the resident to a room closer to the station. The IR did not contain an investigation into the incident. There was no record of the resident using the call light on 10/4/19. A Progress Note dated 10/7/2019 at 5:01 PM, revealed the resident moved to a room closer to nursing staff. A Progress Note dated 10/9/2019 at 6:59 AM, revealed staff found the resident laying on the floor in her room by her bed. Staff noted a limp when the resident transferred. An IR dated 10/9/19 at 4:20 a.m. identified an unwitnessed fall in the resident room. Staff observed the resident on the floor by the bed. Staff assisted the resident to stand and noticed a limp when transferring the resident. Staff did not observe injury. The IR identified the following factors contributing to the fall: confusion, impaired memory and ambulating without assistance. The resident did not wear nonskid socks at the time of the fall. The IR did not identify they asked the resident where she was going or what happened when the fall occurred or when staff last toileted the resident or last saw the resident. There was no intervention listed following the fall. There was no record of the resident using the call light on 10/4/19. Observation on 10/9/19 at 9:50 AM, revealed Resident #34 alone in her room and attempting to stand up out of bed using the handrail on the bed to push off of for leverage.	F 689		

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F 689	Continued From page 43 On 10/7/2019 at 1:10 PM, Resident #34's daughter stated her mother falls all of the time. The resident's daughter stated her mother went to the hospital about a week ago to get an x ray after the fall. The daughter feels there is absolutely not enough staff. The daughter reported the facility is staffing 1 staff to 15 residents. Observation on 10/07/19 at 3:44 PM, showed that staff moving Resident #34's clothing to a room closer to the nursing station and common area related to a fall that morning. Observation on 10/9/2019 at 9:17 AM, revealed Staff T, Certified Medication Aide (CMA), Restorative, transferred Resident #34 to and from her wheelchair to the toilet with a gait belt, from the toilet to the wheelchair and then from the wheelchair to the bed with stand by assist from a Hospice aide. The walker was not used to aide during any of the transfers. Observation showed the walker in the shower stall. Observation on 10/9/2019 at 9:50 AM, Staff U, Certified Nursing Assistant (CNA), transferred the resident from her bed into resident's w/c using a gait belt. Staff U did not use the walker to aide with the transfer. Observation showed the walker in the shower stall. On 10/10/2019 at 9:15 AM, the Director of Nursing (DON), stated she expected staff to follow the care plan with transfers as directed by the care plan. On 10/10/19 at 1205 PM, Staff H, MDS nurse stated the resident was up a lot on her own when she first came into the facility. Staff H stated that	F 689		

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after the fall with fracture, the resident varied when staff would find resident standing on own or walking. Staff H relayed that she feels the cancer has metastasized to the brain and bones. She said resident is definitely not a BIMS of 13 now. Staff H stated the resident may be able to tell you she is at the Masonic Nursing Home because the resident used to work at the facility and recognizes Staff H but the resident would not be able to participate in most of the BIMS testing now. Staff H stated the resident definitely could not repeat things. Staff H also added resident does not use the call light.

On 10/10/2019 at 12:10 PM, Resident #34 shook her head no when asked if she remembered falling. The resident looked at the surveyor when other questions are asked but did not answer.

On 10/10/19 at 12:08 PM, Staff V, CMA stated she observed the resident up walking per self and pushing her wheelchair probably 5 times. Staff V stated prior to fall with fracture resident was up all the time on her own pushing her walker around. Staff V stated that on admission the resident was pleasant, sang and talked to other residents. Staff V stated the resident doesn't do that anymore. The resident hasn't resided at the facility very long. Staff V stated resident did not and has not used the call light.

An interview on 10/10/19 at 12:15 PM, Staff U, CMA/CNA reported she observed the resident up on her own. Staff U added it "happened a lot". Staff U stated recently she found resident in the bathroom holding on to her wheelchair. Staff U unable to give a date as to when that happened. Staff U stated staff try and keep resident out in the common area a lot so they can keep a better

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F 689	Continued From page 45 eye on her. Staff U added that resident tries to stand so they try to intervene. On 10/10/19 at 2:14 PM Staff H, MDS Registered Nurse (RN) revealed that she did care plan fall interventions from the time resident was admitted until the one added on to the care plan (9/30/2019). Staff H stated all nurses should be clued into adding interventions after falls as well and they have not. Staff H stated she is the one that added on the only intervention that she knows of by moving the resident to a different room. On 10/7/2019 at 12:00 PM, Staff V, CMA stated at times there is 1 CMA and 1 CNA in each hall. However other times there is only one staff person doing both jobs. Furthermore she stated there are so many falls and call lights that go unanswered on time. Staff V stated she was by herself on Hall A starting around 7:30 AM this morning. She set a resident up for his morning shower (Resident #25), told him she would be right back but could not return as another resident (Resident #34) was walking in the hallway by herself pushing a wheelchair. Staff V stated this resident falls a lot. Staff V stated this resident at times should have a 1:1 but the facility doesn't have enough staff to provide a 1:1 for the residents. Staff V, said she was in a couple's room on that morning for 45 minutes as she gave them both showers. Staff V reported there were no other staff on the unit during that time. Furthermore, she stated she was charged with medication administration as well and could not administer medications on time. Staff V stated she received help close to 9:00 AM when Staff T arrived to help. Staff V added that Staff T's job is a restorative aide but Staff T is unable to perform	F 689		

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her restorative duties as Staff T doesn't have time. Staff V said on Sunday (10/6/2019) she was late administering medications.

On 10/08/19 at 4:12 PM, Staff N, CMA stated she feels the residents are not getting the care they should. Staff N added she feels residents have fallen because the facility is short of staff.

Staff Interviews pertaining to Resident #34:

On 10/7/19 at 9:48 a.m., Staff C, Licensed Practical Nurse (LPN), stated the facility used to staff 2 nurses on the days and 2 nurses on nights with 3 CNAs (Certified Nurse Aides) on the overnight shift. Staff C said the work load way too much right now and she worked 4 nights in a row. Staff C commented the Director of Nursing (DON) would yell at her and say, what do you want me to do. Staff C recalled working on the overnight shift 9/26/19 and reported Resident #34 sustained a fall at 11:45 p.m. Staff C reported the only staff working in the facility at the time of the fall were: Staff C, LPN; Staff E, CNA; and Staff D, an Environmental Aide (EA) [EAs are not certified and therefore not allowed to do hands on physical cares/assistance for residents]. Staff C reported 17 falls occurred in the facility for the month of September and at the time of interview, 7 or 8 falls occurred in October on all different shifts. Staff C stated she felt the falls occurred because they didn't have staff. Staff C stated call lights go on and on for 30 to 45 minutes. Staff C recalled Staff E assigned to A and C Hall while Staff D assigned to supervise the dementia locked unit, B Hall. Staff C stated she felt they needed more staff the night of 9/26/19 as Resident #34 should be 1:1 (1 staff member for 1 resident) per her assessment, but management

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F 689	Continued From page 47 said no they had other people who needed 1:1. On 10/8/19 at 5:20 p.m. Staff E, CNA, stated she recalled working on the overnight shift 9/26/19 into 9/27/19. Staff E reported she was the only CNA on that night with an LPN (Staff C) and EA (Staff D) assigned to the B Hall dementia unit. Staff E stated Staff D could not do cares and he needed to call her to come anytime someone needed something. Staff E stated she had previously told the nurse and the boss she felt they were understaffed. Staff E stated she felt the ideal number of CNAs should be 4 but they could make it work with 2 to 3 CNA's. Staff E reported she found Resident #34 on the floor that night. Staff E stated Resident #34 a new resident who she only worked with once or twice. Staff E reported Resident #34 said she tried to go to the bathroom and said she had pain. Staff E stated she informed Staff C who then followed up on the resident. The Medication Audit Report showed the actual times when Resident #34 received the pain medication methadone 10 milligrams (mg). The report recorded Resident #34 received 2 doses of the pain medication on 10/4/19 within 1 hour of each other: a. methadone 10 mg, give 1 tablet by mouth at 10:00 p.m. for pain; scheduled 10/3/19 at 10:00 p.m. but given late at 6:49 a.m. on 10/4/19. b. methadone 10 mg, give 1 tablet by mouth in the morning for pain; scheduled 10/4/19 at 6:00 a.m., given at 7:52 a.m. on 10/4/19. Review of the clinical record revealed Resident #34 sustained 2 falls on 10/4/19, 1 prior to and 1 after receiving the 2 doses of methadone pain medication that morning.	F 689		

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The facility failed to ensure Resident #34 was free from accidents by not providing adequate nursing supervision.

2. The quarterly MDS dated 7/4/19, identified diagnosis for Resident #35 included hyperlipidemia, COPD, and atrial fibrillation. According to the MDS the resident scored a fifteen out of fifteen on the BIMS indicating intact cognition. The MDS revealed the resident required supervision and assist of one staff for transfers.

A care plan identified the resident admitted to the facility 12/20/18. The care plan identified the resident with impaired thought processes and a diagnosis of dementia, impaired decision making and short term memory loss. The care plan directed staff to cue, reorient and supervise the resident as needed.

The care plan dated 1/3/19 had a focus area that identified the resident with an activities of daily living (ADL's) self care performance deficit and a date initiated of ambulation 1/3/19 indicating independent in room and facility without devices.

The fall risk assessment dated 3/20/19 indicated moderate risk for falling.

A progress note dated 7/20/19 at 11:17 a.m., revealed the CMA called the nurse into the resident's room. Upon entering the room, the resident laid on the floor near the doorway on her back. Staff that was in the room at the time of the fall stated that the resident walked towards the doorway and lost her balance and fell landing on her left side. During the exam, assessment identified the resident could not move her left leg

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F 689	Continued From page 49 and experienced extreme pain. The resident transferred to the hospital. An incident report dated 7/20/19 (no time) revealed a CMA went to the resident's room to deliver ice water and saw the resident lose her balance and fall to the left side. The resident ambulated independently per care plan. The resident transported to the hospital via EMS (emergency medical services). The IR did not list a new intervention following the incident. A progress note dated 7/20/19 at 2:13 p.m., revealed the hospital informed the facility the resident had a non displaced fracture of the femoral neck. A progress note dated 7/26/19 at 12:44 p.m., revealed the resident was re admitted to the facility status post left femur fracture with repair. The significant change MDS dated 8/4/19, identified diagnoses that included: atrial fibrillation, COPD, and fracture of the left femur. According to the MDS the resident scored a thirteen out of fifteen on the BIMS indicating intact cognition. The MDS revealed the resident required extensive assistance of two staff for bed mobility, transfer, and toilet use. The Kardex had a revision date of 8/16/19 and indicated the resident required extensive assist of 1-2 staff members to be able to transfer. The care plan dated 7/22/19 revealed the resident had an actual fall with left hip fracture and new interventions included: ensure resident's personal belongings are within resident's reach and offer to provide items needed prior to leaving	F 689		

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room. Monitor/document/report as needed time 72 hours to physician signs and symptoms of pain, bruising, changes in mental status, new onset of confusion, sleepiness, inability to maintain posture, agitation. Also physical therapy (PT) consult for strength and mobility. The care plan did not identify the resident did not wait for assistance and would try to ambulate on own and/or not always use the call light.

A fall risk assessment dated 8/17/19 indicated the resident high risk for falling.

A progress note dated 8/3/19 at 5:45 p.m., revealed the facility notified the physician of the need for pain control per family's request due to current Tylenol (analgesic) not controlling resident's pain. A new order was received to resume Fentanyl (narcotic) patch 25 mcg topically.

A progress note dated 8/5/18 at 8:36 p.m., revealed the resident with decreased confusion, but confusion at times, transfers with assist of 1 well.

A progress note dated 8/7/19 at 12:31 p.m., revealed the resident very anxious during therapy or transfers.

A progress note dated 8/13/19 at 11:43 a.m., revealed an order to start Augmentin (antibiotic) 875/125 milligrams (mg.) by mouth for fourteen days for left hip incision.

A progress noted dated 8/13/19 at 5:31 p.m., revealed an order to start Sertraline (antidepressant medication) 25 mg by mouth daily for depression.

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A progress note dated 8/20/19 at 6:57 p.m., revealed an order to discontinue Requip (for Parkinsons) as it may be aggravating her visual hallucinations. An order to start Sinemet 25/100 mg by mouth for tremors and restless leg syndrome (RLS) and start Remeron 15 mg at bedtime for depression and anxiety.

A progress note dated 8/25/19 at 9:33 p.m., revealed the resident more anxious after supper with her hands shaking and multiple minor requests. The CNA reported the resident attempted to transfer herself to the bathroom. The resident did not use the call light.

An incident report dated 8/25/19 10:26 p.m. revealed staff heard a noise from the resident room. The resident laid on her right side in front of the recliner. The resident wore socks at the time of the fall and stated she was going to the bathroom. The resident did not have her walker or wheelchair and knew she needed to wait help. Staff observed the abnormalities of the left lower extremity. The IR identified the following factors contributing to the fall: incontinent, gait imbalance, poor lighting, impaired memory, improper footwear and ambulating without assistance. The incident report identified that after the fall, staff was directed to apply nonskid socks. The IR did not identify when staff last saw or toileted the resident prior to the fall.

A progress note "communication with physician" dated 8/26/19 at 12:07 a.m., revealed the aide heard a noise coming from the resident bedroom and noted the resident on the floor on her right side in front of her recliner with her left leg extended and externally rotated her knee/foot

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was pointing up. The resident stated she was going to the bathroom and after she stood up she just went right over. The resident transferred to the hospital.

Progress notes dated 8/26/19 at 12:04 p.m. revealed the resident was in surgery. She sustained a closed left peri prosthetic fracture and required revision arthroplasty to repair it.

A progress note dated 8/29/19 at 3:32 p.m., revealed the resident re-admitted to the facility status post left hip surgery.

In an interview on 10/10/19 at 1:18 p.m., Staff U, CNA stated the resident would attempt to self transfer herself at times. She was very anxious when she returned from the hospital and wanted to do things like she did before her first fall. Staff U stated the resident was hallucinating and seeing things and would need to be reminded to use her call light for help.

In an interview on 10/10/19 at 1:24 p.m., Staff A CMA, stated the resident was confused in between the first and second fall and thinks it was from the anesthesia. The resident did have a history of self transferring and would get upset that she coutdn't do things herself. Staff A stated the resident had a urinary tract infection before the second fall and the resident would use the call light but not all the time.

On 10/10/19 at 1:51 p.m., Staff I, RN stated the resident tried to self transfer more often and it was reported to her from a CNA that the resident attempted to self transfer prior to falling the second time. Staff I stated the resident was more anxious after supper on Sunday evening.

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F 689	Continued From page 53 On 10/14/19 at 3:26 p.m., the DON stated looking at the care plan after the first fall there was no good intervention put into place. The only intervention noted was to consult physical therapy. The DON verified the facility could have put more interventions in place to prevent the second fall. An incident report dated 9/2/19 (no time) revealed staff found the resident on the floor at 2:45 p.m. The resident guarded the left leg. The resident transported to the ER for examination and x-rays. The IR identified the x-rays "negative". The report revealed the resident did not retain information or remember but occasionally said something. The IR identified factors contributing to the fall to included: confusion, recent cognition change, impaired memory and "other". In the "other" column staff documented the resident did not remember she could not walk and was on 15 minute checks since 8/31/19. Staff did not identify if the resident wore nonskid socks at the time of the fall.	F 689		
F 692 SS=G	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	F 692		

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F 692	Continued From page 54 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview the facility failed to accurately assess the nutritional and hydration needs for 1 of 16 residents (Resident #12). The facility reported a census of 41 residents. Findings include: The Minimum Data Set (MDS) dated 8/9/19 revealed Resident #12's admission date as 7/31/19. The MDS identified Resident #12 with the following diagnoses: aortic valve stenosis, major depressive disorder, right bundle branch block, thoracic aortic aneurysm, dementia, Alzheimer's disease, delusional disorder and unspecified urinary incontinence. The MDS documented the resident's height as 65 inches and weight at 150 pounds and that he was at risk for pressure ulcers. The MDS documented that the Brief Interview for Mental Status (BIMS) was not conducted because the "resident is rarely/never understood". The MDS assessment indicated that the resident did have the ability to understand others. The MDS identified his cognitive skills for daily decision making to be severely impaired-never/rarely made decisions.	F 692		

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F 692	Continued From page 55 The MDS indicated that the residents needed limited assistance of one staff for eating, bed mobility, transferring and walking. The MDS documented that the resident needed extensive assistance with dressing, toilet use and personal hygiene activities. The MDS indicated that the resident had no swallowing problem but was on a mechanically altered diet. The MDS indicated the resident to be frequently incontinent of bowel and bladder but showed that no toileting program was being used to manage the resident's continence. A care plan initiated on 7/31/19 identified the resident as a risk for nutritional problems and skin breakdown due to expressive aphasia and dementia. An intervention was established on the care plan that directed staff to allow adequate time to respond and to repeat communication as necessary. The care plan also indicated that the resident had self-care and toileting deficits related to dementia and a potential nutritional problem related to cognitive decline. The care plan update on 8/13/19 recorded that the resident had some skin breakdown on his buttock and foot related to decline in cognitive functioning. An 8/8/19 speech therapy recommendation revealed the speech therapist (ST) directed staff to serve the resident a mechanical soft diet with ground meat. Continue with nectar thick liquids and crush medications in puree/pudding. Observation on 10/7/19 at 10:15 AM showed Resident #12 seated in a recliner in the upright position in the dining room area. His head hung and he appeared to asleep. The surveyor left the area at 10:40 AM and returned at 11:00 AM to find the resident in the same position. Lunch was	F 692		

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served in the same commons area to the other residents beginning at 12:00 PM. At 12:30 PM Staff Q RN, and Staff J CNA approached Resident #12 and told him that lunch was being served. This worker did not observed or hear a response from the resident. Staff Q then asked him "or do you want to sleep?" The resident was very drowsy with his head hanging and kept his eyes closed. Staff Q then said "we can always save it for him." Staff did not offer fluids or toileting.

At 1:45 of the same date, Staff Q put up the foot-feet of the recliner, tucked a pillow under the left gluteal of Resident #12 and put a blanket over him. The surveyor left the area and returned at 2:10 to find the resident in the same position. The surveyor maintained observation of the resident until 2:30 p.m., returned again at 3:00 p.m. and found the resident's position unchanged. The surveyor remained in the area until 3:53 PM and there were no offers of repositioning, toileting, food or water.

At 4:45 p.m. of the same date, the surveyor entered the unit briefly to find Resident #12 in the same position.

A dietary documentation for the lunch meal on 10/7/19 at 13:45 indicated the "resident refused" his lunch and there was no documentation of the supper meal. The document title Night Snack had a check mark entered at 8:26 p.m. in the Not Applicable column. A review of the chart revealed that fluid intake on 10/7/19 was 480cc's at 9:47 AM. At 1:25 p.m. staff documented the resident refused fluids and there is no other documentation of fluids offered. Based on observation and documentation it appeared that

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F 692	Continued From page 57 Resident #12 only had the breakfast meal and 480cc's of fluid on 10/7/19. Observation of the lunch meal on 10/8/19 at 12:15 revealed Staff Q registered nurse (RN) fed the resident a hamburger on a bun. The resident appeared to hold meat in his cheek and Staff Q commented to the house supervisor "maybe we need to change his order back." The surveyor informed the house supervisor that the order in his electronic chart was for a mechanical soft diet and he was served a hamburger patty. She responded that she requested a diet change from mechanical to regular for the resident because he liked to pick up his food and the ground meats were a problem for him to handle. When asked if he had an updated speech therapy assessment to determine his needs she said "no" but that she received a doctor's order for the change. Observation showed on 10/8/19 lunch meal the resident drank all of the nutrition drink (approximately 12 oz.). He only drank when Staff Q placed the straw to his mouth. At the supper meal on 10/9/19 at 5:40 PM the resident fed himself small pieces of pizza when staff placed the food in his hand. A review of the electronic medical record for Resident #12 revealed an automated alert in red: "nutritional risk assessment - alternate HDG: 55 days overdue - 8/14/19." Upon further investigation it was found that Resident #12 did not have a nutritional assessment by a dietician since his admission on 7/31/19. The MDS dated 8/9/19 identified the resident admission weight as 150 pounds. The electronic record indicated the weight for Resident #12 on	F 692		

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F 692	Continued From page 58 8/27/19 was 137 pounds a weight loss of 8.67% in less than a month. On 10/15/19 his weight was 131 pounds, a weight loss of 12.67%. The clinical record lacked any documentation of communication with the doctor specific to the weight loss. Several interventions were put into place including high calorie shakes two times a day on 8/13/19, and on 8/25/19 finger food supplement and milk shakes added in the afternoon. A review of the clinical record revealed documentation of fluid intake for Resident #12 over a 13 day period (9/27/19 through 10/9/19) to be an average daily fluid intake of 938.5ml. Food eaten over the same period of time, 13 days, 39 meals: 7 times documented the resident refused, 5 times 76-100% of meal eaten, 15 meals 26-50% of meal eaten, and 1 meal 0-25% eaten. A review of the clinical chart revealed a nursing note on 10/2/19 authored by the Minimum Data Set (MDS) coordinator, requested a change in diet from ground meat to regular diet. The nurse practitioner approved the change on 10/2/19. A care plan intervention for Resident #12 initiated on 8/13/19 indicated the registered dietician (RD) would complete dietary changes and recommendations. A review of the clinical chart revealed that on 8/28/19 a skin assessment was completed, documenting a pressure area on the right buttock. A skin condition report on 9/10/19 reported a stage II pressure sore measuring 1cm x 1cm on the right foot. On 9/30/19 in a wound treatment plan from Metro Geriatric Services it's documented to be 1.5 cm x 1.3 cm. On 10/7/19 in	F 692		

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a document from Metro Geriatric Services the wound measurement is 2.1-3.0. The wound treatment team comes to assess and treat the wounds weekly for Resident #12.

On 10/8/19 at 13:54 a nutritional needs assessment was provided by a dietician and determined the following: estimated energy Needs: 1580-1895 kcal/day (25-30 kcal/kg)
Estimated protein needs: 75.8 g pro/day (1.2 g pro/kg)
Estimated fluid needs: 1580 ml/kg (25 ml/day)

A facility policy titled: Dietitian Qualified, with a revision date of November 2016, stated that the facility will employ a qualified dietitian either full time, part time or on a consultant basis.

During an interview on 10/8/19 at 8:00 AM with licensed dietician she stated that she would expect residents have a full nutritional assessment completed within seven days of admission. The dietician stated that she started in her position three weeks ago and has been working to catch up on records. She stated she expected a swallow assessment conducted before changing diet orders from mechanical soft to regular. The dietician also stated she expected the goal for a resident for fluids as 25-30 ml of fluid per kilogram of weight or a minimum of 1500 ml a day.

On 10/8/19 at 2:00 PM the Director of Nursing stated she expected any change in a diet from mechanical soft to regular only done after a follow up assessment from speech therapy and not initiated by nursing staff.

On 10/10/19 at 10:10 AM the Director of Nursing

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F 692	Continued From page 60 stated that she expected staff to offer food and fluids throughout the day and expected them to prompt dementia residents to eat. She went on to say that in her experience with Resident #12 is that when the food is put in his hand he will eat. She observed him reaching for food but needing some help to find it.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, respiratory supplier interview, and facility policy review, the facility failed to ensure they stored emergency equipment at the bedside of a resident who received tracheostomy (trach) respiratory services and failed to develop policies and procedures for the care of that resident to address the resident's individual care needs prior to admission to the facility, for 1 of 1 residents reviewed with a tracheostomy (Resident #44). The facility reported a census of 41 residents. Findings include: The Education Record Form dated 9/20/19 titled Trach Education/Demonstration provided trach education to the facility nurses. The Trach Cheat	F 695		

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F 695	Continued From page 61 Sheet provided with the education included the following: Point 1. Trach Tube Basics: A. Need to know the type, size, and if it has a cuff or inner cannula. Document the type and size in patient chart and ask physician to write order on frequency of trach changes. Make sure the obturator is in the patient room. Spare trach tube and an AMBU bag (a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) are recommended to have in the patient room. The Entry tracking Minimum Data Set (MDS) dated 9/26/19 for Resident #44 recorded the resident admitted to the facility on that date. The Discharge Return Not Anticipated (DRNA) MDS dated 9/29/19 recorded the resident discharged from the facility on that date. The Baseline Care Plan dated 9/26/19 recorded the resident received special treatments while a resident of: oxygen therapy; suctioning; and tracheostomy care. The Admit/Readmit Assessment dated 9/26/19 at 6:30 p.m. documented the following: a. the resident admitted from a hospital b. admitting diagnosis included type 1 diabetes mellitus, respiratory failure trach dependent, g-tube (gastrostomy feeding tube), and Stage 4 (full thickness wound) pressure ulcer on sacrum. c. the resident required extensive assistance with bed mobility and dressing and totally dependent for transfers and toilet use d. respiratory status - sputum frothy white, diminished breath sounds in both lungs, oxygen at 15 liters via mask to tracheostomy,	F 695		

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F 695	Continued From page 62 tracheostomy type #6 Shiley XLT The Progress Notes included the following documentation: a. On 9/26/19 at 6:30 p.m. the resident admitted to the facility and transferred to the bed from the gurney with the assistance of 5 persons; the room set up with a suction machine, feeding pump, and oxygen at 15 liters with 2 machines with heated humidification. b. On 9/27/19 at 9:08 a.m., suctioning performed 4 times during the night and removed a small amount of clear phlegm. c. On 9/28/19 at 5:30 p.m. the resident checked on multiple times in relation to trach, oxygenation, O2 (oxygen) sat (blood oxygen level), perform suctioning, trach cares, and to reposition. A small amount of thick yellow tinged sputum from the cannula returned and then the resident with unresponsive episode and O2 sat down to 49% (normal range greater than 90%). Emergency Medical Services (EMS) immediately called, airway cleared, and the resident declined to go to the ER (Emergency Room). d. On 9/29/19 at 3:10 a.m. the notes included a summary of what occurred to the resident. The entry recorded during cares the resident quit breathing and his heart stopped; staff initiated CPR (Cardiopulmonary Resuscitation) at 3:30 a.m. CPR continued per facility staff until the ambulance crew arrived and took over. The crew obtained a pulse, a blood pressure, and the resident transferred to the hospital. At 5:45 a.m., the hospital reported the resident passed away. The Order Summary Report printed 10/9/19 lacked any orders pertaining to the tracheostomy size, supplies, or cares.	F 695		

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F 695	Continued From page 63 On 10/7/19 at 9:48 a.m., Staff C, Licensed Practical Nurse (LPN), stated Resident #44 died on 9/29/19 at approximately 3:30 a.m. Staff C reported she had a limited crash cart and no back board. She identified the resident as too heavy to move to the floor, and no AMBU bag available when she initiated CPR on Resident #44. On 10/8/19 at 11:10 a.m., Staff M, Clinical Nurse Manager, and Staff L, Director of Operations, both stated the resident should not have admitted to the facility. Staff M commented the facility needed to look at the nursing skill levels compared to the acuity level of an admitting resident. On 10/8/19 at 1:10 p.m., Staff G, Certified Medication Aide (CMA), recalled the night the resident passed away. Staff G stated while she assisted the resident to get cleaned up, the resident passed away. Staff G said she called the nurse who started chest compressions and Staff G called 911. Staff G recalled it was about 3 to 3:30 a.m. when the CPR occurred. Staff G stated she witnessed Staff F, Certified Nurse Aide (CNA) doing chest compressions and, when the ambulance arrived, they connected the Lucas device (a mechanical device providing automatic deep chest compressions). Staff G reported they lowered the bed because of the resident's heavy weight. She did not know if they deflated the air mattress on the bed, but the bed went low enough for them to perform CPR. Staff G stated she did not see rescue breathing through the mouth or the trach as she went to the door to wait for EMS. In response to what facility training Staff G received related to the resident and his trach, Staff G responded just that he had a trach and he stayed in bed; she didn't know much. Staff G	F 695		

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stated she knew where to go to get info on the care plan, but there was no time to do it. Staff G reported no back board used and when they transferred the resident from the bed they used a blanket with 9 people to transfer the resident. Staff G commented it probably took more hands due to the resident's extra lines for equipment.

On 10/8/19 at 2:15 p.m., the Director of Nursing (DON), stated the facility had a limited crash cart with suction machine available for emergency codes; a back board behind the cart, in the med room, between ABC halls, a coded door; and she did not honestly know if the facility had AMBU bags. The DON stated the facility provided in-servicing on trachs to all nurses except one who did not work with Resident #44. The DON reported the resident wore oxygen continuously via a mask at 35/15 liters per minutes and all the facility's Respiratory Supply company. set up all the resident's supplies. The DON revealed the facility did not get many residents that used a trach and equipment and that was why the facility did the in-service. The DON stated the staff did not tell her how they performed CPR and she was under the impression the staff performed no rescue breathing or compressions. The DON stated she was informed the resident left the facility without CPR started. The DON commented she was pretty sure the facility's Respiratory Supply company supplied an AMBU bag for the resident.

On 10/8/19 at 2:35 p.m., Staff H, Registered Nurse (RN), reported the facility had 1 back board in the building. Staff H said she thought they may have used the back board for the cook who passed away 9/28/19 or for Resident #44, and perhaps the back board went with EMS.

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Observation revealed Staff H unable to locate a back board in the facility. Staff H asked the Dietary Manager if the back board was used with the cook's incident and the manager denied seeing the staff use a back board. Staff H did show the supply room with an AMBU bag on a cart. The closet did not contain a suction machine and Staff H wondered if the respiratory supply company inadvertently took that.

On 10/9/19 at 8:49 a.m., a follow up interview conducted with Staff C. Staff C confirmed Staff F did the chest compressions as she didn't want to give the breath in because they couldn't find the equipment. Staff C stated she quickly looked in the supply room, did not see an AMBU bag, and just went right back. Staff C reported in the resident's room they had no emergency equipment available. Staff C reported she tried to breathe into the resident's trach with her mouth as she had nothing, not even a mouth piece. Staff C reported facility staff provided CPR for about 4 minutes and then the ambulance crew arrived to take over. Staff C responded the AMBU bag may be in the supply room now (at the time of the interview) but there was no AMBU bag on the night of the incident.

On 10/9/19 at 10:05 a.m., Staff F, CNA, recalled the night Resident #44 passed away. Staff F stated while she assisted the resident to roll back and forth during cares, the resident passed away. Staff F reported it occurred around 3:00 a.m. It was the first time she met the resident, and she did not know much about him. Staff F commented she was informed the facility admitted a new resident with a trach that day. Staff F stated she arrived to work at 6 p.m. and when she first saw the resident she did not know

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if he walked or ate. Staff F revealed when the resident went unresponsive, Staff G called the nurse who came really fast and started CPR. Staff F commented she pulled the plug on the cushion (air bed) so the air came out. Staff F reported no back board available and no time to look for one. Someone said they did not have one in the facility. Staff F commented Resident #44's incident happened so fast she had to think what to do. Staff F thought the bed felt hard enough to do CPR on. Staff F recalled the nurse started CPR then she took over to allow Staff C to try to get oxygen into the resident's trach. Staff C responded they did not have an AMBU bag or back board available in the room at the time. Staff F reported Staff C blew into the resident's trach because there was no time to get an AMBU bag. Staff F commented she only worked 3 times a week and she did not know where they put the resident's equipment. Staff F stated it took the ambulance less than 5 minutes to arrive. The ambulance crew then placed a back board under the resident and then placed a machine that did automatic chest compressions and an AMBU bag on the trach.

On 10/9/19 at 12:18 p.m., the facilities Respiratory Supply company manager confirmed they supplied the facility with respiratory equipment. The company manager checked records to see what they sent or set up for Resident #44.

On 10/10/19 at 11:28 a.m., a confirmation email received from the manager of the Respiratory Supply company informed they did not supply the facility with an AMBU bag for the resident.

On 10/10/19 at 1:15 p.m., the DON provided only

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F 695	Continued From page 67 2 resident care policies and procedures revised 12/13/13 titled Tracheotomy Care and revised 12/23/13 titled Tracheotomy Suctioning. The DON reported she had a call out to the Respiratory Therapist to see what she had for bullet points of teaching if any. The DON commented otherwise, the facility had no other policies or procedures available for respiratory/tracheostomy cares. A death certificate revealed the resident expired 9/29/19 at 4:55 a.m. with immediate cause of death due to cardiopulmonary arrest.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F 700		

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F 700	Continued From page 68 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to provide assessment in use of bed rails and failed to obtain consent for use of bed rails in 2 out of 2 residents (Resident #20 and #34). The facility reported a census of 41. Findings include: 1. A Minimum Data Set (MDS) dated 9/27/2019, showed Resident #20's diagnoses included: fracture, Alzheimer's disease and age related osteoporosis. The Brief Interview for Mental Status (BIMS) documented a score of 3 out of 15 indicating severe cognitive impairment. The resident required limited assist of one staff for bed mobility, transfers and toilet use. An observation on 10/9/2019 at 2:00 PM showed 2 upper side rails positioned in the upright position on Resident #20's bed. A review of Resident #20's most current care plan revealed no assessment or documentation of bed rails. A review of Resident #20's chart revealed no documentation of risk and benefits for use of bed rails with the resident or the resident representative. 2. The Minimum Data Set (MDS) dated 10/1/2019, showed diagnoses for Resident #34 included: cancer, restless leg syndrome, and pain in right hip. The Brief Interview for Mental Status (BIMS), documented a score of 8 out of 15 indicating moderate cognitive impairment. The	F 700		

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F 700	Continued From page 69 resident was dependent on 1 staff for bed mobility and toilet use. The resident required assistance of 2 for transfers. An observation on 10/9/2019 at 9:50 AM, revealed 1 quarter upper bed rail positioned in the upright position on Resident #34's bed. A review of Resident #34's most current care plan revealed no assessment or documentation of bed rails. A review of Resident #34's chart revealed no documentation of risk and benefits for use of bed rails with resident or the resident representative. On 10/9/19 at 2:33, the Director of Nursing (DON) verified the facility did not have the resident or their representative fill out a consent for either resident. Furthermore the DON stated the facility did not care plan the bed rails for either resident.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		

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F 725	Continued From page 70 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on facility assessment review, observations, facility daily schedules, staff interviews, group interview, call light reports, clinical record review, resident interview, and family interview, the facility failed to staff a sufficient number of nursing personnel to ensure they met the needs of each resident in a timely manner for 3 of 3 group residents interviewed and 5 of 16 residents reviewed for sufficient staffing (Residents #21, #25, #34, #28, #30). During the survey, the resident matrix identified 12 residents housed on A hall, 14 residents housed on the CCDI (chronic confusion and dementing illness) unit (B hall) and 15 residents housed on C hall. The facility reported a census of 41 residents. Findings include: 1. Facility Assessment Review: The Facility Assessment Tool created 2/15/19 and revised on 8/20/19 and 10/7/19, included the following documentation. Part 1- Resident Profile	F 725		

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F 725	Continued From page 71 a. 3 neighborhoods (halls) - A neighborhood has 16 beds; B neighborhood has 17 beds, this is the secured dementia neighborhood; C neighborhood has 16 beds; and F neighborhood has 8 beds (this is the skilled wing which housed no residents during the time of survey) b. average daily census 35 to 45 residents Part 3 - Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies Staffing Plan - Staffing levels are based on number of residents, resident care needs, and facility care needs. a. Licensed Nurses (LN): RN (Registered Nurse), LPN (Licensed Practical Nurse): - Director of Nursing (DON), Unit Managers, MDS (Minimum Data Set Coordinator) - RN or LPN Charge Nurse: 2 for each shift (12 hour shifts) routinely; sometimes 1 RN/LPN on shift with support of ADON (Assistant Director of Nursing) and MDS nurse. b. Direct care Staff CNA/CMA (Certified Nurse Aide/Certified Medication Aide) - 1:8 ratio Days (certified) - 1:8 ratio Evenings - 1:16 ratio Nights c. Individual staff assignments - Nursing staff is assigned by halls; 2 CNA/CMA staff members per hall; licensed nurse staff assigned 2 halls each for assessments and resident needs. Full time staff is consistently assigned to same halls for continuity of care of residents. 2. Review of the Daily Nursing Assignment Sheet schedules from 9/6/19 thru 10/7/19 revealed the following days documented fewer nursing staff than the Facility Assessment planned for ratios and number of staff assigned per halls: 9/6, 9/7,	F 725		

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F 725	Continued From page 72 9/8, 9/9, 9/10,9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, 9/24, 9/25, 9/26, 9/27, 9/28, 9/29, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7 3. Staff interviews related to staffing needs: On 10/7/19 at 9:48 a.m., Staff C, LPN, stated the facility used to staff 2 nurses on the days and 2 nurses on nights with 3 CNAs (Certified Nurse Aides) on the overnight shift. Staff C identified the work load as way too much right now and she worked 4 nights in a row. Staff C commented the DON yelled at her and said, "what do you want me to do?" regarding staffing). Staff C recalled working on the overnight shift 9/26/19 and reported Resident #34 sustained a fall at 11:45 p.m. Staff C reported the only staff working in the facility at the time of the fall were: Staff C, LPN; Staff E, CNA; and Staff D, an Environmental Aide (EA) [EAs are not certified and therefore not allowed to provide hands on physical cares/assistance for residents]. Staff C reported 17 falls occurred in the facility for the month of September and at the time of interview, 7 or 8 falls occurred in October on all different shifts. Staff C stated she felt the falls occurred because they didn't have staff. Staff C stated call lights go on and on for 30 to 45 minutes. Staff C recalled Staff E assigned to A and C Hall with Staff D (uncertified) assigned to supervise the dementia locked unit, B Hall. Staff C stated she felt the facility needed more staff the night of 9/26/19 as Resident #34 should be 1:1 (1 staff member for 1 resident) per her assessment, but management said no they had other people who needed 1:1. Staff C reported other tasks not completed due to short staff included: residents not eating and staff did not inform her until later, not that they don't	F 725		

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want to eat but no staff to help with dining; residents not assisted out of the dining room in a timely manner; residents not getting assistance to go to bed in a timely manner; treatments scheduled for day shift not get done until later; and medications passed late. Staff C reported the night before the interview, medications all late as not done until 11:00 p.m. Staff C identified medications as late because Staff N, CNA, worked all by herself on A and C Halls until Staff O, CNA, came in from 2:00 p.m. to 10:00 p.m. Staff C reported the dementia locked unit staffed by the uncertified environmental aide, Staff D. Staff C reported Staff N asked the DON for help and the DON said, "what do you want me to do?" regarding the request for help. Staff C stated at 2:00 p.m., Staff G, Certified Medication Aide (CMA), arrived to administer medications on A and C Halls. Staff C reported she told Staff G to help get the residents into bed and Staff C would pass the medications. Staff C stated they didn't get done until 10 p.m. that night. Staff C stated Staff E, CNA, supposed to arrive at 6:00 p.m. but did not arrive to work until 9:45 p.m.

On 10/7/19 at 12:39 p.m., Staff D, EA, reported he began "sitting shifts" in nursing approximately 2 months prior. Staff D stated basically "sitting shifts" meant he sat in B wing (the locked CCDI dementia unit) with 1 CNA on night shifts. Staff D clarified the facility had someone like activity or dietary departments sit with the residents in case of emergency. Staff D stated the CNA handled the nursing care situations while a non-certified staff member called for a nurse to come help. Staff D further clarified the job as EA basically entailed sitting on A, B, or C Halls for the over night shift or evening shift and he could answer call lights. Staff D reported he would enter the

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resident's room to see what they needed and if something he couldn't do, like transfers or changing them or blood pressures, something he couldn't legally perform then he would ask the resident to wait. Staff D stated he was just there to answer the light more quickly so if an emergency arose, he would run out and get a CNA to respond quicker. Staff D commented he couldn't do transfers or physical hands on assistance. Staff D clarified, yes at times there was only 1 aide for A and C Halls while he was the only 1 assigned to B Hall. Staff D reported the staff did rounds at 1:00 a.m. and 4:00 a.m. and he personally looked in resident rooms every hour to make sure residents were not on the floor or needed to go to the restroom and if they did, he would get the aide. Staff D stated if a resident was a fall risk, he sat in their rooms to try to distract them and if only 1 CNA was staffed in the facility, that aide would come back when they could. Staff D reported he had a phone on the unit and if he called the nurse comes immediately. Staff D said when staff come to assist, he went out to answer call lights on A and C Halls in their place. Staff D confirmed he never touched a resident for cares; he supervised the unit, and if a resident needed a CNA, he called out of the unit for help. Staff D identified himself as the only staff member on the CCDI unit when Resident #4 made the resident to resident contact on 10/4/19. Staff D stated he was in Resident #13's room as Resident #13 wondered when they would put the resident to bed because she wanted to get ready for bed and it was really late. Staff D said he told Resident #13 the CNA would come back shortly and he had to inform Resident #13 he couldn't actually perform care but he would be certified soon. Staff D stated while he spoke with Resident #13, Resident #31 came

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down the hall to report Resident #4 tried to get into her room. Resident #31 said Stop, and Resident #4 went in her room and attacked her. Staff D ran out to the phone and called the nurse who picked up immediately. Staff D said Staff C came in the next minute and sorted it out and talked with Resident #31 while Staff D went into Resident #4's room. Staff D commented he couldn't leave Resident #4 alone as she wandered. Staff D commented he had a concern the facility was really understaffed with cares not getting done as the aides really ran behind not completing cares until 11:00 p.m. at times. Staff D identified the facility understaffed as B hall should have a CNA working. He felt B hall required 2 CNA's as the residents were up moving and talking. Staff D recalled there used to be 2 aides on B Hall but now just him.

On 10/8/19 at 1:10 p.m., Staff G, CMA, stated there were times she had to help the aides and this resulted in medications passed late; anywhere from 30 minutes to an hour.

On 10/8/19 at 5:20 p.m. Staff E, CNA, stated she recalled working on the overnight shift 9/26/19 into 9/27/19. Staff E reported she was the only CNA on that night with an LPN (Staff C) and EA (Staff D) assigned to the B Hall dementia unit. Staff E stated Staff D could not do cares and he needed to call her to come anytime someone needed something. Staff E stated she previously told the nurse and the boss she felt they were understaffed. Staff E stated she felt the ideal number of CNAs should be 4 but they could make it work with 2 to 3 CNA's.
Staff E reported she found Resident #34 on the floor the night she fell. Staff E reported Resident #34 said she tried to go to the bathroom and said

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F 725	Continued From page 76 she had pain. The Medication Admin Audit Report printed 10/9/19 revealed Resident #21 and Resident #34 received some medications late. 4. The Minimum Data Set (MDS) dated 9/14/19, identified diagnoses for Resident #28 included: hypertension, anemia, and peripheral vascular disease (PVD). According to the MDS the resident scored a fifteen out of fifteen on the Brief Interview for Mental Status (BIMS) test indicating intact cognition. In an interview on 10/7/19 at 2:13 p.m., the resident stated it took an hour to have staff turn her lights off. 5. The MDS dated 8/22/19, identified diagnoses for Resident # 21 included: heart failure, PVD, depression, and muscular dystrophy. According to the MDS the resident scored a fifteen out of fifteen on the BIMS indicating intact cognition. The MDS revealed the resident totally dependent on two staff for transfers. In an interview on 10/8/19 at 9:23 a.m., Resident #21 stated there is just not enough staff. He stated he is a two person assist and he has waited 2 hours before he was transferred into bed. He voiced staff may answer his call light within fifteen minutes but takes a lot longer to get his needs met. 6. The MDS dated 9/17/19, identified diagnoses for Resident #30 included: depression and chronic obstructive pulmonary disease (COPD). According to the MDS the resident scored a fifteen out of fifteen on the BIMS indicating intact	F 725		

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ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

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F 725	Continued From page 77 cognition. In an interview on 10/7/19 at 2:19 p.m., the resident stated the call lights can take a while, over an hour. He voiced once the call light is answered the staff shut it off without meeting the resident's needs. 7. Continuous observations of staff coverage on 10/7/19 from 2:10 PM to 3:40 PM revealed the following: . Upon entering the locked dementia unit (B hall) at 2:10 PM it was discovered that there were no staff in the unit. At 2:11 PM, Staff H, RN and Staff Q, CMA entered the unit and went to the medication cart to count and document the narcotics. At 2:13 PM, they both left the unit, leaving no staff. The Timecard Report showed that Staff Q clocked out at 2:14 PM. The Daily Nursing Assignment Sheet, identified Staff Q as scheduled to work until 6:00 PM on 10/7/19. She clocked back in at 4:56 PM and out again at 6:06 PM. At 2:20 PM, Staff A CMA came onto the unit and said she was looking for the charge nurse. She mentioned that she was working on the C hall that day and quickly left the unit. At 2:21 PM, the activity director, Staff R, came onto the unit pushing Resident #4 in a wheelchair. Staff R walked up and down the hallway with the	F 725		

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F 725	Continued From page 78 resident looking for staff. She stated that the resident needed toileting. At 2:23 PM, CNA Staff J, came onto the unit with Resident #13. She assisted him to the couch in the commons area. At 2:26 PM, CNA Staff P came onto the unit and said she worked the afternoon shift. The Timecard Report indicated that Staff J clocked out at 2:48. Staff P was the only staff person in the dementia unit at that time. Several observations of residents during this timeframe include Resident #4 in her wheelchair by the door attempted to exit and yelled "help me" many times. At 3:25 Resident #7 became agitated and yelled at Staff P while she tried to assist him in the bathroom. At 3:37 Resident #2 wandered into a room that was not hers. At 3:40 PM, CMA Staff S came onto the unit. She stated it was her day off and that she received a call to come in to pass medications. When asked if it was common for a CNA to be the only staff on the floor in the dementia unit she responded "some nights". Staff S administered two medications to Resident #4, obtained a blood glucose level on another resident and then left the unit at 3:53. The Timecard Report indicated that Staff S clocked in at 2:48 and out at 3:56. An observation at 4:45 PM revealed that Staff P was still the only staff on the unit. On 10/8/19 at 9:00 AM the DON acknowledged it's not uncommon for a CNA to be alone in the dementia care unit and the CMA or nurse will "pop in" to pass medications.	F 725		

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In another Interview with DON on 10/14/19 at 1:42 p.m., she stated that many times when staff agree to pick up a double shift they may do that with the stipulation that they are able to leave for a period of time to take care of family responsibilities. This would be the explanation for gap in coverage beginning at 2:10 p.m. on 10/7/19.

In an interview with activity director on 10/9/19 at 7:40 AM she recalled bringing Resident #4 back to the dementia unit and not being able to find any staff present. She said she needed someone to toilet the resident because she was unable to do that task. When asked if it's common to go into that department and find it unattended she replied that it happens "occasionally".

8. Resident #28's MDS revealed a BIMS of 15, indicating no cognitive impairment.

The Care Plan revealed Resident 28 required assistance of 1 staff for transfers and toileting.

Review of Resident 28's Call Light logs revealed the following:

On 10/5/19 call light was on 32 minutes. Call light was activated at 9:51 a. m. and deactivated at 10:24 am.

On 10/5/19 am call light was on 26 minutes. Call light was activated at 11:49 and deactivated at 12:15 PM.

On 10/5/19 Call light was on 21 minutes. Call light was activated at 4:49 PM and deactivated 5:11 PM. On 10/5/19 Call light was on 20 minutes. Call light was activated at 5:20 PM and deactivated at

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F 725	Continued From page 80 5:49 PM. On 10/5/19 Call light was on 18 minutes. Call light was activated at 5:37 PM and deactivated at 5:55 PM. On 10/6/19 call light was on 37 minutes. Call light activated at 2:21 PM and deactivated at 2:58. During Resident Group interview on 10/7/19 at 1:36 PM, Resident #28 revealed on 10/6/19 they waited an hour for staff to answer their call light. Resident #30 further revealed they could hear staff laughing in the hall while waiting for staff to answer their call light. 9. Resident #30's MDS revealed a BIMS of 15, indicating no cognitive impairment. The Care Plan revealed Resident #30 required assistance of 1 staff for toileting. Review of Resident 28's Call Light logs revealed the following: On 10/5/19 call light was on 16 minutes. Call light was activated at 7:15 am and deactivated at 7:31 am. On 10/5/19 call light was on 20 minutes. Call light was activated at 11:52 am and deactivated at 12:13 p.m. On 10/6/19 call light was on 16 minutes. Call light was activated at 7:18 am and deactivated at 7:35 am. During Resident Group interview on 10/7/19 at 1:36 PM, Resident #30 revealed on 10/6/19 they	F 725		

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F 725	Continued From page 81 waited 35 minutes before staff answered the call light. The resident further revealed staff came in, shut off call light and asked what they wanted. Staff said they would get the nurse. The resident revealed they waited another 40 minutes before the nurse came to assist with Resident #30's colostomy. 10. The MDS revealed Resident #37 with had a BIMS of 15, indicating no cognitive impairment. During Resident Group Interview, on 10/7/19 at 1:36 PM, Resident #37 revealed staff deactivated call lights and told residents they would return. Staff told the resident they didn't want to get in trouble for not answering the call light timely. On 10/08/19 at 09:44 am Staff A, CMA, stated staff tries to answer call lights within 10 minutes. Staff A further revealed residents complained call lights response took a long time in the morning when staff gave showers. On 10/08/19 at 09:50 am Staff B CMA, identified self as on light duty and not able to push or lift residents. Staff B further revealed this sometimes caused call lights to go over 15 minutes because she needed to call someone from another area to come take care of resident needs. On 10/08/19 at 10:38 am the DON revealed staff should answer call lights within 15 minutes or less. The DON further revealed if staff could not meet the resident's need/request that staff should leave the call light on until staff could be meet the need/request. 11. The MDS dated 9/6/19 for Resident #25, documented diagnoses that included: heart	F 725		

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failure, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. The MDS identified the BIMS score as 13 out of 15 indicating intact cognition. Resident #25 was required assist of 1 staff bed mobility, transfer, and toilet use. Resident #25 resided on A wing.

On 10/7/2019 at 10:04 AM, Resident #25 stated he activated his call light on at 9 PM. Resident stated he felt short of breath and needed a breathing treatment. He further reported the nurse did not come until 10:00 PM. He felt this was unacceptable and said he mentioned the lack of staff issues on several different occasions but nothing changed. The resident stated all shifts are short of staff. He felt it may have something to do with administration changing 4 times in 2 years. The resident shared the desire to move to a different place.
The call light report showed Resident #25 activated his call light 4 times between 9:00 PM and 10:00 PM. The following are the times the call light came on and the amount of time before the call light was turned off on 10/6/19.

a. 9:14:03 PM 3 minutes and 12 seconds
b. 9:22:38 PM 18 minutes and 19 seconds
c. 9:42:18 PM 9 minutes and 23 seconds
d. 9:52:37 PM 2 minutes and 22 seconds

On 10/08/19 at 10:54 AM Resident #25 reported he had to wait for a breathing treatment again last night until after 10:00 PM. The resident stated he found the nurse in C hall. The resident reported he was short of breath all evening and he did not see anyone all evening.

In an interview on 10/8/2019 at 11:12 AM, Staff O, CNA reported he did not answer resident's call

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light after 9:00 PM on the evening of 10/6/2019. Staff O reported he was on C hall at that time helping with transfer residents that require a second staff person for their transfer.

In a phone interview on 10/8/2019 at 1:35 PM, Staff G, CMA confirmed she worked the evening of 10/6/2019. Staff G reported answering Resident #25's call light around 9:30 PM. Staff G said the resident requested a breathing treatment. Staff G found Staff C, LPN and relayed resident's request and Staff C, LPN gave Staff G, CMA the supplies and medication for the treatment. Staff G stated she then returned to the Resident #25's room and administered the breathing treatment.

An interview on 10/08/19 at 4:12 PM, Staff N, CMA stated she worked Sunday night 10/6/2019. Staff N said she did not answer Resident #25's call light that evening. Staff N reported that staff know what time Resident #25's call light comes on and that he wants a breathing treatment. Staff N reported that staff can turn the call lights off at the computer. Staff N reported that they do not carry radios. Staff N said if an emergency happened and she was alone on a hall she would have to leave the resident, hope someone comes to the unit, ask a resident to turn on their call light or try to get to a phone. Staff N shared she feels the residents are not getting the care they should. She added she feels residents have fallen because the facility is short of staff.

In a phone interview on 10/9/19 at 5:16 PM, Staff C, LPN stated if she signed she gave Resident #25 a breathing treatment a little after 7 PM on Sunday 10/6/19 then she did. Staff C added that she would not document she administered the

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breathing treatment without giving it first just to be in compliance. Staff C worked the floor and administered medications. She said the breathing treatment for Resident #25 is due at 9 PM. Staff C did not remember answering resident's light. Staff C was told that Staff G reported getting the breathing treatment supplies and medicine from Staff C, then Staff G reported administering the breathing treatment around 9:30 PM that evening. Staff C replied that she must have thought she was going to administer the treatment at 7:16 PM but got too busy to give it. She must have meant to administer it but forgot. Staff C added that this was another example of not having enough help.

In an interview on 10/10/19 at 9:16 AM, the DON stated it is not acceptable to document a medication as administered when it was not. Furthermore, she said if the staff signed that they administered it and were unable to administer the medication, the staff could could go back into the system and document they did not administer it with rationale.

A Medication Administration Record dated 10/1/2019-10/31/2019 for Resident #25, directed staff to give Ipratropium-Albuterol Solution 3 milliliters four times a day (breathing treatment). The times set up for the breathing treatment are 8 AM, 12 PM, 4 PM, and 8 PM.

A Medication Audit Report for Resident #25 revealed that the 8:00 PM dose for the Ipratropium-Albuterol was documented as administered at 7:16 PM by Staff C.

The facility failed to provide sufficient nursing staff to ensure Resident #25's highest practicable

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F 725	Continued From page 85 physical needs were met. An interview on 10/7/2019 at 12:00 PM, Staff V, CMA stated at times there is 1 CMA and 1 CNA in each hall. However other times these is only one staff person doing both jobs. Furthermore she stated there are so many falls and call lights that go unanswered on times. Staff V stated she was by herself on Hall A starting around 7:30 AM that morning. She set a resident up for his morning shower (Resident #25), told him she would be right back but was unable to return as another resident (Resident #34) was walking in the hallway by herself pushing a wheelchair. Staff V stated this resident falls a lot. Staff V stated this resident at times should have a 1:1 but the facility doesn't have enough staff to provide a 1:1's for the residents. Staff V, said she was in a couple's room on that morning for 45 minutes as she gave them both showers. Staff V reported there were no other staff on the unit during that time. Furthermore, she stated she was charged with medication administration as well and was unable to give medications on time. Staff V stated she received help close to 9:00 AM when Staff T arrived to help. Staff V added that Staff T's job is a restorative aide but Staff T is unable to perform her restorative duties as Staff T doesn't have time. Staff V stated last Monday (9/30/2019) she was by herself in B hall (CCDI unit). Staff V said it is very hard to be in that hall alone and watch over the residents who yell at each other. Staff V said there is not enough staff to watch the residents. Staff V said on Sunday (10/6/2019) she was late giving her medications. In an interview on 10/10/19 at 12:18 PM, Staff V stated she did ask for help on 10/7/2019 but does not remember who. Staff V believes it was a	F 725		

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F 725	Continued From page 86 nurse but is not sure which one. Staff V stated she did not get help when she asked for it.	F 725		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation	F 728		

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F 728	Continued From page 87 program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on employee record review, testing results, staff interview, and facility record review, the facility failed to ensure they utilized certified nurse aides (CNAs) to perform hands on physical assistance to residents and failed to ensure they did not utilize an environmental aide (EA) in a nursing, supervisory position, for 2 of 7 employee files reviewed (Staff K, Staff D). The facility reported a census of 41 residents. Findings include: 1. Review of Staff K, CNA, personnel file revealed Staff K hired on 4/5/19 as a CNA. The direct care worker (DCW) check completed after hire on 4/29/19 and revealed Staff K ineligible to work as a CNA. The Nurse Aide Roster updated by the Director of Nursing (DON) on 10/7/19 documented Staff K a CNA and hired 4/5/19. The Department of Inspections & Appeals Certification details report dated 10/3/19 revealed Staff K failed the skills test for certification on 6/8/19, 7/13/19, and 8/8/19. On 10/7/19 at 11:50 a.m., the DON responded she only employed 1 EA that she knew of, Staff D. The DON stated to her knowledge, Staff D was the only staff working not certified. The DON denied having any other CNA's working who did not passed the certification tests within 4 months of employment. The DON commented all staff	F 728		

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not certified as CNAs transferred to different departments prior to her starting work at the facility in August 2019.

On 10/7/19 at 4:50 p.m., the DON confirmed Staff K worked as a CNA. When shown the employee file that identified Staff K as not eligible as a CNA, the DON said she had no knowledge Staff K did not have CNA certification. The DON commented Staff K worked only part-time and she did not know if Staff K worked since 8/5/19 (the date at which Staff K would have worked 4 months). Staff M, Clinical Nurse Consultant, instructed the DON that Staff K could not work again until the facility received confirmation of CNA status. When informed the CNA failed the skills test 3 times, the DON again responded she had no knowledge of such.

The Time Sheet Summary for Staff K from 8/5/19 thru 10/7/19 revealed Staff K worked a total of 144 hours.

On 10/8/19 at 1:10 p.m., Staff G, Certified Medication Aide (CMA), reported she worked with Staff K and observed Staff K perform hands on physical assist with another aide as a 2nd person.

On 10/8/19 at 2:39 p.m., the Human Resources (HR) Manager, stated she began employment in March 2019. The HR Manager reported she gave the previous Administrator a list that showed Staff K as ineligible to work as a CNA. A previous office manager hired Staff K. The HR Manager identified Staff K as already employed when the HR manager started working. The HR Manager said she ran the eligibility check on 4/29/19. The HR Manager stated when she did not find Staff K on the direct care registry, she double checked to

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be sure, but it did not show up. The HR Manager said she reported on 4/29/19, and monthly, to the previous Administrator. The HR Manager stated she last had proof showing Staff K ineligible on 5/3/19 and 5/6/19. Staff M, Clinical Nurse Consultant, stated she interviewed the previous Administrator via phone and was told she instructed Staff K if she retested to notify the facility and she did not hear back. Staff L, Director of Operations, stated she also verified that Staff K worked hands on with residents.

2. Review of Staff D, Environmental Aide (EA), employee file revealed Staff D hired 5/28/19 as a dietary aide. The direct care worker check completed 5/28/19 revealed Staff D not listed as a CNA. The file lacked documentation of dementia training.

On 10/7/19 at 9:48 a.m., Staff C, Licensed Practical Nurse (LPN), reported at one time there were 2 EAs. She observed both EAs provide care and transfer residents. Staff C stated the aide said he just helped to transfer to a resident to the bed and if he didn't assist then not when would they get the residents to bed. Staff C stated she reported to the DON that Staff D assisted and the DON just shrugged her shoulders.

On 10/7/19 at 12:39 p.m., Staff D reported he started "sitting shifts" in nursing approximately 2 months prior. Staff D stated basically sitting shifts meant he sat in B wing, the locked dementia unit, with 1 CNA on night shifts. Staff D clarified the facility had someone like activity or dietary departments sit with the residents in case of emergency. Staff D stated the CNA handled the situation while a non-certified staff member called for a nurse to come help. Staff D stated just 2

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

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people on the wing. Staff D said he did sitting shifts for awhile and still worked in the kitchen. He then left the dietary department to do sitting shifts more often as the job of EA. Staff D reported he was not certified yet as a CNA. He planned to take the written test 10/8/19 and the skills test 10/19/19. Staff D confirmed he was not enrolled in a CNA class as he planned to just challenge the certification test. Staff D reported he did his own research from family and friends who worked in healthcare as well as online individual study. Staff D further clarified the job as EA basically entailed sitting on A, B, or C Halls for the over night shift or evening shift and he could answer call lights. Staff D reported he went to a resident's room to see what they needed and he asked them to wait if they needed something that he couldn't do, like transfers, toilet needs or blood pressures, something he couldn't legally. Staff D stated he was just there to answer the light more quickly so if an emergency, he could run out and get a CNA to respond quicker. Staff D said his assignment tasks included: passing ice water; passing towels/washcloths/supplies; cleaning rooms; making beds; general duties; and his main job to answer call lights and see what the residents needed. Staff D commented he couldn't perform transfers or physical hands on assistance. Staff D stated he did not with help hands on physical assistance as that would risk his career. Staff D clarified, yes at times there was only 1 aide for A and C Halls while he was the only staff assigned to B Hall. Staff D commented he was lucky though as at 10:00 p.m. everyone was already in bed asleep and did not need to the bathroom. Staff D reported the staff did rounds at 1:00 a.m. and 4:00 a.m. and he personally looked in resident rooms every hour to make sure residents were not on the floor or

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needed the restroom and if they did, he would get the aide. Staff D stated if a resident was a fall risk, he sat in their rooms to try to distract them and if only 1 CNA staffed, that aide would come back when they could. Staff D commented usually no one needed transferred and as most residents on the unit transferred and ambulated independently. Staff D stated Resident #4 (resident on B hall) couldn't get out of bed at all on her own. Staff D said no one needed transferred, some needed restroom, like Resident #43 needed transferred out of the chair to restroom, but she could walk on own, if she didn't stay in the recliner on night shift then Staff D could hold the wheelchair and Resident #43 transferred self but he did not touch her, just pushed the resident around to keep her distracted. Staff D said if there an emergency arose then the nurse came immediately. Staff D reported he had a phone on the unit he could use. Staff D confirmed Resident #4 as a 2 person transfer. Staff D said when staff come to B hall then he leaves and answers call lights on A and C Halls in their place. Staff D commented everyone else needed supervision while on the toilet but no one in except Resident #4 used a wheelchair. Only some of the residents were incontinent. They just needed awoken and walked to the restroom but most residents took themselves. Staff D confirmed he never touched a resident for cares; he supervised the unit, and if a resident needed a CNA, he called out of the unit for help. Staff D reported when Resident #4 made the resident to resident contact on 10/4/19 he was the only staff member on the CCDI unit when that occurred. Staff D commented he couldn't leave Resident #4 alone as she wandered. Staff D commented he kept the residents separated the rest of the night. Staff D

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responded he received no professional or dementia training from the facility; he just asked the CNA's and nurses and got hands on experience. Staff D stated he felt the facility was understaffed as they should staff a CNA on B Hall and he felt it needed 2 CNA's with all the residents moving and talking. Staff D recalled there used to be 2 aides on B Hall but now just him.

On 10/8/19 at 11:10 a.m., Staff M and Staff L both said Staff D provided no hands on cares to any residents. Staff M identified Staff D as a prior solution to correct staffing on the unit. Staff D was a second person to provide, not physical. Staff M stated the DON reported they used Staff D only as the 2nd person on the unit and they staffed a certified nurse aide as well on the dementia unit. Staff M confirmed the expectation that an environmental aide (EA) would not be the sole staff member on the CCDI unit and could not provide supervision.

On 10/8/19 at 11:30 a.m. the DON responded yes, there were times where Staff D worked as the only employee on the unit to provide supervision. The DON stated Staff D did not provide hands on physical assistance, and expected him to call out of the unit to get help from a certified staff member who could provide the assistance. The DON responded yes a second time when clarifying the daily schedules accurate when listed Staff D as the only staff member on B Hall, dementia unit.

Review of the Daily Nursing Assignment Sheet schedules from 9/6/19 thru 10/11/19 revealed Staff D worked on the dementia unit alone on the following dates: 9/14, 9/26, 9/27, 10/2, 10/3, 10/4,

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F 728	Continued From page 93 10/6, 10/8, 10/11.	F 728		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced	F 729		

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by:
Based on personnel file reviews and staff interview, the facility failed to obtain registry verification of a certified nurse assistant (CNA) prior to hire for 1 of 3 currently employed CNA's. (Staff K) The facility reported a census of 41 residents.

Findings include:

The personnel file for Staff K, CNA, documented a hire date of 4/5/19. The file contained a direct care worker (DCW) registry check completed after hire on 4/29/19 which listed Staff K as ineligible and not meeting competency evaluation requirements.

The Department of Inspections & Appeals Certification details report dated 10/3/19 revealed Staff K failed the skills test for certification on 6/8/19, 7/13/19, and 8/8/19.

On 10/8/19 at 10:45 a.m., Staff M, Clinical Nurse Manager, and Staff L, Director of Operations, reported they identified issues with the hiring process in June 2019. They both said the management company made the decision to move the hiring process to the Central Office so they could ensure the completion of proper process as the facility did not do it correctly.

On 10/8/19 at 2:39 p.m., the Human Resources (HR) Manager, stated she started in March 2019. The HR Manager reported she gave the previous Administrator a list that showed Staff K an ineligible CNA. A previous HR manager hired Staff K. The HR Manager said she ran the eligibility check on 4/29/19. The HR Manager stated when she did not find Staff K on the direct

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F 729	Continued From page 95 care registry, she double checked for accuracy, but it did not show up. The HR Manager said she reported on 4/29/19, and monthly, to the previous Administrator. The HR Manager stated she last had proof showing Staff K ineligible on 5/3/19 and 5/6/19.	F 729		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff interview, and facility record review, the facility failed to assure all staff working in the CCDI (Chronic Confusion and Dementing Illness) received 6 hours of in-service education related to dementia training for 4 of 4 sampled staff working in the CCDI in a nursing service capacity or as a CNA (Certified Nurse Aide). The facility reported a census of 41 residents. Findings include: 1. The personnel file for Staff D, Environmental Aide (EA), documented a hire date of 5/28/19. The file lacked documentation of any dementia specific training. On 10/7/19 at 9:48 a.m., Staff C, Licensed Practical Nurse (LPN), reported Staff D worked at times as the only staff member assigned to the	F 730		

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F 730	Continued From page 96 dementia unit. On 10/7/19 at 12:39 p.m., Staff D reported he started sitting shifts in nursing approximately 2 months prior. Staff D stated basically sitting shifts meant he sat in B wing, the locked dementia unit, with 1 CNA on night shifts. Staff D clarified, yes at times there was only 1 aide for A and C Halls while he was the only 1 assigned to B Hall. Staff D reported he was the only staff member on the CCDI unit when Resident #4 made the resident to resident contact 10/4/19. Staff D commented he couldn't leave Resident #4 alone as she wandered. Staff D commented he kept the residents separated the rest of the night. Staff D responded he received no professional or dementia training from the facility; he just asked the CNA's and nurses and got hands on experience. Staff D recalled there used to be 2 aides on B Hall but now just him. On 10/8/19 at 11:30 a.m. the Director of Nursing (DON) responded yes, there were times where Staff D worked as the only employee on the unit to provide supervision, did not provide hands on physical assistance, and expected to call out of the unit to get help from a certified staff member who could provide the assistance. The DON responded yes a second time when clarifying the daily schedules accurate when listed Staff D as the only staff member on B Hall, dementia unit. Review of the Daily Nursing Assignment Sheet schedules from 9/6/19 thru 10/11/19 revealed Staff D worked on the dementia unit alone on the following dates: 9/14, 9/26, 9/27, 10/2, 10/3, 10/4, 10/6, 10/8, 10/11.	F 730		

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F 730	Continued From page 97 2. The personnel file for Staff K, CNA, documented a hire date of 4/5/19. The file lacked documentation of any dementia specific training. Review of the daily schedules from 9/6/19 thru 10/11/19 revealed Staff K worked in the dementia unit alone on: 9/14, 9/15, and 9/28. 3. The personnel file for Staff E, CNA, documented a hire date of 7/21/19. The file lacked documentation of any dementia specific training. On 10/8/19 at 5:20 p.m. Staff E stated she recalled working on the overnight shift 9/26/19 into 9/27/19. Staff E reported she was the only CNA on that night with an LPN and Staff D who was assigned to B Hall dementia unit. Staff E stated Staff D could not do cares and he needed to call her to come anytime someone needed something. 4. The personnel file for Staff J, CNA, documented a hire date of 3/19/19. The file lacked documentation of any dementia specific training. On 10/9/19 at 9:15 a.m., the DON reported the facility had no policies or procedures available for the dementia unit in general or for training of staff to meet the required 6 hours annual training. 5. The Facility Assessment Tool created 2/15/19 and revised on 8/20/19 and 10/7/19, included the following documentation: Part 3 - Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies	F 730		

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F 730	Continued From page 98 Staff training/education and competencies - All staff hired at the facility must complete training in the following areas upon hire and annually: - included Dementia and related disorders care	F 730		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		

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F 756	Continued From page 99 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and clinical review the facility failed to provide monthly drug regimen review by a licensed pharmacist for 5 of 7 Residents #18, #4, #31, #35 and #24. The facility reports a census of 41. Findings include: 1. Review of the clinical files for Resident #18 revealed an admission date of 11/15/18. Medications for Resident #18 included Haloperidol (antipsychotic) 0.5 milligrams (mg) in the evening for anxiety, Tramadol (narcotic) 50 mg two times a day for pain, Trazodone (antidepressant) 50 mg at bedtime for depression and Seroquel (antipsychotic) 25 mg 1.5 tablets two times a day. The care plan directed staff to monitor for side effects from psychotropic medications. The chart lacked documentation of a medication review from admission until July of 2019. 2. Resident #4 admitted to the facility on 1/1/19. The chart lacked documentation of a medication review from January of 2019 through June of 2019. The clinical record identified Resident #4 with medication orders that included: Lorazepam (antianxiety) 0.5 mg in the morning and at night, Olanzapine 15 mg one tablet at night for anxiety, and Sertraline 50 mg daily related to depression. The care plan for Resident #4 directed staff to	F 756		

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F 756	Continued From page 100 monitor for adverse reaction to antipsychotics. 3. Resident #31 admitted to the facility on 4/5/18. The chart lacked documentation of a monthly medication review from November of 2018 through June of 2019. Resident #31 had medication orders for: Lasix 40 mg daily for edema, Coumadin 3 mg twice a day for atrial fibrillation and Citalopram 10 mg daily for anxiety. The care plan for Resident #31 instructed staff to monitor for side effects of antianxiety, anticoagulants and diuretic medications. On 10/8/19 at 2:20 PM, the Director of Nursing (DON) revealed the facility lacked documentation of monthly medication reviews for the residents before July of 2019. The DON indicated that the pharmacists sent the monthly reviews to the previous director of nursing via email and the current DON did not know how to access them. 4. The MDS dated 8/2/19, identified diagnosis for Resident #35 included atrial fibrillation, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). The MDS revealed the resident scored a thirteen out of fifteen on the BIMS indicating intact cognition. According to the MDS the resident received an anticoagulant medication during the last seven days of the MDS look back. The care plan dated 1/3/19 revealed the resident used antidepressant medications related to major depressive disorder. The care plan also indicated the resident on anticoagulant therapy related to atrial fibrillation with a date of 7/4/19. The medication review report dated and signed by the physician 9/24/19 revealed the resident on	F 756		

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Mirtazapine 15 mg by mouth at bedtime for depression with a start date of 8/20/19. The resident on Sertraline 25 mg by mouth daily for depressive disorder with a start date of 8/14/19. The resident on Xarelto 15 mg by mouth at bedtime for atrial fibrillation with a start date of 5/16/19.

The chart lacked a monthly pharmacy reviews completed by a licensed pharmacist prior to July 2019.

The policy titled Pharmacy Services dated November 2016 indicated a licensed pharmacist will determine that drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled through Drug Regimen Review (DRR). If any irregularity is noted during the DRR, the pharmacist is required to notify the attending physician, DON, and medical director and the DRR will be conducted monthly.

5. The MDS dated 9/6/19 identified diagnosis for Resident #24 included Alzheimer's Disease, Depression and Chronic Atrial Fibrillation. The MDS revealed the resident with a BIMS of 5 out of 15. According to the MDS dated 9/6/19 the resident had an anticoagulant in the MDS 7 day look back.

The care plan dated 6/26/18 revealed the resident receives Jantoven (anticoagulant) daily for a history of pulmonary embolism.

The medication review report dated and signed 9/10/19 revealed the resident is on Exelon Patch 24 hour 4.6 mg/24 hr (Rivastigmine) 1 patch transdermal in the morning related to unspecified dementia without behavioral disturbances with a

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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 756	Continued From page 102 start date of 7/31/19. The resident is on Jantoven tablet 0.5 mg by mouth one time a day with a start date of 9/7/19. The chart lacked monthly pharmacy reviews prior to July 2019.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (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	F 758		

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	165149	A. BUILDING _____ B. WING _____	10/15/2019

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F 758	Continued From page 103 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to keep 1 out of 5 residents (Residents #34) free of unnecessary psychotropic PRN (as needed) medication. The facility reported a census of 41 residents. Findings include: The Minimum Data Set (MDS) dated 10/1/2019, showed diagnosis for Resident #34 included cancer, restless leg syndrome, and pain in right hip. The Brief Interview for Mental Status (BIMS), documented a score of 8 out of 15 indicating moderate cognitive impairment. The resident was dependent on 1 staff for bed mobility and toilet use. The resident required assistance of 2 for transfers. A care plan goal dated on 9/16/2019, documented Resident #34 used anti-anxiety	F 758		

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F 758	Continued From page 104 medications related to an anxiety disorder. The care plan directed staff to monitor and report any adverse reactions of PRN anti-anxiety therapy including drowsiness, slow reflexes, clumsiness, and impaired thinking. The Medication Administration Record (MAR) dated 9/1/2019 to 9/30/2019, identified Lorazepam (anti-anxiety medication) administered every 6 hours as needed for anxiety. The start date for this order was 9/17/2019. The MAR documented this medication administered 13 times in September. The MAR showed this medication was given twice on 10/7/2019. On 10/9/2019, the Director of Nursing (DON), stated the PRN lorazepam order did not contain a stop date, therefore it was not discontinued by the end of the 14th day per regulation. The facility failed to ensure Resident #34's PRN anti-anxiety medication was limited to 14 days.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

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F 761	Continued From page 105 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional standards for 6 of 41 residents. The facility failed to properly label medications with the date it was opened for Resident #27 #25 #11 #18 #7 and #14. The facility reported a census of 41 residents. Findings include: In an observation of two of three medication carts on 10/8/19 at 7:40 AM identified 10 bottles of medications opened without documented open dates. The medication cart located on wing A contained 5 bottles of medications opened without dating; a bottle of Lactulose solution 10 g/15 milliliters (ml) opened with the resident identifier label torn off. Observation showed the resident's initials written on the lid. Staff B Certified Med Aide (CMA) identified the resident that the medication	F 761		

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F 761	Continued From page 106 belonged to as no longer at the facility. A bottle of UTI-Stat cranberry prescribed to Resident #27 observed opened with no documentation of opened date. Other opened medications without dating include: carafate 1gram/10 ml for Resident #25, Milk of Magnesia for Resident #25 and a bottle of Gaviax for Resident #11. The medication cart on B hall contained 5 bottles of opened medication without an open date which included: Docu liquid stool softener and Milk of Magnesia for Resident #14, liquid stool softener for Resident #18, and Gaviax stool softener for Resident #7. During staff interview on 10/8/19 at 7:05 AM Staff B, CMA in hall A stated that the expectation is that when a bottle of medication is opened, staff should date and initial it. During staff interview on 10/8/19 at 7:20 AM with Staff Q, CMA in hall B she indicated that the expectation for documentation is to write the opened date on the bottle and initial. On 10/14/19 at 10:45 AM the Director of Nursing (DON) revealed her expectation is that medications to contain a documented date of opening. The DON stated that she could not find any facility policy regarding medication labeling.	F 761		
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	F 880		

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F 880	Continued From page 107 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 least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 108 (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, record review, interview, and policy, the facility failed to follow infection control practices in order to prevent and control the spread of infection by failing to perform proper hand hygiene and glove changing while performing peri-care for 1 of 4 residents (Resident #3) and failed to ensure the annual review and revision of policy and procedures. The facility reported a census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) dated 9/28/19, identified diagnoses for Resident #3 included: Alzheimer's Disease, Diabetes Mellitus, and peripheral vascular disease (PVD). The resident had severely impaired cognitive ability. The MDS	F 880		

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F 880	Continued From page 109	F 880		

revealed the resident totally dependent with two staff for bed mobility, transfers, toilet use, and always incontinent of bowels and bladder.

The care plan dated 7/10/19 revealed the resident as incontinent of both bowel and bladder and totally dependent on staff for all cares associated with incontinence. The care plan directed staff to check for incontinence every two hours and provide necessary incontinence cares.

Observation on 10/7/19 at 12:01 p.m., revealed Staff P, certified nurses aide (CNA) entered the room and washed her hands and donned gloves. Staff P obtained pants and a brief from the resident's cabinet. Staff A, certified medical assistant (CMA) entered room and donned gloves. Staff P used a wash rag and cleaned the supra pubic area and around the penis using the same surface of the wash rag. With the same gloved hands she placed barrier cream on her gloves and smeared it into the residents groin areas. The resident was then rolled to his side and briefs removed. A bowel movement was noted and Staff P used a wash rag to clean up the bowel movement. With the same gloved hands Staff P placed a clean brief under the resident. There was noted moisture associated dermitis to coccyx. With the same gloved hands Staff P placed Calmoseptine cream (moisture barrier) on to her glove and smeared it onto the coccyx. Staff P removed her gloves and continued to secure the brief, put on the resident's pants and placed the hoyer sling under the resident. Staff failed to wash her hands.

A policy titled Perineal Care with a revision date of 3/1/14 directed staff to remove fecal material with toilet tissue and discard it in toilet or soiled tissue

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F 880	Continued From page 110 disposal bag, cleanse area from the rectal area over the buttock using warm soap and water always washing front to back. Wash and rinse area if soap and water was used, then remove gloves, wash hands, reapply clean gloves and apply barrier cream to area, if indicated. On 10/10/19 at 11:54 a.m., the Director of Nursing (DON) stated she expected staff to wash hands after removing gloves and to change gloves when going to clean to dirty and applying treatment. 2. Review of the Infection Prevention and Control Policy revealed a date of 10/20/16 and a reviewed and revised date of 3/1/17. In an interview on 10/14/19 at 10:54 a.m., the Director of Nursing (DON) verified the infection prevention and control policy has not been reviewed and revised annually.	F 880		

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	IA0135	A. BUILDING: _____ B. WING _____	10/15/2019

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L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093		

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L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249 A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veteran's affairs. Where appropriate, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A. Based on record review and interview, the facility failed to submit 3 of 5 resident admissions reviewed to the Iowa Department of Veteran Affairs (Resident #1, #30, #35). The facility reported a census of 41 residents. Review of The Iowa Department of Veterans Affairs Resident Eligibility form revealed Resident #30 was admitted on 3/27/19 and received information on 10/9/19.	L1093		

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L1093	Continued From page 2 Review of The Veterans Affairs dated 12/2018 revealed Resident #35 was a Veteran's Spouse. Review of The Iowa Department of Veterans Affairs Resident Eligibility form lacked resident #35 was submitted into the database. Review of the Veterans Affairs dated 1/4/19 revealed Resident #1 was a veteran. Review of the Iowa Department of Veterans Affair Resident Eligibility form lacked Resident #1 was submitted into the database. In an interview on 10/9/19 at 4:09 p.m., the Administrator verified resident # 30 ,#35, and #1 were not submitted into the VA website. He stated he went through the entire facility and submitted multiple resident's who were eligible. He stated the facility hasn't been submitting resident's into the Iowa Department of Veterans Affairs website since 2017.	L1093		

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C 136	50.7(1) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(1) Of any accident causing major injury. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report incidents involving major injury to the State Agency for 2 of 2 residents reviewed. (Resident #35 and Resident #34) Facility census was forty-one (41) residents. Findings include: 1. A MDS dated 8/2/19, identified diagnosis for Resident #35 included atrial fibrillation, hyperlipidemia and chronic obstructive pulmonary disease (COPD). According to the MDS the resident scored a thirteen out of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS indicated the resident required extensive assistance of two staff for bed mobility, transfers, and toilet use. The care plan dated 7/20/19 revealed the resident sustained an actual fall with left hip fracture and a second fall with revision on 8/31/19. An intervention created on 2/5/19 revealed the resident independent in room and facility without devices and cancelled 8/16/19. A print out of changes prior to completion of last review indicated on 8/16/19 that the resident required extensive assist of 1-2 staff members to	C 136		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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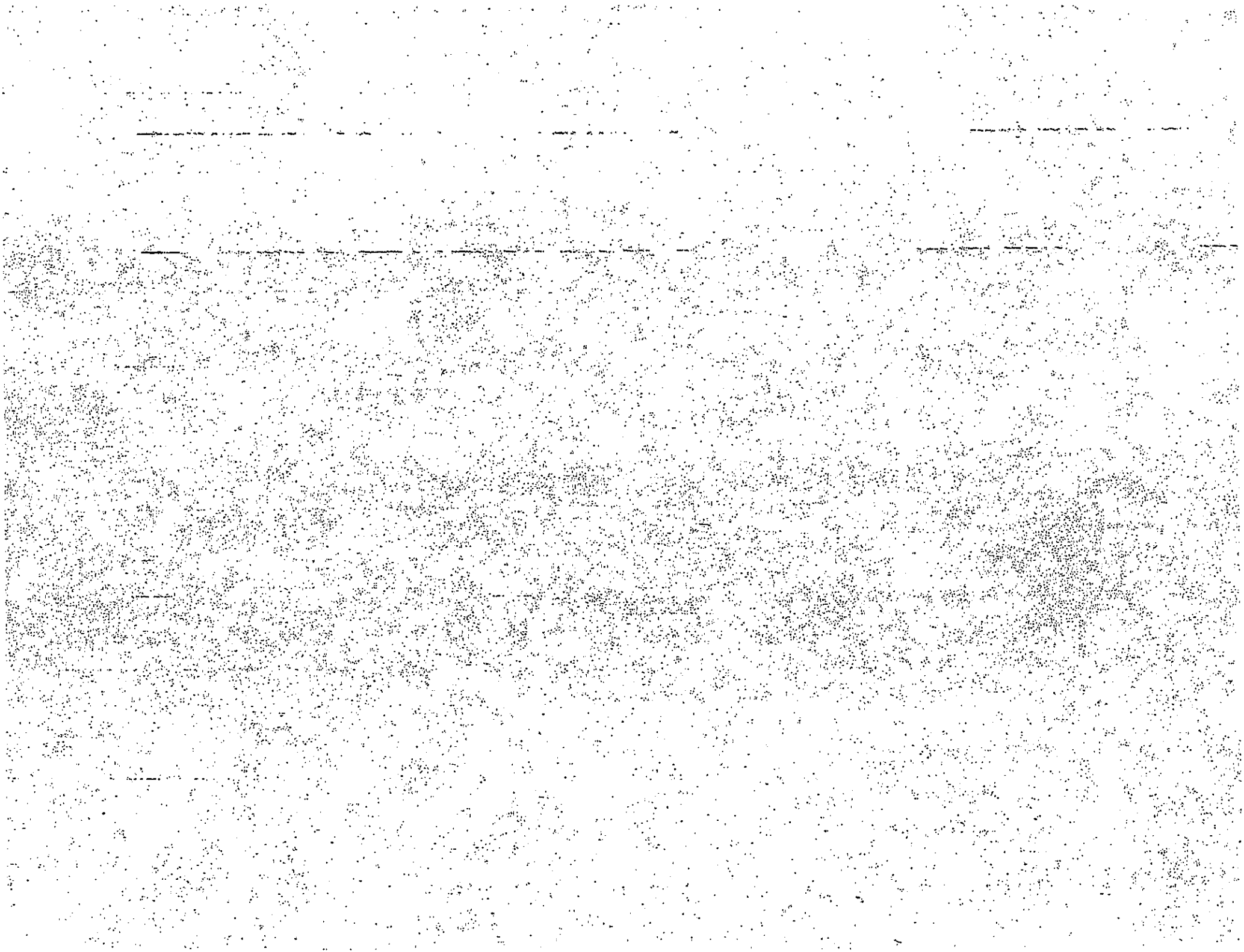
C 136	Continued From page 1 be able to transfer. Review of the fall risk dated 8/17/19 revealed the resident high risk for falling. A progress note dated 8/25/19 at 9:33 p.m., revealed the resident experienced anxiety after supper with her hands shaking. The resident had multiple minor requests. The CNA (certified nurse aide) reported the resident attempted to transfer herself to the bathroom. A progress note dated 8/25/19 at 10:26 p.m. revealed an aide heard a noise coming from the resident's bedroom and observed the resident on the floor on her right side in front of the recliner with her left leg extended and externally rotated with the knee/foot pointing up. Staff immediately called 911 and propped the resident with pillows to stabilize her. The resident stated she planned to go to the bathroom and after she stood up she just went right over. A progress note dated 8/29/19 at 3:32 p.m. revealed the resident re-admitted status post left hip surgery that day at 11:55 a.m. . The chart lacked a major injury determination form for the fall on 8/25/19. The on line self-report from the facility lacked a self-reported incident for the resident's fall with fracture on 8/25/19. On 10/9/19 at 12:34 p.m., the Director of Nursing verified there was not a major injury determination form completed and the facility did not report the fall with fracture to the Department of Inspection and Appeals.	C 136		



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

(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) COMPLETE DATE
C 136	Continued From page 2 2. An admission Minimum Data Set (MDS) dated 9/20/2019, showed diagnosis for Resident #34 included cancer, Chronic Pulmonary Obstructive Disorder (COPD), and pain in the right hip. The Brief Interview for Mental Status (BIMS), documented a 13 out of 15 indicating intact cognition. The resident was dependent on 2 staff for bed mobility, transfers, and toilet use. The MDS indicated resident had 2 falls with injury prior to admission. A Fall Risk Assessment dated 9/13/2019 indicated resident was at high risk for falling. A Baseline Care Plan dated 9/13/2019, revealed Resident #34 required 1 person physical assist for bed mobility, transfer, toilet use and ambulation in room and corridor. Mobility devices were listed as a wheel chair and walker. The baseline care plan contained the question asking if the resident had a history of falls. Staff checked "no". The baseline care plan failed to identify the resident at high risk for falls. An incident report (IR) dated 9/20/19 at 7:33 a.m. revealed an unwitnessed fall in the resident room. A CMA (certified medication aide) found the resident on the floor at the foot of her bed at 6:35 a.m.. Staff noted a skin tear to the left elbow (no size listed). The report documented staff observed no injuries post incident. The IR identified the following predisposing fall factors: confusion, recent change in cognition, impaired memory and recent medication changes and "other". In the "other info" area staff documented the resident was a new admission (9/13/19) and restless with increased complaints of pain. the incident. A Progress Note dated 9/20/2019 at 7:33 AM,	C 136		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0135	A. BUILDING: _____ B. WING _____	10/15/2019

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

(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) COMPLETE DATE
C 136	Continued From page 3 documented staff observed the resident on the floor. The resident denied pain but yelled out. The resident transported to the hospital emergency room (ER) for examination. A Progress Note dated 9/20/2019 at 9:55 AM, revealed the resident returned to the facility with a diagnosis of non-displaced vertical fracture of the left iliac wing with no new orders. The resident received Fentanyl (narcotic) in the ER. The chart lacked a major injury determination form for the fall on 9/20/19. The on line self-report from the facility lacked a self-reported incident for the resident's fall with fracture on 9/20/19.	C 136		

Rowley Memorial Masonic Home
3000 East Willis Avenue
Perry IA. 50220

Disclaimer:
Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as admission against the interest of the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the center of the truth of any facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the center has prepared and submitted the Plan of Correction prior to the resolution of this matter at this time solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within 10 days of the survey as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should no way be considered as an agreement with the allegations of non-compliance or admission by the center. Despite the facility objection to the alleged violation, the following is the proposed as a Plan of Correction in accordance with state and federal regulations. The center has alleged that it will be in substantial compliance with all conditions of participation on

Date of Compliance for tags F606, F689, F692 and C136 is 10/24/19

Date of Compliance for remaining tags in this POC is 11/13/19

F606 **Immediate Action:**
Human Resources sent SING, Criminal Record and Authorization to run background check to Iowa Department of Human Services for may work approval for Staff E immediately upon notification. Staff C is no longer employed by the facility. Staff J has not completed the Record Check Evaluation form and was removed from the schedule.

Other Residents with the Potential to be Affected:
Human Resources completed an audit on all current employee files to determine need to send SING, Criminal Record and Authorization to run background check to Iowa Department of Human Services for a may work approval. Any records needing 2nd step completed were sent to obtain may work approval

Systemic Changes to Ensure Compliance:
Human Resources was re-educated to the State requirement on 10/14/2019. Interdisciplinary Team was re-educated to the State requirement on 10/22/2019. NHA/designee will complete an audit of all new hires weekly times 1 month, then monthly times 2 months.

System Maintenance:

Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F609 **Immediate Action:**
Incidents reviewed and reported according to the reporting requirements.

Other Residents with the Potential to be Affected:
All residents have the potential to be affected. Re-education provided to the IDT Team to the 609 regulation, including reporting time frames and resident to resident altercation policy and procedure.

Systemic Changes to Ensure Compliance:
All allegations of resident-to-resident abuse, resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation will be reported to the Director of Operations/designee. Director of Operations/designee will initiate a "Rapid Response" call with facility management and Clinical Director to assist in determining next steps in reporting and documentation in resident clinical records.

System Maintenance:
Allegations of resident-to-resident abuse, resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F623 **Immediate Action:**
The SW notified the ombudsman of Residents #35 and #37 transfers to the hospital.

Other Residents with the Potential to be Affected:
All residents have the potential to be affected. The Executive Director, Director of Nursing and Social Service Director were educated to the regulation and the need to notify the ombudsman when residents transfer to the hospital as well as of discharges.

Systemic Changes to Ensure Compliance:
Executive Director/designee will review Social Worker log monthly, prior to SW sending to the ombudsman, to ensure transfers are included in the notification.

System Maintenance:
Reviews will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F625 **Immediate Action:**
Social Worker and Director of Nursing educated on the Bed Hold policy and the regulation.

Other Residents with the Potential to be Affected:
Executive Director, Director of Nursing, and Professional nurses were educated to the policy and regulation regards to providing a written bedhold notice to residents and the resident representative upon transfer to a hospital or therapeutic leave. Written notice must be returned in 48 hours of transfer.

Systemic Changes to Ensure Compliance:
Social Worker will complete a "Notification of Bedhold" audit. Executive Director will review weekly times 1 month to ensure resident and family representative received and returned notification.

System Maintenance:
Reviews will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F644 **Immediate Action:**
A PASRR level I was completed on Resident #27 due to diagnosis of a major mental illness that was added on 11/16/2017. PASRR Level I returned with no changes needed.

Other Residents with the Potential to be Affected:
All resident records were reviewed to ensure a PASRR level I was completed for a new diagnosis of major mental illness. A new PASRR Level I was sent for any new major mental illness. Executive Director, Director of Nursing, Social Worker and Professional Nurses were re-educated on the requirement.

Systemic Changes to Ensure Compliance:
Social Worker will complete an audit monthly times 2 months to ensure compliance.

System Maintenance:

Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F656 **Immediate Action:**

Resident #20's care plan and Kardex was revised to reflect current needs. Resident #34 no longer resides at the facility.

Other Residents with the Potential to be Affected:

Care Plans for current residents were reviewed and revised to reflect current needs and correlated care plan to Kardex. All nursing staff were re-educated on 10/29 and 10/30 related to following care plans and Kardex and to report changes to professional nurse when needed.

Systemic Changes to Ensure Compliance:

MDS Nurse/designee will review and revise care plans and Kardex with each MDS assessment and as changes in resident status requires. DON/designee will complete 6 audits weekly times 2 weeks then monthly times 2 months to ensure care plan is followed. Any deficient practice will be addressed at time of discovery.

System Maintenance:

Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F657 **Immediate Action:**

Resident #20's care plan and Kardex was revised to reflect current needs.

Other Residents with the Potential to be Affected:

Care Plans for current residents were reviewed and revised to reflect current needs and correlated care plan to Kardex. All nursing staff were re-educated on 10/29 and 10/30 related to revising care plans and Kardex and to report changes to professional nurse when needed.

Systemic Changes to Ensure Compliance:

MDS Nurse/designee will review and revise care plans and Kardex with each MDS assessment and as changes in resident status requires. DON/designee will complete 6 audits weekly times 2 weeks then monthly times 2 months to ensure care plan reflects current status

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F658 **Immediate Action:** Resident #25 did not sustain any negative affects from this violation. Resident #34 no longer resides in the facility.

Other Residents with the Potential to be Affected: Any resident receiving medications in the facility could be affected by this violation. Education was provided to the nurses and the medication aides regarding the 6 rights to med pass including documentation.

Systemic Changes to Ensure Compliance: Point Click Care dashboard will be reviewed for med pass status by DON/Designee 5x/week every week.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F661 **Immediate Action:**
Resident #39 no longer resides in the facility.

Other Residents with the Potential to be Affected:
Current residents care plans were reviewed for discharge planning and updates as needed. Staff were re-educated on 10/29/19 and 10/30/19 related to documentation of discharge summary, disposition of medications and completing a recapitulation of stay upon discharge.

Systemic Changes to Ensure Compliance:
DON/designee will monitor compliance through the discharge audit with each new admission and discharge times 2 months. Any employee deficient practice will be addressed at the time of discovery.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F689 **Immediate Action:** Education was provided to center leadership regarding reporting an accident causing major injury. Resident #34 no longer resides at the facility. Resident #35 did not sustain any negative affects due to the failure of reporting.

Other Residents with the Potential to be Affected: Any residents sustaining a major injury could be affected by this violation.

Systemic Changes to Ensure Compliance: Education provided to professional nursing staff regarding reporting requirements of any accident causing major injury. Director of Operations/designee will initiate a "Rapid Response" call with facility management and Clinical Director to assist in determining next steps in reporting and documentation in resident clinical records. DON or designee will be conduct audits of Point Click Care 5 days per week for one month.

System Maintenance: Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F692 **Immediate Action:**
Registered Dietician reviewed and updated resident plan of care and provided recommendations on 10/8/2019. Will continue to follow.

Other Residents with the Potential to be Affected:
All residents will be reviewed quarterly and/or as necessary by a Registered Dietician. New admissions will be reviewed within 14 days of admission for nutritional needs. Upgrading of mechanical altered diets will be referred to speech therapy for evaluation and recommendations. Staff education was provided to all nursing staff related to nutrition, hydration and documentation of food and fluid intake.

Systemic Changes to Ensure Compliance:
Professional nurses will monitor meal and fluid intake documentation. DON/designee will review meal intake on 4 randomly selected residents weekly times 1 month then monthly times 2 months. Any employee deficient practice will be addressed at time of discovery.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F695 **Immediate Action:** Resident #44 no longer resides in the facility. Education was provided to staff. Crash cart has been re established with appropriate supplies.

Other Residents with the Potential to be Affected: Any resident residing in the facility could be affected by this violation.

Systemic Changes to Ensure Compliance:
List was developed of what a crash cart should contain. List is posted for staff review. Daily audits will be conducted of the crash cart contents.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F700 **Immediate Action:**
A bedrail assessment was completed on Resident #20. Bedrails removed.

Other Residents with the Potential to be Affected:
All current residents will have a bedrail assessment completed to determine need. Bedrails will be removed on residents that are unnecessary. Residents determined to need a bedrail will have a signed consent and care plan developed. Unoccupied beds will have bedrails removed. All nursing staff were educated on the use of bedrails on 10/29 and 10/30.

Systemic Changes to Ensure Compliance:
DON/designee will complete an audit on 6 residents weekly times 2 weeks then monthly times 2 months. Any employee deficient practice will be addressed at time of discovery.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F725 On 10/10/2019, facility updated the web-based employment ads for nursing department staff, including "sponsoring" the ads so they appear toward the top of the list when candidates conduct web-based job searches.

Facility has placed "Now Hiring" flags on property, close to Willis Road, the main road that passes facility grounds.

Facility is placing employment ads for nursing staff in several area news and community publications.

Facility staff were re-educated on 10/29/19 and 10/30/19 with respect to answering call signals timely and the regulatory requirement that resident call signals are answered within no more than 15 minutes.

The Executive Director/designee will audit call reports periodically throughout the week to determine whether they are being answered within 15 minutes. Any concerns will be addressed with the Charge Nurse and floor staff responsible for the resident(s) and time(s) involved. Call signal >15 minutes will be addressed with resident.

Executive Director/DON/designee will analyze resident call signal reports to identify any discernible patterns in call signal volume and will make efforts to adjust staffing to address "hotspots".

The above plan of correction will be included in the facility's QAPI program for 3 months to ensure resident call signals are answered timely and in accordance with applicable regulations.

F728 **Immediate Action:**
Staff K was immediately removed from schedule. Staff D was immediately removed from environmental aide duties.

Other Residents with the Potential to be Affected:
Human Resources completed an audit to ensure there were not any other employees working without certification or license.

Systemic Changes to Ensure Compliance:
Human Resources was re-educated to the requirement on 10/14/2019. NHA/designee will complete an audit of all new hires weekly times 1 month, then monthly times 2 months.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F729 **Immediate Action:**
Staff K was immediately removed from schedule

Other Residents with the Potential to be Affected: Human Resources completed an audit to ensure there were not any other employees working without certification or license.

Systemic Changes to Ensure Compliance: Human Resources was re-educated to the requirement on 10/14/2019. NHA/designee will complete an audit of all new hires weekly times 1 month, then monthly times 2 months.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F730 **Immediate Action:** Staff D has been removed from schedule. Staff C no longer is employed at the facility.

Other Residents with the Potential to be Affected: No residents were named as concerned to this violation. Any residents with a diagnosis of dementia could be affected.

Systemic Changes to Ensure Compliance:
Current employees are scheduled for six hours of Dementia care training. Any new employees will be scheduled for the required six hours of Dementia care training. HR audits will be conducted monthly times 2 months.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F756 **Immediate Action:** Education was provided to NHA, DON, and Social Service. Access and understanding to pharmacy on line was established.

Other Residents with the Potential to be Affected: Any resident residing in the facility could be affected by this violation.

Systemic Changes to Ensure Compliance:

Pharmacy recommendations will be printed and reviewed monthly by DON/designee.

System Maintenance:
Pharmacy recommendations will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F758 **Immediate Action:** Resident #34 no longer resides in the facility. Education was provided to DON and Social Service.

Other Residents with the Potential to be Affected: Any resident receiving PRN psychotropic medications could be affected by this deficient practice.

Systemic Changes to Ensure Compliance:
Medication orders will be reviewed 5 times per week to ensure 14 day requirement of PRN psychotropic medications is being met.
Audit will be conducted weekly for 4 weeks, then bi weekly for an additional 4 weeks.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F761 **Immediate Action:** Medications without appropriate labels were destroyed. Medications left behind by discharged residents were destroyed.

Other Residents with the Potential to be Affected: Resident #27, #25, #11, #18, #7, and #14 did not exhibit any adverse affects related to this violation.

Systemic Changes to Ensure Compliance:
Nurses and CMA's were educated regarding medication storage and labeling.
DON/Designee will audit med carts and storage to ensure proper labeling 2 times weekly for 4 weeks, then 1 time weekly for 1 month.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

F880 **Immediate Action:**

Staff A and staff P were re-educated on proper perineal cares regarding changing of gloves, washing hands and infection control.

Other Residents with the Potential to be Affected:
All staff were re-educated on 10/29/19 and 10/30/19 on proper gloving technique, hand washing and infection control. Education has been provided to NHA and DON regarding this component of the regulation requiring the Infection Control Policy to be reviewed and potentially revised annually. Policy reviewed. Policy of Infection Control has been reviewed and signed with the Medical Director for 2019.

Systemic Changes to Ensure Compliance:
DON/designee will complete audits on direct care staff on proper gloving technique, handwashing and perineal cares until proficiency is observed. Any employee deficient practice will be addressed at time of discovery.

System Maintenance:
Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans.

L1093 **Immediate Action:** Facility Administrator entered all facility current residents with applicable veteran status (who had not been entered) into the IDVA Resident Eligibility Application during DIA Surveyors' on-site visit and provided copy of website entries to the Surveyors.

Other residents with Potential to be Affected: During the Admission process for new residents, Admissions Coordinator or designee will ensure that Veterans status questionnaire will be completed by resident or Responsible Party. When the resident indicates they are eligible for Veteran or Veteran spouse designation, Admissions Coordinator or Designee will notified Business Office Manager or Designee, who will enter the resident's information into the IDVA Resident Eligibility Application. BOM or designee will print of the completed IDVA website entry with the new resident's name displayed and place in the resident admission record.

Systemic Changed to Ensure Compliance: Once all initial Admission paperwork is completed, facility Administrator or designee will review resident file to ensure completeness, including completion of Veteran Status Questionnaire and that a print off of the IDVA entry showing the resident has been entered is present.
System Maintenance:

Administrator or designee will provide summary of his admission record review and verify completion of all IDVA Application entries to QAPI Committee each month for 3 months.

C 136

Immediate Action: Education was provided to center leadership regarding reporting an accident causing major injury. Resident #34 no longer resides at the facility. Resident #35 did not sustain any negative affects due to the failure of reporting.

Other Residents with the Potential to be Affected: Any residents sustaining a major injury could be affected by this violation.

Systemic Changes to Ensure Compliance: Education provided to professional nursing staff regarding reporting requirements of any accident causing major injury. Director of Operations/designee will initiate a "Rapid Response" call with facility management and Clinical Director to assist in determining next steps in reporting and documentation in resident clinical records. Audits will be conducted of Point Click Care 5 days per week for one month.

System Maintenance: Audits will be presented to the facility's Quality Assurance Performance Improvement Committee to identify any patterns or trends and to determine need for further education, audits and/or action plans