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PEARL VALLEY REHABILITATION AND NURSING AT LAKE PA	1304 SOUTH MARKET LAKE PARK, IA 51347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 1-31-2020 A recertification survey and investigation of complaints #85761-C and #78875-C completed 11/24/19-12/12/19 resulted in the following deficiencies. Complaints #85761 and #78875 were substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing	F 576		

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 576	Continued From page 1 implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and chart review the facility failed to provide the residents access to mail on Saturdays. The facility reported a census of 25. Findings include: In a resident council meeting on 11/24/19 at 3:30 PM several of the residents in attendance stated they are not receiving mail on Saturdays. In an interview with the administrator on 11/24/19 at 4:24 PM, she stated mail is delivered to the mail box located in the driveway in the parking lot of the facility. She went on to say that a staff member will get the mail on Mondays to be delivered to the residents.	F 576		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		

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F 578	Continued From page 2 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure there was a code status documented for 1 of 16 resident reviewed,	F 578		

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F 578	Continued From page 3 (Resident #77). The facility reported a census of 25. Findings include: A record review on 11/25/19 at 10:45 AM, for Resident # 77, showed an empty sheet protector labeled IPOST. There was no Physicians Order or other form in the chart that documented a code status for the resident. During an interview on 11/25/19 at 10:54 AM, the Assistant Director of Nursing (ADON) stated Resident #77's IPOST was sent out for a signature and was not back yet. She stated there should be a sticker on the resident's chart to indicate a full code. The ADON acknowledged the sticker was not present. She stated by looking at the chart, the staff would assume the resident was a Do Not Resuscitate (DNR) and that would not be correct. She stated the resident's wishes were to be a full code. During an interview on 11/25/19 at 12:31 PM, Resident # 77 stated she wanted to be a full code.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		

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F 584	Continued From page 4 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure the cleanliness of the building. The facility identified a census of 25 residents. Findings include:	F 584		

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F 584	Continued From page 5 Observation on 11/24/19 between 2:00 PM and 4:30 PM revealed dirt, clumps of dust and dead bugs in with window sills of 9 resident rooms. Resident room window sill observations include rooms 1, 4, 5, 6, 7, 8, 9, 10, 11, and 13. Observation on 11/25/19 between 8:30 AM and 4:00 PM showed the window sills had not been cleaned. During interview on 11/25/19, the Housekeeping Supervisor stated rooms are deep cleaned once a month. Stated each day a different room is deep cleaned. She acknowledged room window sills are dirty. Observation on 11/26/19 between 7:30 AM and 7:45 showed the window sills had not been cleaned.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to obtain Department	F 607		

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F 607	Continued From page 6 of Human Services (DHS) approval for staff with criminal history to work in the facility for 2 of 5 staff reviewed, (Staff G and Staff E). The facility reported a census of 25 residents. Findings include: 1. A New Hire Form printed 11/24/19, included Staff G, Certified Nursing Assistant (CNA) hired 6/19/19. A Single Contact License and Background Check completed 6/11/19, directed to please await the Division of Criminal Investigation (DCI's) final response for Staff G's criminal history. An Iowa Record Check Request Form showed Staff G had a criminal history. An Iowa DHS Record Check Evaluation form showed Staff G the person being evaluated, but lacked an entry in the provider requesting the evaluation, or a determination by DHS whether Staff G may work in the facility. 2. A New Hire Form printed 11/24/19, included Staff E, Certified Nursing Assistant (CNA) hired 4/8/19 and terminated 8/8/19. A Single Contact License and Background Check completed 4/1/19, directed to please await the DCI's final response for Staff E's criminal history. An Iowa Record Check Request Form showed Staff E had a criminal history. Staff E's personnel record lacked a DHS evaluation form with determination of whether Staff E could work in the facility.	F 607		

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F 607	Continued From page 7 During an interview on 11/26/19 at 1:21 p.m., the Administrator stated she did not have the DHS determination for the 2 staff. She called DHS and they don't keep them that long. She stated neither staff work at the facility any longer. She said Staff D terminated 11/21/19. The facility Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 12/18/16, documented the facility would conduct an 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 607		
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 adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		

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F 609	Continued From page 8 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 interviews and record review, the facility failed to report a major injury with in twenty-four hours of determining a major injury had occurred for one of one resident reviewed (Resident #12). Per the record review the resident fell from the mechanical lift on 11/13/19. The provider documented on 11/17/19 the resident to have a major injury. The facility reported a census of 25. Findings include: The Minimum Data Set (MDS) completed for Resident #12 with an Assessment Reference Date of 9/15/19 showed a Brief Interview for Mental Status score of 00, indicating severe cognitive impairment. The MDS determined the resident was at risk for pressure ulcers. The resident had diagnoses of displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal and Diabetes Mellitus. The Progress Note dated 11/13/19 at 12:15 PM, stated the nurse was requested to the resident's room. Upon arrival the resident was noted to be laying on her left side under the mechanical lift, head resting on the left of the lift with two CNAs	F 609		

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present. The Progress Note reported a laceration noted to the back of the left side of the head, back of the left ear. The resident usually non-verbal sentences and only mumbles few words as per usual. Unable to obtain vital signs as a resident was resistive with arms as per usual. Ambulance called, resident maintained in the same position until the ambulance arrived. At 12:40 PM, the resident was transported to the emergency room (ER) per ambulance. The provider notified per fax and the family was notified at 12:50 PM by the ADON.

The Progress Note dated 11/13/19 at 3:30 PM, reported the resident returned from the ER per ambulance. Vital signs were a temperature of 100.2, a pulse of 56, respirations of 20 and blood pressure of 148/108. The discharge instructions were received. The resident assisted in the bed with no bruises noted on the assessment. The resident received the scheduled Tylenol.

The Progress Note dated 11/13/19 labeled 6 AM to 6 PM, out of order, indicated the charge nurse called the hospital about the resident. The nurse informed the hospital staff the resident had fallen on the left side and requested to make sure the resident's hip and shoulder were not affected. An ER charge nurse stated everything looked good with no injury to the hip or shoulder. The resident returned to the facility.

The Incident Report dated 11/13/19 indicated at 12:15 PM, the resident, was lifted into the mechanical lift when turned to move to the bed the resident slid to the floor. The resident was being raised in the mechanical lift by two CNAs to assist into bed, the left side of the sling came loose, and the resident slid to the floor. The

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resident went to the ER for assessment. The ER called to report that the resident would be returning to the facility following a CT of the head and neck. No bleeds or fractures observed on the exam.

The Fall Review Assessment Form dated 11/13/19 indicated the resident did not have a history of falls.

The Physician Contact Form dated 11/13/19 indicated the resident slid out of the sling of the mechanical lift and landed on the floor. The resident went to the ER per ambulance.

The Emergency Department Tests, procedures, and medications form dated 11/13/19 indicated the resident had a CT to the head without intervenous (IV), CT to the cervical spine without IV, and blood work.

The Progress Note dated 11/16/19 at 10:00 AM, reported a call placed to the provider related to concerns of the right hip pelvis area. An observation of the resident showed the resident to have swelling of the knee with non-verbal signs of pain. X-rays ordered and the resident sent to the hospital via ambulance.

The Progress Note dated 11/16/19 at 2:30 PM, stated the hospital notified of a displaced right hip with spiral fracture, fever, and increased blood pressure with increased d-dimer. The hospital would be running more tests and would call back with more information.

The Progress Note dated 11/16/19 at 5:30 PM indicated a call received from the ER. The provider spoke with the family. The family

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F 609	Continued From page 11 requested the resident to return to the facility and on hospice level of care. The Progress Note dated 11/16/19 at 7:00 PM, noted the resident returned to the facility from the hospital via ambulance. The resident returned with new orders and diagnoses of spiral fracture to right hip and sepsis. The hospital inserted a catheter for the resident. New orders received for Rocephin 1 gram intermuscular for four days for sepsis with a referral to hospice. Progress Note dated 11/16/19 at 11:00 PM, indicated the resident planned for admission to hospice. The Emergency Room Visit Notes dated 11/16/19 indicated the resident arrived via an ambulance due to complaints of right hip pain and external rotation. The resident lived in nursing home but was residing at another care center due to boiler repairs. The facility reported the resident was in a mechanical lift on 11/13/19 to transfer the resident. The resident fell from the lift and hit her head. The resident was sent to the ER at that time and had a head CT with stitches placed. There was no report or noted injury reported to the resident's right hip at that time. The staff noted concerns with the right hip prior to sending the resident to the ER to be evaluated with x-rays. The resident had a history of dementia and was not able to give history at time of evaluation. The review of presenting symptoms indicated the resident did not report any pain, but after speaking with the resident's representative, the patient's normal daily behavior was sitting in a chair with her face downward, eyes closed with little speech. The hip exam showed the hip non-tender with normal ROM, shortening of the	F 609		

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right lower extremity, and deformity noted as external rotation. The provider was able to lift, externally, and internally rotate the leg with minimal to no grimacing. The medical decision making determined that the family discussed with the provider treatment options and family decided to forego surgical options and admit the resident to comfort care with a transition to hospice. The resident would return to the nursing home on hospice level of care. The resident would receive a catheter and Rocephin due to urinary infection with sepsis.

The Physician Contact Form dated 11/16/19 stated that the resident returned from the hospital with a noted right hip displaced spiral fracture on x-ray. The resident had new orders to admit to hospice level of care. The plan was for the resident to admit to hospice upon return to the facility.

The Physician Contact Form dated 11/16/19 stated the resident went to the hospital for x-rays of the right femur, pelvis, and hip.

The Radiology - Diagnostic Imaging form dated 11/16/19 indicated the findings showed there was a displaced spiral subtrochanteric proximal femoral diaphyseal fracture. Severe right hip joint arthrosis was unchanged.

The form labeled Hospice Medication Orders SNF dated 11/16/19 indicated an order to admit to hospice.

The Care Plan dated 11/16/19, indicated the resident admitted to hospice.

The Major Injury Determination Form dated

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F 609	Continued From page 13 11/14/19 indicated an injury occurred on 11/13/19 at 12:20 PM. The form stated the provider reviewed the circumstances of the incident causing the injury, the previous function ability of the patient, and the patient's prognosis, and determined the injury sustained was not a major injury. The rationale provided indicated the resident presented with neck pain, scalp laceration, no complaints of chest pain, abdominal pain, or joint paint - no complaints of discomfort outside of the scalp and neck at that time. A Computed Tomography scan (CT) of the resident's head and neck were negative. The circumstances of the incident causing the injury was questioned to be from the strap on the mechanical lift sliding off. The resident's previous functional ability documented as total cares with activities of daily living (ADLs) and mechanical lift for transfers The Major Injury Determination Form dated 11/17/19 indicated an injury occurred on 11/13/19 at 12:15 PM. The form stated the provider reviewed the circumstances of the incident causing the injury, the previous function ability of the patient, and the patient's prognosis, and determined the injury sustained was a major injury. The circumstances of the incident causing the injury was documented to be related to the resident sliding out of the mechanical lift. The resident's previous functional ability recorded as total care. The Major Injury Determination Form dated 11/25/19 indicated an injury occurred on 11/13/19 at 12:15 PM. The form stated the provider reviewed the circumstances of the incident causing the injury, the previous function ability of the patient, and the patient's prognosis, and	F 609		

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F 609	Continued From page 14	F 609		

determined the injury sustained was not a major injury. The circumstances of the incident causing the injury was not documented on the form. The resident's previous functional ability recorded as total care with advanced dementia.

The email dated 9/16/19, labeled Determination of Major Injury Requirements, stated additional notification was required to the director of the director's designee within twenty-four hours or the next business day, by the most expeditious means available of any accident causing major injury. Major injury was defined as an injury which required consultation with the attending physician, designee of the physician or physician extender who determines in writing on a form designated by the department that an injury is a major injury based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis.

The Major Injury Determination Form, with no date provided, indicated the form needed completing if the facility was relying on the physician, designee, or extender to determine whether a major injury had occurred. The facility could independently determine that a major injury had occurred and submit a self-report. If the physician, designee, or extender determined a major injury had occurred, the signed form should be kept by the facility in the resident's clinical record, and the facility should notify the department of the major injury.

During an interview on 11/25/19 at 9:22 AM, the Administrator said she did not report the fall or the fracture.

During an interview on 11/25/19 at 9:25 AM, the

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F 609	Continued From page 15 Acting DON and Assistant Director of Nursing stated the fracture did not happen from the fall from the mechanical lift. They said the facility did not do an investigation related to an injury of unknown origin. The Administrator stated this was called in and followed the form but did not report it to the Department of Inspections and Appeals (DIA). During a follow-up interview on 12/12/19 at 11:16 AM, the ADON said if a major injury occurred, she would notify the Administrator or DON who would report it to the state if necessary. The DON could do it but the Administrator was excellent about getting it done and reported. During a follow-up interview on 12/12/19 at 11:18 AM, the Administrator said she would follow the flow sheet to determine when to report it to the state. During an interview on 11/25/19 at 8:13 AM, the resident's representative indicated the resident fell and staff reported it was the facility staff that was caring for the resident but the staff was using the equipment of a different facility. Resident #12's representative reported having the incident report and the hospital report.	F 609		
F 657 SS=E	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--	F 657		

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F 657	Continued From page 16 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to revise the care plan to demonstrate an accurate picture of the resident's plan of care for 4 of 12 residents reviewed, (Resident #7, #12, #4, and #23). The facility reported a census of 25 residents. Findings include: 1. The Minimum Data Set (MDS) completed for Resident #7 with an Assessment Reference Date (ARD) of 8/20/19 showed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The resident had diagnoses of chronic pain and gastroesophageal reflux disease without esophagitis.	F 657		

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F 657	Continued From page 17 A review of the Progress Note dated 11/11/19, mentioned the resident choked on food particles at lunch. The nurse performed the Helmick maneuver. The resident explained she couldn't remember what was in her mouth. The assessment of the resident determined the resident's lungs were clear to auscultation. The resident was noticed to have clear and stringy phlegm after coughing. The note revealed a fax was sent to the provider requesting a Speech Therapy evaluation. A review of the fax to the provider dated 11/11/19, determined the resident choked at lunchtime. The resident was unable to recall what she had in her mouth. The nurse requested an order for a Speech Therapy (ST) evaluation. The resident had a mechanical soft diet with regular liquids. The provider returned the form with an order for ST to evaluate and treat dysphagia on 11/12/19. During the audit of the Care Plan, the documentation lacked information regarding the resident's increased risk of choking at meals. A review of a fax received on 5/20/19 indicated the provider ordered to discontinue Zoloft. During the review of the Care Plan, an intervention to monitor for the usage of Zoloft remained on the resident's Care Plan. 2. The MDS completed with an ARD of 9/15/19 showed a BIMS score of 00, indicating severe cognitive impairment. The MDS determined the resident was at risk for pressure ulcers. The resident had diagnoses of displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal and Diabetes Mellitus.	F 657		

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F 657	Continued From page 18 The Progress Note dated 11/21/19 at 9:00 PM, showed the resident had a blood blister to the left heel that measured approximately 2.5 centimeters (cm) by 2.5 cm. The nurse applied skin prep to the heel and then elevated the resident's feet on the pillow with bunny boots. The nurse indicated the area would be monitored per facility protocol. A review off the Hospice Progress Note dated 11/19/19 stated no concerns. A review of the Hospice Progress Note dated 11/22/19 showed the left heel reddened. The Progress Note showed no documentation on the appearance of the right heel. On 11/22/19 at 4:51 PM, A fax to the provider, informed of the blood blister to the resident's left heel. The nurse reported the application of skin prep to the heel and indicated the facility would monitor the wound. The provider responded, noted. A review of the Hospice Progress Note dated 11/24/19 indicated an observation of the left heel to be observed purple and the right heel to be observed pink. During an observation on 11/25/19 at 3:45 PM, observed a large black area to the left heel. The heels visualized resting on the resident's bed in the padded blue boots. A deflated pillow observed to be under the resident's shins. During an interview on 11/25/19 at 4:20 PM, the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN), reported the resident	F 657		

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F 657	Continued From page 19 received the air mattress on the day she returned to the facility from the temporary facility from the Hospice provider. The ADON said that before this, the resident had an air overlay mattress. A review of the resident's Care Plan problem dated 11/17/11, indicated the resident at risk for impaired skin integrity related to the diagnoses of diabetes, malnutrition, and dehydration. The goal was the resident's skin would remain intact. The problem included the following interventions; 1. Wound Nurse (ET) visit dated 4/6/17. 2. Heel protectors on when in bed dated 3/31/17. 3. ET Nurse consult as recommended dated 3/30/17. 4. Elevate lower extremities with pillows while in bed dated 3/20/17. 5. An air overlay to the bed dated 11/25/15. The review of the Care Plan showed the most recent intervention related to skin integrity to be dated 4/6/17. A review of the undated policy labeled, Identified Skin Concerns, declared the purpose was to provide resident's that have a pressure sore the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The purpose was to provide the essential care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The policy finished with the direction for the plan of care. The plan of care should ensure that all pressure and surgical wounds have identification on the plan of care. 3. The MDS completed for Resident #4, with an ARD of 8/17/19 showed a BIMS score of 00, indicating severe cognitive impairment. The MDS	F 657		

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F 657	Continued From page 20 showed the resident always incontinent of urine and frequently incontinent of stool. The resident had diagnoses of Parkinson's Disease and Dementia. The Care Plan intervention dated 5/17/19, stated the resident took Depakote for depression and anxiety disorders. The resident's Medication Administration Order (MAR) for November 2019 lacked documentation related to the use of Depakote. The resident's MAR for July 2019 indicated the Depakote was discontinued on 7/8/19. During an interview on 11/25/19 at 5:52 PM, the Acting Director of Nursing stated she would expect the updates to the care plan to be within twenty-four hours of a change in a resident. She said the care plan would be expected to be updated to reflect a risk for choking. The Director of Nursing expressed she would also intend for the care plan to be updated to reflect a discontinued medication to be removed from the care plan. The policy dated 10/15/19 labeled, Care Plan Frequent Update, directed the resident care plan to be updated whenever there was a change in the plan of care. The procedure section stated to update the care plan to reflect the change in a resident whenever a change in physician orders and/or nursing interventions occurred. 4. The MDS completed for Resident #23 with an ARD of 11/1/19 showed a BIMS of 11, indicating moderate cognitive impairment. The resident had diagnoses of fibromyalgia and chronic pain.	F 657		

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F 657	Continued From page 21 During an interview on 11/24/19 at 12:32 PM, the resident described falling out of the wheelchair at the other facility she had stayed at while this facility had the boiler repaired. The resident did say she didn't always call for help. The resident stated she knew she should but still did not call for help. The resident reported there was an aide with her when the fall happened. The resident said she went to the Emergency Room (ER) and assessed with no injuries. The Progress Note dated 11/8/19, showed the resident sent to the ER due to pain to bilateral hips and lumbar spine. The resident's chart lacked documentation related to an intervention to prevent future falls. A review of the Care Plan showed the last revision related to falls was completed on 10/15/19. The Incident Report completed on 11/8/19 at 6:50 PM, determined the resident said she fell because she leaned too far and lost her footing, causing her to land on her butt. The Incident Report lacked documentation related to an intervention to prevent a future fall. During an interview on 11/26/19 at 9:38 AM, the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN)stated she would have to look up the intervention. During a follow-up interview on 11/26/19 at 9:42 AM, the ADON stated the resident's intervention was to ensure immediate foot placement while ambulating the resident with staff. The ADON did	F 657		

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F 657	Continued From page 22 say that the response should be on the Care Plan but confirmed the Care Plan did not contain the intervention.	F 657		
F 661 SS=D	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 record review and staff interview the facility failed to develop a discharge summary	F 661		

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F 661	Continued From page 23 which included a recapitulation of resident's stay, final summary of resident status and reconciliation of all pre and post discharge medications for one of one closed record reviewed (Resident # 24). The facility reported a census of 25 residents. Findings include: A review of the Minimum Data Set (MDS) dated 9/26/19 for Resident # 24 documented a discharge return not anticipated. The MDS documented a planned discharge to another nursing home or swing bed with a discharge date of 9/26/19. A review of the closed record revealed lack of documentation of a discharge summary, of a final summary of resident status and of reconciliation of pre and post discharge medications. During interview with Administrator on 11/26/19 at 10:29 AM, she stated we didn't do a discharge on him, we transferred him to a sister facility when asked to provide a discharge recapitulation of resident's stay. During interview with Assistant Director of Nursing (ADON) on 11/26/19 at 10:29 AM, she stated we don't have it, when asked to provide a final summary of resident status. During interview with ADON on 11/26/19 at 11:01 AM, she stated they do not have documentation in the resident's record for disposition of medications. The ADON provided a fax from the pharmacy that was a hand written list of medications they received back from the facility at the time of discharge.	F 661		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide adequate assessment and timely intervention for 1 of 12 active residents reviewed (Resident #11). The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 9/6/19, Resident #11 scored 1 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for toilet use and always incontinent of bowel and bladder. The resident's diagnoses included diabetes and Alzheimer's disease. A hospital Patient Visit Form dated 8/2/19, documented the resident seen for volvolus (an obstruction which can occur in older adults with constipation). The resident's physician's orders included Milk of Magnesia 30 cc's daily as needed, Bisacodyl suppository daily as needed, and Fleet enema as needed, all initiated 5/24/16.	F 684		

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F 684	Continued From page 25 A Bowel Monitoring Policy and Procedure dated 11/18/10, documented the charge nurse on the overnight shift would review daily Bowel movement (bm) records and identify residents on day 2 or greater without a bm. Day 1 would be the 1st day without a bm documented. A resident 2 days without a bm should receive an oral laxative on the morning of the 3rd day. Residents 3 days without a bowel movement should receive a suppository on the morning of the 4th day. Residents greater than 3 day without a bm and have no results from a suppository, should be given available laxative and physician notified for further orders. The ADL (activity of daily living) flowsheet for July 2019 showed the resident had no bm the 16th, 17th or 18, or the 20th, 21st and 22nd. The PRN Medication Notes documented the resident did not receive MOM until 7/19, day 4, or 7/23, day 4. The ADL flowsheet for August 2019 showed the resident had no bm the 2nd, 3rd, or 4th, or the 14th, 15th, or 16th. The PRN Medication Notes documented the resident received a bisacodyl suppository on 8/5, day 4, with no MOM given on day 3, and a bisacodyl suppository on 8/17, day 4 with no MOM on day 3. The ADL flowsheet for September 2019 showed the resident had no bm the 17th, 18th, 19th or 20th. The PRN Medication Notes documented the resident did not receive a bisacodyl suppository until 9/21/19, day 5, with no MOM on day 3 or suppository on day 4.	F 684		

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F 684	Continued From page 26 The ADL flowsheet for October 2019 showed the resident had no bm the 9th, 10th or 11th. The PRN Medication Notes lacked any documentation the resident received MOM or suppository. The ADL flowsheet for November 2019 showed the resident had no bm the 1st, 2nd, 3rd, or 4th, or the 18th, 19th, or 20th. The PRN Medication Notes documented the resident did not receive MOM until 11/4/19, day 4. During an interview on 11/26/19 at 10:23 a.m., the Assistant Director of Nursing (ADON) stated they had a bowel protocol and staff should follow it unless otherwise documented. She stated she could find no additional documentation of the resident receiving as needed medication per the bowel protocol.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		

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F 686	Continued From page 27	F 686		

by:
Based on observation, interviews, record reviews the facility failed to prevent the development of a pressure ulcer on one resident, (Resident #12). The facility reported a census of 25 residents.

Findings include:

The Minimum Data Set (MDS) completed with an Assessment Reference Date of 9/15/19 showed a Brief Interview for Mental Status score of 00, indicating severe cognitive impairment. The resident was at risk for pressure ulcers. The resident had diagnoses of displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal and Diabetes Mellitus.

A review of the Hospice Progress note dated 11/19/19, stated no concerns.

The Progress Note dated 11/21/19 at 9:00 PM, showed the resident had a blood blister to the left heel that measured approximately 2.5 centimeters (cm) by 2.5 cm. The nurse applied skin prep to the heel and then elevated the resident's feet on the pillow with bunny boots. The nurse indicated the facility would monitor the area per facility protocol.

A fax to the provider dated 11/22/19 informed of the blood blister to the resident's left heel measuring approximately 2.5 centimeters (cm) by 2.5 cm. The nurse reported the application of skin prep to the heel and indicated the facility would monitor the wound. The provider responded to noted.

A review of the Hospice Progress note dated 11/22/19, showed the left heel reddened. The

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F 686	Continued From page 28 Progress Note showed no documentation on the appearance of the right heel. A review of the Hospice Progress Note dated 11/24/19, indicated an observation of the left heel to be seen purple and the right heel to be observed pink. During an observation on 11/25/19 at 11:33 AM, observed the resident with padded blue boots to bilateral feet with feet elevated up on a pillow. During an observation on 11/25/19 at 3:45 PM, observed a large black area to the left heel. The heels visualized resting on the resident's bed in the padded blue boots. A deflated pillow observed to be under the resident's shins. During an interview on 11/25/19 at 3:55 PM, Staff A, Registered Nurse (RN), said the resident's peri-wound was observed to be improving. Staff A stated the wound continued to have a scab on it. She said she would observe the wound daily while completing the skin prep to the wound. Staff A said she had seen the wound earlier that day. Staff A stated the first observation of the area was on the prior Thursday. The facility intended for the Wound Nurse to observe the area to the resident when she came to the facility on Wednesday. Staff A said the wound would be measured and documented weekly. During an interview on 11/25/19 at 4:20 PM, the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN), reported the hospice provider sent the air mattress on the day the resident returned to the facility from the temporary evacuation. The ADON said prior to this the resident had an air overlay mattress.	F 686		

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F 686	Continued From page 29 The Braden Scale-For Predicting Pressure Sore Risk completed on 8/16/19 showed a score of 12, indicating high risk for pressure ulcers. A review of the resident's Care Plan problem, dated 11/17/11, showed the resident at risk for impaired skin integrity related to the diagnoses of diabetes, malnutrition, and dehydration. The goal documented said the resident's skin would remain intact. The problem included the following interventions; 1. Wound Nurse (ET) visit dated 4/6/17. 2. Heel protectors on when in bed dated 3/31/17. 3. ET Nurse consult as recommended dated 3/30/17. 4. Elevate lower extremities with pillows while in bed dated 3/20/17. 5. An air overlay to the bed dated 11/25/15. The review of the Care Plan showed the most recent intervention related to skin integrity to be dated 4/6/17. A review of the undated policy labeled, Identified Skin Concerns, stated the purpose was to provide resident's that have a pressure sore the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The purpose was to provide the essential care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The procedure indicated the following; 1. Make sure all preventative programs for skin at risk were in place. a. Mobility/Activity Deficit, b. Skin Care c. Moisture/Incontinence	F 686		

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F 686	Continued From page 30 d. Nutritional Deficit - Review protein needs and ensure adequate intake. 2. Complete the Resident Assessment Protocol for Pressure Ulcers to determine risk factors and causative factors. Utilize the information to establish goals and approaches for the plan of care. 3. The initial documentation needed to be completed with follow-up on areas not addressed. A. Preventative measures in place. B. Type of Wound. C. Location D. Stage E. Measurements F. Drainage G. Wound Base/phase H. Odor I. Surrounding Skin J. Conditions that may cause unavoidable pressure sores and/or any risk factors unable to control 4. Orders for wound treatment needed to be obtained from physicians by Nursing to aid in the healing process of all pressure wounds. The Nursing department would follow wound treatment orders as written or notify the physician if unable to complete the order for further instruction. The policy finished with the direction for the plan of care. The plan of care should ensure that all pressure and surgical wounds have identification in the plan of care.	F 686		
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	F 689		

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F 689	Continued From page 31 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 record reviews, the facility failed to prevent a resident from falling with the use of a mechanical lift for one of one resident reviewed, (Resident #12). Staff interview revealed the facility was aware the sling was not the correct sling for the mechanical lift used before the residents fall. Even after the resident's fall, the facility continued to use the sling and mechanical lift together. The facility reported a census of 25. Findings include: The Minimum Data Set (MDS) completed for Resident #12 with an Assessment Reference Date of 9/15/19 showed a Brief Interview for Mental Status score of 00, indicating severe cognitive impairment. The resident was at risk for pressure ulcers. The resident had diagnoses of displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal and Diabetes Mellitus. The form labeled, LTC Progress Note, dated 10/4/19, noted the resident saw the provider on nursing home rounds. The resident continued to be in a semi-attentive state. The resident required total care. The form labeled, Routine Nursing Home Rounds, dated 10/4/19, indicated the resident transitioned to the mechanical full-body lift as the	F 689		

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F 689	Continued From page 32 transfers with the standing lift were not appropriate at times. The Progress Note dated 11/13/19 at 12:15 PM, stated the nurse was requested to the resident's room. Upon arrival the resident was noted to be laying on her left side under the mechanical lift, head resting on the left of the lift with two CNAs present. The Progress Note reported a laceration noted to the back of the left side of the head, back of the left ear. The resident usually non-verbal sentences and only mumbles few words as per usual. Unable to obtain vital signs as resident was resistive with arms as per usual. Ambulance called, resident maintained in the same position until the ambulance arrived. At 12:40 PM, the resident was transported to the emergency room (ER) per ambulance. The provider notified per fax and the family was notified at 12:50 PM by the ADON. The Progress Note dated 11/13/19 at 3:30 PM, reported the resident returned from the ER per ambulance. Vital signs were a temperature of 100.2, a pulse of 56, respirations of 20 and blood pressure of 148/108. The discharge instructions were received. The resident was assisted in the bed with no bruises noted on the assessment. The resident received the scheduled Tylenol. The Progress Note dated 11/13/19 labeled 6 AM to 6 PM, out of order, indicated the charge nurse called the hospital about the resident. The nurse informed the hospital staff the resident had fallen on the left side and requested to make sure the resident's hip and shoulder were not affected. An ER charge nurse stated everything looked good with no injury to the hip or shoulder. The resident returned to the facility.	F 689		

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F 689	Continued From page 33 The Incident Report dated 11/13/19 indicated at 12:15 PM, the resident, was lifted into the mechanical lift when turned to move to the bed the resident slid to the floor. The resident was being raised in the mechanical lift by two CNAs to assist into bed, the left side of the sling came loose, and the resident slid to the floor. The resident went to the ER for assessment. The ER called to report the resident would be returning to the facility following a CT of the head and neck. No bleeds or fractures observed on the exam. The Fall-Investigation Report dated 11/13/19 at 1:30 PM, indicated transfer techniques were followed appropriately with no environmental concerns noted. No observation of the resident being combative at the time of the incident. The resident did hit their head and a neurological assessment flow sheet needed initiating. The corrective action taken was staff education on the use of mechanical resident lifts. The Root Cause Analysis Investigative Tool dated 11/13/19, described the incident as the resident slid out of the mechanical lift while being transferred. No report of vital signs as the nurse was unable to obtain. The resident noted to be non-verbal. The equipment involved was a non-faulty mechanical lift appropriately used. The intervention for the incident was staff education related to lift transferring training. The Fall Review Assessment Form dated 11/13/19 indicated the resident did not have a history of falls. The Physician Contact Form dated 11/13/19 indicated the resident slid out of the sling of the	F 689		

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F 689	Continued From page 34	F 689		

mechanical lift and landed on the floor. The resident went to the ER per ambulance.

The Emergency Department Tests, procedures, and medications form dated 11/13/19 indicated the resident had a CT to the head without intervenous (IV), CT to the cervical spine without IV, and blood work.

The Progress Note dated 11/13/19 at 8:20 PM, stated the resident fall follow-up showed a blood pressure of 132/88, the pulse of 84, the temperature of 100.1. The as-needed (PRN) Tylenol was given. The resident was unable to speak or verbalize pain.

The Progress Note dated 11/13/19 at 11:45 PM, revealed the resident was resting in bed with eyes closed with no facial grimacing or moaning at that time. The assessment showed no new injuries noted related to the fall, but the nurse would continue to observe.

The resident's chart lacked neuro assessments following the resident's fall.

The Progress Note dated 11/14/19 at 2:00 PM noted the resident observed resting in bed with no signs of pain. The resident's sutures to the head remained intact - temp 99.1. The resident's ROM observed to be normal per the resident's baseline. The resident received the scheduled Tylenol.

The Progress Note dated 11/14/19 at 4:00 PM, the fall follow-up showed the resident moved all extremities as the resident did before the fall. The nurse saw the resident with slight grimaces with movement. The resident's vital signs were a

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F 689	Continued From page 35	F 689		

temperature of 101.2, a pulse of 86, respirations of 20, and blood pressure of 156/70. The resident's temperatures ranged from 101.1 to 99.4 throughout the day - scheduled Tylenol given to the resident. The resident remained in the room for meals and ate 75-100% of meal. At 4:30 PM the provider was called regarding increased temperatures. The facility notified the family of the resident's status.

The Progress Note dated 11/14/19, the fall follow-up showed the resident denied pain when asked. The resident moved all extremities with ease with observed slight grimacing at times. The resident's vital signs were a temperature of 98.9, a pulse of 80, respirations of 18, a blood pressure of 139/76, and Oxygen saturation of 94% on room air. Scheduled Tylenol given for pain and to prevent the temperature from increasing throughout the shift. No new injuries noted to the resident, but the nurse would continue to monitor.

The resident's chart lacked assessment of the resident on 11/15/19.

The Progress Note dated 11/16/19 at 10:00 AM, reported a call placed to the provider related to concerns of the right hip pelvis area. An observation of the resident showed the resident to have swelling of the knee with non-verbal signs of pain. X-rays ordered and the resident sent to the hospital via ambulance.

The Progress Note dated 11/16/19 at 2:30 PM, stated the hospital notified of a displaced right hip with spiral fracture, fever, and increased blood pressure with increased d-dimer. The hospital would be running more tests and would call back with more information.

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F 689	Continued From page 36 The Progress Note dated 11/16/19 at 5:30 PM indicated a call received from the ER. The provider spoke with the family. The family requested the resident to return to the facility and on hospice level of care. The Progress Note dated 11/16/19 at 7:00 PM, noted the resident returned to the facility from the hospital via ambulance. The resident returned with new orders and diagnoses of spiral fracture to right hip and sepsis. The hospital inserted a catheter for the resident. New orders received for Rocephin 1 gram intermuscular for four days for sepsis with a referral to hospice. Progress Note dated 11/16/19 at 11:00 PM, indicated the resident planned for admission to hospice. The Emergency Room Visit Notes dated 11/16/19 indicated the resident arrived via an ambulance due to complaints of right hip pain and external rotation. The resident lived in nursing home but was residing at another care center due to boiler repairs. The facility reported the resident was in a mechanical lift on 11/13/19 to transfer the resident. The resident fell from the lift and hit her head. The resident was sent to the ER at that time and had a head CT with stitches placed. There was no report or noted injury reported to the resident's right hip at that time. The staff noted concerns with the right hip prior to sending the resident to the ER to be evaluated with x-rays. The resident had a history of dementia and was not able to give history at time of evaluation. The review of presenting symptoms indicated the resident did not report any pain, but after speaking with the resident's representative, the	F 689		

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patient's normal daily behavior was sitting in a chair with her face downward, eyes closed with little speech. The hip exam showed the hip non-tender with normal ROM, shortening of the right lower extremity, and deformity noted as external rotation. The provider was able to lift, externally, and internally rotate the leg with minimal to no grimacing. The medical decision making determined that the family discussed with the provider treatment options and family decided to forego surgical options and admit the resident to comfort care with a transition to hospice. The resident would return to the nursing home on hospice level of care. The resident would receive a catheter and Rocephin due to urinary infection with sepsis.

The Physician Contact Form dated 11/16/19 stated the resident went to the hospital for x-rays of the right femur, pelvis, and hip.

The Radiology - Diagnostic Imaging form dated 11/16/19 indicated the findings showed there was a displaced spiral subtrochanteric proximal femoral diaphyseal fracture. Severe right hip joint arthrosis was unchanged.

The Physician Contact Form dated 11/16/19 stated that the resident returned from the hospital with a noted right hip displaced spiral fracture on x-ray. The resident had new orders to admit to hospice level of care. The plan was for the resident to admit to hospice upon return to the facility.

The form labeled Hospice Medication Orders SNF dated 11/16/19 indicated an order to admit to hospice.

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F 689	Continued From page 38 The Care Plan dated 11/16/19, indicated the resident admitted to hospice. The Care Plan problem dated 11/16/18, indicated the resident was at risk for falls due to a history of falls at home and impaired gait. An intervention dated 11/1/19, showed the resident used the mechanical lift with the assist of two for transfers. The Care Plan interventions related to falls lacked documentation of new interventions following the 11/1/19 update. The form labeled, LTC Progress Note, dated 11/21/19, noted the resident was seen by provider on nursing home rounds. The resident had fallen approximately two weeks prior to the visit. At that time, the resident had a head CT and cervical neck CT that was normal. The resident noted to have hip issues but later noted to have a hip rotation, so the resident went back to the hospital. Once there, the hospital determined the resident had a right hip fracture. Due to the resident's advanced age and dementia, it was recommended not to do any treatments. The nursing staff felt her general mentation, breathing and lungs were all unchanged as long as not to move the hip excessively. The Major Injury Determination Form dated 11/14/19 indicated an injury occurred on 11/13/19 at 12:20 PM. The form stated the provider reviewed the circumstances of the incident causing the injury, the previous function ability of the patient, and the patient's prognosis, and determined the injury sustained was not a major injury. The rationale provided indicated the resident presented with neck pain, scalp laceration, no complaints of chest pain, abdominal pain, or joint paint - no complaints of	F 689		

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F 689	Continued From page 39 discomfort outside of the scalp and neck at that time. A Computed Tomography scan (CT) of the resident's head and neck were negative. The circumstances of the incident causing the injury was questioned to be from the strap on the mechanical lift sliding off. The resident's previous functional ability documented as total cares with activities of daily living (ADLs) and mechanical lift for transfers The Major Injury Determination Form dated 11/17/19 indicated an injury occurred on 11/13/19 at 12:15 PM. The form stated the provider reviewed the circumstances of the incident causing the injury, the previous function ability of the patient, and the patient's prognosis, and determined the injury sustained was a major injury. The circumstances of the incident causing the injury was documented to be related to the resident sliding out of the mechanical lift. The resident's previous functional ability recorded as total care. The Major Injury Determination Form dated 11/25/19 indicated an injury occurred on 11/13/19 at 12:15 PM. The form stated the provider reviewed the circumstances of the incident causing the injury, the previous function ability of the patient, and the patient's prognosis, and determined the injury sustained was not a major injury. The circumstances of the incident causing the injury was not documented on the form. The resident's previous functional ability recorded as total care with advanced dementia. The email dated 9/16/19, labeled Determination of Major Injury Requirements, stated additional notification was required to the director of the director's designee within twenty-four hours or the	F 689		

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next business day, by the most expeditious means available of any accident causing major injury. Major injury was defined as an injury which required consultation with the attending physician, designee of the physician or physician extender who determines in writing on a form designated by the department that an injury is a major injury based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis.

The Major Injury Determination Form, with no date provided, indicated the form needed completing if the facility was relying on the physician, designee, or extender to determine whether a major injury had occurred. The facility could independently determine that a major injury had occurred and submit a self-report. If the physician, designee, or extender determined a major injury had occurred, the signed form should be kept by the facility in the resident's clinical record, and the facility should notify the department of the major injury.

During an interview on 11/25/19 at 9:08 AM, the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN), reported the facility does an orientation checklist on hire for the employees for the mechanical lift training. They don't do specific training for the Agency staff with mechanical lifts. She stated the agency was responsible for this. She noted that the stated CNAs working with the resident was Staff C, Agency Certified Nurses' Aide (CNA), and Staff B, CNA.

During an interview on 11/25/19 at 9:12 AM, the Acting Director of Nursing (DON), Registered Nurse (RN), stated she was the nurse who initially

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F 689	Continued From page 41 responded to the fall. She noted the upper left strap was not on the hook of the mechanical lift arm. She stated the mechanical lift and the sling was another facilitys equipment. During an interview on 11/25/19 at 9:18 AM, the ADON stated there was an immediate staff education for the mechanical lifts following the fall. She said she believed it was reported either by Nurse Consultant or by the Administrator but wasn't sure so she would visit with the Administrator to find out. During an interview on 11/25/19 at 9:22 AM, the Administrator said she did not report the fall or the fracture to the Department of Inspections and Appeals. During an interview on 11/25/19 at 9:25 AM, the Acting DON and Assistant Director of Nursing stated that the fracture did not happen from the fall from the mechanical lift. They said the facility did not do an investigation related to an injury of unknown origin. The Administrator stated this was called in and followed the form but did not report it to the Department of Inspections and Appeals (DIA). During an interview with Staff C and Staff B on 11/25/19 at 10:37 AM Staff C said she told the facility they were the wrong slings, but they didn't get the correct slings. Even after the fall, they didn't get the right sling. Staff B said the mechanical lift was different from this facility's mechanical lift. Staff B said they did not get training for the mechanical lift. The other facilities mechanical lift had six small prongs, on each side of the lift. This facilitys lift has four but the prongs were much bigger. Staff C stated she was in	F 689		

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charge of pushing the button to raise the mechanical lift. Staff C said the fall happened so fast. Staff C said the nurse did check pulses and the resident was usually very stiff, so it was hard to check the range of motion (ROM). Staff C said the resident doesn't respond to pain doesn't even moan. Staff C stated the resident was moaning when they were asking if she was ok. Staff C and Staff B said the facility educated them on the use of mechanical lifts right after the fall. They reported the only staff that was present was the ADON from the other facility and the first and second shift staff that worked that day. The ADON from the other facility provided the education by getting into the mechanical lift sling, then was lifted by the her own staff into the air. The ADON shared to make sure everything was tight.

During an interview on 11/25/19 at 10:49 AM, Staff A, RN, said she sent the resident to the emergency room on 11/16/19. She stated before that assessment, the resident had no nonverbal cues of pain. She said that yes, she believed the fall caused the fracture.

During an interview on 11/25/19 at 8:13 AM, the resident's representative indicated the resident fell and staff reported it was the facility staff that was caring for the resident but the staff was using the equipment of a different facility. Resident #12's representative reported having the incident report and the hospital report.

During an interview on 12/12/19 at 10:43 AM, the ADON, stated if a fall occurred, the nurse was to go and do vitals immediately. Then the nurse would notify the Administrator, DON, Doctor and family. Once notifications were complete the

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F 689	Continued From page 43 nurse was to document everything and complete the fall packet. If the resident hit their head or had dementia the facility was to do standard neuro checks. Then add the incident to the nurse report sheet to pass on to the other shifts for follow-up. The nurse then should put in an entry in each shift for three days is what they would normally do. Any new orders would be added to the MAR. The nurse would notify the family if applicable with any new orders. If the provider says noted then there would be nothing to notify the family about. During a follow-up interview on 12/12/19 at 11:16 AM, the ADON stated if a major injury occurred, she would notify the Administrator or DON who would report it to the state if necessary. The DON could do it but the Administrator was excellent about getting it done and reported. During a follow-up interview on 12/12/19 at 11:18 AM, the Administrator stated she would follow the flow sheet to determine when to report it to the state. During a follow-up interview on 12/12/19 at 1:40 PM, the Acting DON said no completion of neuros done as the resident was sent to the ER and had a CT of her head. The form labeled, Accidents/Incidents Investigation and Reporting Policy and Procedure, dated 7/7/08, stated accidents and incidents must be investigated and reported to the Director of Nursing for quality assurance review. The follow-up assessment and documentation of the resident's accident or incident needed completed every shift for 72 hours. One definition of a fall was indicated to be	F 689		

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F 689	Continued From page 44 a witnessed accident or injury. The form labeled, Fall Protocol, stated fall follow-up assessments would proceed for 72 hours post-incident. Range of Motion, neuro assessment if the resident struck their head or if a fall was unwitnessed even with a BIMS over 11, pain assessment, skin assessment, and fall assessment following the incident. Should the immediate assessment show or reveal any potential injury, the primary care provider (PCP) should be notified of the concern immediately for intervention. If the resident showed any signs or symptoms of potential injury or change in the condition, the facility was to inform the PCP for further intervention. Fall prevention interventions would be care planned per facility protocol following investigation.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		

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F 690	Continued From page 45 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide aseptic technique while emptying a catheter for one of two residents reviewed (Resident #12) the facility failed to provide aseptic technique while providing perineal cares for one of six residents reviewed (Resident #4) and the facility failed to ensure there was a clinical indication for 1 of 2 residents with a urinary catheter (Resident #3). The facility reported a census of 25. Findings include: 1. The Minimum Data Set (MDS) completed for Resident #12 with an Assessment Reference Date (ARD) of 9/15/19 showed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The resident was at risk for pressure ulcers. The resident had diagnoses of displaced spiral fracture of the	F 690		

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F 690	Continued From page 46 subtrochanteric proximal right femoral diaphyseal and Diabetes Mellitus. During an observation on 11/25/19 at 11:25 AM, observed the resident have a catheter in a privacy bag hanging from the foot of the bed frame off of the floor. Staff C, Certified Nurses' Aide (CNA), emptied the catheter bag into a graduate. Upon finishing the emptying of the catheter, Staff C tapped the end of the drainage tube on the graduate then cleansed the drainage tube with an alcohol wipe. Once completed, Staff C dumped the urine into the toilet. Staff C then placed the graduate into a bag on the floor without rinsing out the graduate. Staff C removed her gloves and washed her hands. Staff C walked back into the bathroom to shut off the light before leaving the resident's room. The graduate remained in the bag on the floor, not rinsed. A review of the resident's Care Plan lacked of documentation related to the resident's use of a catheter. The Progress Note dated 11/16/19 at 7:00 PM, stated the resident returned to the facility from the hospital via the ambulance. The resident returned with new orders and diagnoses. The new diagnoses included a diagnosis of spiral fracture to the right hip and sepsis. The resident had a catheter placed at the hospital. The Emergency Room visit note dated 11/16/19, showed documentation the resident was started on Vancomycin related to sepsis until the source identified. The suspected cause for the sepsis was potentially associated with positive urinalysis. The provider wrote for a catheter to be used daily for incontinence.	F 690		

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F 690	Continued From page 47 During an interview on 11/25/19 at 5:52 PM, the Acting Director of Nursing said she would expect the catheter to be put on to the care plan. Revision of the care plan expected to update within 24 hours of a change in a resident. The Acting Director of Nursing reported she would not expect the CNA to tap the drainage end of the catheter on the graduate and she would expect the CNA to rinse the graduate after emptying the catheter. 2. The MDS completed for Resident #4 with an ARD of 8/17/19 showed a BIMS score of 00, indicating severe cognitive impairment. The MDS showed the resident always incontinent of urine and frequently incontinent of stool. The resident had diagnoses of Parkinson's Disease and Dementia. During an observation on 11/25/19 at 12:19 PM, witnessed Staff D, Certified Nurses' Aide (CNA), walk into the resident's room without completing hand hygiene and proceed to ask the resident to stand up, then walked the resident to the bathroom. Staff D applied gloves, then pulled down the resident's pants and removed the dirty liner without washing hands or changing gloves placed a new liner into the resident's pants. With the same gloves on, Staff D then walked into the resident's room from the bathroom. Noted a strong urine smell odor coming from the bathroom. Staff D, walked back into the bathroom to assist the resident with the same gloves on and no completed hand hygiene. Staff D removed wipes from the package and wiped the front of the resident. Following this, the CNA with the same gloves on took a wet washcloth and sprayed with cleanser. Staff D cleansed the urine	F 690		

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F 690	Continued From page 48 off the floor from in between the resident's legs. Without changing gloves or hand hygiene, Staff D then checked the resident's pants and noted dampness on the resident's pants. Staff D continued with the same gloves and went into the resident's closest and got out a clean pair of pants for the resident. Staff D took the clean pants and went to the resident in the bathroom. Staff D removed the damp pants, with the same initial pair of gloves, and put on the new pair of pants. Staff D then stood resident with the same gloves. Staff D got the wipe package and removed two wipes, then cleansed the resident's backside crease, then got more wipes from the container and continued to wipe the resident's crease of the buttocks. Staff D then took wipes out of the package two more times with the same gloves and no hand hygiene. Staff D dropped a dirty wipe onto the floor, and then picked up the wipe and placed it into the garbage. Staff D proceeded to clean the resident with wipes pulled from the package. Staff D has yet to complete hand hygiene or change gloves. Staff D continued to wipe the resident removing wipes from the container an additional seven more times, only wiping up the center of the resident. No cleaning of the buttocks or thighs observed. Staff D finished cleaning the resident and pulled up the resident's pants. Staff D removed her gloves and helped the resident to the bed without hand hygiene. Staff D adjusted the resident's legs into the bed and then adjusted the resident's pillow. Staff D covered the resident and gave the resident the call light. Staff D entered the bathroom and cleaned up the garbage and the laundry, wearing one glove on the left hand and no glove on the right hand. Staff D replaced the garbage bag, closed the wipe package, and placed the container onto the back of the toilet.	F 690		

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F 690	Continued From page 49 Staff D left the bathroom and replaced the alarm on the bathroom door. Staff D left the resident's room and went to the dirty utility hallway to put away the dirty laundry and garbage. No hand hygiene noted throughout the entire observation. During an interview on 11/25/19 at 5:52 PM, the Acting Director of Nursing stated the CNA should have washed her hands when providing care to the resident and when changing her gloves. The Acting Director of Nursing said she would expect the CNA to change her gloves while providing care and she should have washed her hands before putting on new clean pants on the resident. The undated policy labeled, Peri Care Policy and Procedure, directed staff to wash their hands with soap and water after explaining the process to the resident. The staff was to clean the female resident by separating the labia, wiping front to back, including the inner and outer thighs. The policy directed the staff to wash across the abdomen from navel to groin then hip to hip. 3. During the initial screening on 11/24/19 at 1:05 PM, Resident # 3 was noted to have a urinary catheter in a dignity bag underneath her wheelchair. Review of the Minimum Data Set (MDS) dated 8/10/19 documented Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The MDS documented diagnoses including Hypertension, Muscle Weakness (generalized) and Difficulty in Walking, not elsewhere classified. There was no documented diagnosis of Neurogenic Bladder or	F 690		

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F 690	Continued From page 50 Obstructive Uropathy. A review of Resident # 3's face sheet documented a diagnosis of over active bladder. There was no other bladder related diagnosis. Review of the Care Plan dated 11/14/18 documented an intervention of Foley Catheter placed by hospice due to retention and recurrent UTIs. A Physician Contact Form dated 10/7/19, sent to the physician by the facility stated the resident may benefit from discontinuing (D/C) the Foley catheter (urinary catheter). The facility also documented there is no clear explanation in the resident's chart for why the catheter was inserted. The physician documented it was ok to D/C the Foley. The order was noted on 10/7/19 with a note documenting the family did not want the Foley taken out. Review of Nurse Notes dated 10/7/19 at 2:30 PM, documented the primary care provider (PCP) was in agreement with the facility regarding the removal of the catheter but the family did not want the catheter removed. There is no documentation the PCP was notified the family did not want the catheter removed or that the catheter was left in per the family's request. There was no documentation regarding family education including the risks and benefits of having a urinary catheter in place that is not clinically indicated. During an interview on 11/24/19 at 3:13 PM with Resident # 3's daughter, she stated she thought the catheter was placed due to Resident # 3 being unable to empty her bladder and Urinary	F 690		

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F 690	Continued From page 51 Tract Infections (UTI).	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to manage the resident's pain to the extent of the resident's goal and preferences for one of two residents reviewed (Resident #7). The facility reported a census of 25 residents. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 8/20/19 showed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The resident had diagnoses of chronic pain and gastroesophageal reflux disease without esophagitis. During an interview on 11/24/19 at 11:57 AM, the resident reported only being able to have Tylenol and ibuprofen. However, it did not help and continued to have more pain in her back. The resident stated the Tylenol upset her stomach. The Routine Nursing Home Rounds form dated 9/19/19, showed an order for Tramadol 50 milligrams (mg) every six hours as needed for pain.	F 697		

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F 697	Continued From page 52 The Medication Administration Record for the month of September 2019 showed an order for Tramadol 50 mg every six hours as needed. The order was initialed for use nine times from 9/19/19 until 9/25/19. The PRN Medication Notes for the dates from 9/11/19 until 10/11/19, showed documentation of use for the tramadol thirteen times. Of the thirteen doses documented, the nurses recorded eight times the medication was effective. The following five times showed no documentation related to the effectiveness of the drug. A review of a fax to Physician dated 9/26/19, noted the resident had increased urinary incontinence and increased medication seeking behaviors. The resident refused all alternate forms of pain relief demanding tramadol. The script was filled on 9/18/19 and the resident only had two tablets left. The nurse requested to discontinue the tramadol and return to 650 mg Tylenol three times a day. The Physician responded to stop the tramadol and start Tylenol 650 milligrams (mg) three times a day, and ask the nurse practitioner to see for follow-up. The PRN Medication Notes dated from 9/27/19 through 10/11/19 showed twelve doses of ibuprofen given. Of the twelve doses given, only three showed documentation related to effectiveness. The remaining nine doses show no documentation of efficacy. During an interview on 11/25/19 at 5:45 PM, Staff A, Registered Nurse (RN), stated the resident was not displaying medication seeking behavior but was asking for the drug very frequently and	F 697		

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F 697	Continued From page 53 then would ask for more. She said the medication was not attempted to be scheduled to see if the pain improved as the resident would not have to ask for the medicine. The resident did have a history of having therapy for her back pain and utilized topical pain relievers. Staff A said the resident's pain would happen in spurts. During an interview on 11/26/19 at 10:13 AM, the Acting Director of Nursing stated the resident had a history of medication seeking behaviors. She stated a nurse should not request to discontinue a pain-relieving medication if the resident reported they had pain. The policy dated 9/1/19 labeled, Pain Management Protocol, defined the policy of the facility to assess the residents for the presence of pain and manage accordingly to improve the quality of life. The facility would provide the residents with the most effective method of pain relief. The facility should monitor the resident's response to the treatment plan and adjusted as needed (PRN). If there was not an acceptable level of pain relief as perceived by the resident, the nurse should contact the Physician for re-evaluation or medical intervention orders. All PRN medications must have documentation on the PRN MAR with the effectiveness noted.	F 697		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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	F 726		

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F 726	Continued From page 54 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to assess a resident following a fall from a mechnical lift resulting in a displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal for one of one resident's reviewed (Resident #12). The facility reported a census of 25. Findings include: The Minimum Data Set (MDS) completed for Resident #12 with an Assessment Reference Date (ARD) of 9/15/19 showed a Brief Interview	F 726		

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F 726	Continued From page 55 for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS determined that the resident was at risk for pressure ulcers. The resident had diagnosed displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal and Diabetes Mellitus. The form labeled, LTC Progress Note, dated 10/4/19, noted the resident saw the provider on nursing home rounds. The resident continued to be in a semi-attentive state. The resident required total care. The form labeled, Routine Nursing Home Rounds, dated 10/4/19, indicated the resident transitioned to the mechanical full-body lift as the transfers with the standing lift were not appropriate at times. The Progress Note dated 11/13/19 at 12:15 PM, stated the nurse was requested to the resident's room. Upon arrival the resident was noted to be laying on her left side under the mechanical lift, head resting on the left of the lift with two CNAs present. The Progress Note reported a laceration noted to the back of the left side of the head, back of the left ear. The resident usually non-verbal sentences and only mumbles few words as per usual. Unable to obtain vital signs as a resident was resistive with arms as per usual. Ambulance called, resident maintained in the same position until the ambulance arrived. At 12:40 PM, the resident was transported to the emergency room (ER) per ambulance. The provider notified per fax and the family was notified at 12:50 PM by the ADON. The Progress Note dated 11/13/19 at 3:30 PM,	F 726		

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F 726	Continued From page 56	F 726		

reported the resident returned from the ER per ambulance. Vital signs were a temperature of 100.2, a pulse of 56, respirations of 20 and blood pressure of 148/108. The discharge instructions were received. The resident assisted in the bed with no bruises noted on the assessment. The resident received the scheduled Tylenol.

The Progress Note dated 11/13/19 labeled 6 AM to 6 PM, out of order, indicated the charge nurse called the hospital about the resident. The nurse informed the hospital staff the resident had fallen on the left side and requested to make sure the resident's hip and shoulder were not affected. An ER charge nurse stated everything looked good with no injury to the hip or shoulder. The resident returned to the facility.

The Incident Report dated 11/13/19 indicated at 12:15 PM, the resident, was lifted into the mechanical lift when turned to move to the bed the resident slid to the floor. The resident was being raised in the mechanical lift by two CNAs to assist into bed, the left side of the sling came loose, and the resident slid to the floor. The resident went to the ER for assessment. The ER called to report that the resident would be returning to the facility following a CT of the head and neck. No bleeds or fractures observed on the exam.

The Fall-Investigation Report dated 11/13/19 at 1:30 PM, indicated transfer techniques were followed appropriately with no environmental concerns noted. No observation of the resident being combative at the time of the incident. The resident did hit their head, and a neurological assessment flow sheet needed initiating. The corrective action taken was staff education on the

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F 726	Continued From page 57 use of mechanical resident lifts. The Root Cause Analysis Investigative Tool dated 11/13/19, described the incident as the resident slid out of the mechanical lift while being transferred. No report of vital signs as the nurse was unable to obtain. The resident noted to be non-verbal. The equipment involved was a non-faulty mechanical lift appropriately used. The intervention for the incident was staff education related to lift transferring training. The Fall Review Assessment Form dated 11/13/19 indicated the resident did not have a history of falls. The Physician Contact Form dated 11/13/19 indicated the resident slid out of the sling of the mechanical lift and landed on the floor. The resident went to the ER per ambulance. The Emergency Department Tests, procedures, and medications form dated 11/13/19 indicated the resident had a CT to the head without intervenous (IV), CT to the cervical spine without IV, and blood work. The Progress Note dated 11/13/19 at 8:20 PM, stated the resident fall follow-up showed a blood pressure of 132/88, the pulse of 84, the temperature of 100.1. The as-needed (PRN) Tylenol was given. The resident was unable to speak or verbalize pain. The Progress Note dated 11/13/19 at 11:45 PM, revealed the resident was resting in bed with eyes closed with no facial grimacing or moaning at that time. The assessment showed no new injuries noted related to the fall, but the nurse would	F 726		

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F 726	Continued From page 58 continue to observe. The resident's chart lacked neuro assessments following the resident's fall. The Progress Note dated 11/14/19 at 2:00 PM noted the resident observed resting in bed with no signs of pain. The resident's sutures to the head remained intact - temp 99.1. The resident's ROM observed to be normal per the resident's baseline. The resident received the scheduled Tylenol. The Progress Note dated 11/14/19 at 4:00 PM, the fall follow-up showed the resident moved all extremities as the resident did before the fall. The nurse saw the resident with slight grimaces with movement. The resident's vital signs were a temperature of 101.2, a pulse of 86, respirations of 20, and blood pressure of 156/70. The resident's temperatures ranged from 101.1 to 99.4 throughout the day - scheduled Tylenol given to the resident. The resident remained in the room for meals and ate 75-100% of meal. At 4:30 PM the provider was called regarding increased temperatures. The facility notified the family of the resident's status. The Progress Note dated 11/14/19, the fall follow-up showed the resident denied pain when asked. The resident moved all extremities with ease with observed slight grimacing at times. The resident's vital signs were a temperature of 98.9, a pulse of 80, respirations of 18, a blood pressure of 139/76, and Oxygen saturation of 94% on room air. Scheduled Tylenol given for pain and to prevent the temperature from increasing throughout the shift. No new injuries noted to the resident, but the nurse would continue to monitor.	F 726		

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F 726	Continued From page 59 The resident's chart lacked assessment of the resident on 11/15/19. The Progress Note dated 11/16/19 at 10:00 AM, reported a call placed to the provider related to concerns of the right hip pelvis area. An observation of the resident showed the resident to have swelling of the knee with non-verbal signs of pain. X-rays ordered and the resident sent to the hospital via ambulance. The Progress Note dated 11/16/19 at 2:30 PM, stated the hospital notified of a displaced right hip with spiral fracture, fever, and increased blood pressure with increased d-dimer. The hospital would be running more tests and would call back with more information. The Progress Note dated 11/16/19 at 5:30 PM indicated a call received from the ER. The provider spoke with the family. The family requested the resident to return to the facility and on hospice level of care. The Progress Note dated 11/16/19 at 7:00 PM, noted the resident returned to the facility from the hospital via ambulance. The resident returned with new orders and diagnoses of spiral fracture to right hip and sepsis. The hospital inserted a catheter for the resident. New orders received for Rocephin 1 gram intermuscular for four days for sepsis with a referral to hospice. Progress Note dated 11/16/19 at 11:00 PM, indicated the resident planned for admission to hospice. The Emergency Room Visit Notes dated 11/16/19	F 726		

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F 726	Continued From page 60 indicated the resident arrived via an ambulance due to complaints of right hip pain and external rotation. The resident lived in nursing home but was residing at another care center due to boiler repairs. The facility reported the resident was in a mechanical lift on 11/13/19 to transfer the resident. The resident fell from the lift and hit her head. The resident was sent to the ER at that time and had a head CT with stitches placed. There was no report or noted injury reported to the resident's right hip at that time. The staff noted concerns with the right hip prior to sending the resident to the ER to be evaluated with x-rays. The resident had a history of dementia and was not able to give history at time of evaluation. The review of presenting symptoms indicated the resident did not report any pain, but after speaking with the resident's representative, the patient's normal daily behavior was sitting in a chair with her face downward, eyes closed with little speech. The hip exam showed the hip non-tender with normal ROM, shortening of the right lower extremity, and deformity noted as external rotation. The provider was able to lift, externally, and internally rotate the leg with minimal to no grimacing. The medical decision making determined that the family discussed with the provider treatment options and family decided to forego surgical options and admit the resident to comfort care with a transition to hospice. The resident would return to the nursing home on hospice level of care. The resident would receive a catheter and Rocephin due to urinary infection with sepsis. The Physician Contact Form dated 11/16/19 stated the resident went to the hospital for x-rays of the right femur, pelvis, and hip.	F 726		

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F 726	Continued From page 61 The Radiology - Diagnostic Imaging form dated 11/16/19 indicated the findings showed there was a displaced spiral subtrochanteric proximal femoral diaphyseal fracture. Severe right hip joint arthrosis was unchanged. The Physician Contact Form dated 11/16/19 stated that the resident returned from the hospital with a noted right hip displaced spiral fracture on x-ray. The resident had new orders to admit to hospice level of care. The plan was for the resident to admit to hospice upon return to the facility. The form labeled Hospice Medication Orders SNF dated 11/16/19 indicated an order to admit to hospice. The Care Plan dated 11/16/19, indicated the resident admitted to hospice. The Care Plan problem dated 11/16/18, indicated the resident was at risk for falls due to a history of falls at home and impaired gait. An intervention dated 11/1/19, showed the resident used the mechanical lift with the assist of two for transfers. The Care Plan interventions related to falls lacked documentation of new interventions following the 11/1/19 update. The form labeled, LTC Progress Note, dated 11/21/19, noted the resident was seen by provider on nursing home rounds. The resident had fallen approximately two weeks prior to the visit. At that time, the resident had a head CT and cervical neck CT that was normal. The resident noted to have hip issues but later noted to have a hip rotation, so the resident went back to the hospital. Once there, the hospital determined the resident	F 726		

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had a right hip fracture. Due to the resident's advanced age and dementia, it was recommended not to do any treatments. The nursing staff felt her general mentation, breathing and lungs were all unchanged as long as not to move the hip excessively.

During an interview on 11/25/19 at 9:25 AM, the Acting DON and Assistant Director of Nursing stated the fracture did not happen from the fall from the mechanical lift. They said the facility did not do an investigation related to an injury of unknown origin. The Administrator stated this was called in as she followed the form but did not report it to the Department of Inspections and Appeals (DIA).

During an interview on 11/25/19 at 10:37 AM, Staff C said she told the facility they were the wrong slings, but they didn't get the correct slings. Even after the fall, they didn't get the right sling. Staff B said that the mechanical lift was different from this facility's mechanical lift. Staff B said they did not get training for the mechanical lift. The other facilities mechanical lift had six small ones prongs on each side of the lift. This facilitys lift has four but the prongs were much bigger. Staff C stated she was in charge of pushing the button to raise the mechanical lift. Staff C said the fall happened so fast. Staff C said the nurse did check pulses, and the resident was usually very stiff, so it was hard to check the range of motion (ROM). Staff C said the resident doesn't respond to pain doesn't even moan. Staff C stated the resident was moaning when they were asking if she was ok. Staff C and Staff B said the facility educated them on the use of mechanical lifts right after the fall. They reported the only staff that was present was the ADON from the other facility and

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F 726	Continued From page 63 the first and second shift staff that worked that day. The ADON from the other facility provided the education by getting into the mechanical lift sling, then was lifted by her own staff into the air. The ADON shared to make sure everything was tight. During an interview on 11/25/19 at 10:49 AM, Staff A, Registered Nurse (RN), said she sent the resident to the emergency room (ER) on 11/16/19. She stated before that assessment, the resident had no nonverbal cues of pain. She said that yes, she believed the fall caused the fracture. During a follow-up interview on 12/12/19 at 10:43 AM, the ADON said if a fall occurred, the nurse was to go and do vitals immediately. Then the nurse would notify the Administrator, DON, Doctor, and family. Once notifications were complete the nurse was to document everything and complete the fall packet. If the resident hit their head or had dementia the facility was to do standard neuro checks. Then add the incident to the nurse report sheet to pass on to the other shifts for follow-up. The nurse then should put in an entry in each shift for three days is what they would normally do. Any new orders would be added to the MAR. Then the nurse would notify the family if applicable with any new orders. If the provider says noted then there would be nothing to notify the family about. During a follow-up interview on 12/12/19 at 1:40 PM, the Acting DON said no completion of neuros were done as the resident was sent to the ER and had a CT of her head. The form labeled accidents/incidents investigation and reporting policy and procedure dated 7/7/08	F 726		

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F 726	Continued From page 64 stated accidents and incidents must be investigated and reported to the Director of Nursing for quality assurance review. The follow-up assessment and documentation of the resident's accident or incident needed completed every shift for 72 hours. One definition of a fall was indicated to be a witnessed accident or injury. The form labeled fall protocol stated fall follow-up assessments would proceed for 72 hours post-incident. ROM, neuro assessment if the resident struck their head or if a fall was unwitnessed even with a BIMS over 11, pain assessment, skin assessment, and fall assessment following the incident. Should the immediate assessment show or reveal any potential injury, the primary care provider (PCP) should be notified of the concern immediately for intervention. If the resident showed any signs or symptoms of potential injury or change in the condition, the facility was to inform the PCP for further intervention. Fall prevention interventions would be care planned per facility protocol following investigation.	F 726		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		

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F 803	Continued From page 65 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and resident interviews the facility failed to follow the menu to meet the nutritional requirements of the residents. The facility reported a census of 25 residents. Findings include: Observed meal serving on 11/24/19 at 12:30 PM. The meal served was herbed pork loin, pork gravy, baked sweet potato, mixed vegetables, roll/margarine, pie, milk. No bread and butter was served to any of the residents. The Weekly Menu approved by the Registered Dietician for the week of 11/24/19 documented bread and margarine would be served with the noon meal. In an interview with the Dietary Manager on 11/24/19 at 5:00 PM, she acknowledged that	F 803		

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	165445	A. BUILDING _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT LAKE PA	1304 SOUTH MARKET LAKE PARK, IA 51347

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F 803	Continued From page 66 bread and butter was on the menu and it should have been served. She stated she forgot to put it out on the counter as she was serving the trays.	F 803		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility policy review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility reported a census of 25 residents. Findings include: Observation of the kitchen on 11/24/19 at 10:30 AM revealed the following:	F 812		

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F 812	Continued From page 67 a) Two walls in the corner under the dishwasher had significant water damage to the wall board. It was deteriorating and blackened. There was a dirty, stained towel under the dishwasher. b) An observation of the storage area revealed six bags of hamburger buns from the bakery with no dates and three bags of raisin bread with no dates. c) An observation of the plastic cutting boards revealed three of the six were damaged to the point of them being not sanitizable. d) An observation of a deep dish used to serve lunch to resident #15 on 11/24/19 at 11:47 AM, had a chipped corner with sharp edges. In an interview with the Dietary Manager on 11/24/19 at 1:00PM, she stated she had done some spraying of dishes earlier in the morning and had thrown a towel on the floor below to soak up the overspray. She stated maintenance was aware of the damaged wall boards. In an interview with the Maintenance Manager on 11/24/19 at 2:30PM ,he stated he is aware of the damage under the dishwasher and he has some materials ordered to repair the area. The Dietary Manager also stated the unmarked buns had been in the kitchen since last week and the raisin bread was from over a week ago but did not know the date for sure. In an interview with the Dietary Manger on 11/25/19 9:55AM, she revealed she had noticed the dish she used to serve resident #15 had a	F 812		

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F 812	Continued From page 68 chip out of it. She then went on to say she would throw it away. She stated they have other deep dish bowls that can be used to fulfill the residents needs.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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	F 880		

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F 880	Continued From page 69 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and record reviews, the facility failed to follow appropriate infection control techniques while providing care for one of twelve residents reviewed (Resident #4). The facility reported a census of 25.	F 880		

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F 880	Continued From page 70 Findings include: The Minimum Data Set completed for Resident #4 with an Assessment Reference Date of 8/17/19 showed a BIMS score of 00, indicating severe cognitive impairment. The MDS showed the resident always incontinent of urine and frequently incontinent of stool. The resident had diagnoses of Parkinson's Disease and Dementia. During an observation on 11/25/19 at 12:19 PM, witnessed Staff D, Certified Nurses' Aide (CNA), walk into the resident's room without completing hand hygiene and proceed to ask the resident to stand up, then walked the resident to the bathroom. Staff D applied gloves, pulled down the resident's pants and removed the dirty liner and without washing hands or changing gloves placed a new liner into the resident's pants. With the same gloves on, Staff D walked into the resident's room from the bathroom. Noted a strong urine smell odor coming from the bathroom. Staff D, then walked back into the bathroom to assist the resident with the same gloves on and no completed hand hygiene. Staff D removed wipes from the package and wiped the front of the resident. Following this, the CNA with the same gloves on took a wet washcloth and sprayed with cleanser. Staff D cleansed the urine off the floor from in between the resident's legs. Without changing gloves or hand hygiene, Staff D checked the resident's pants and noted dampness on the resident's pants. Staff D, continued with the same gloves and went into the resident's closest and got out a clean pair of pants for the resident. Staff D took the clean pants and went to the resident in the bathroom. Staff D removed the damp pants, with the same	F 880		

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F 880	Continued From page 71 initial pair of gloves, and put on the new pair of pants. Staff D then stood resident with the same gloves. Staff D got the wipe package and removed two wipes, then cleansed the resident's backside crease, then got more wipes from the container and continued to wipe the resident's crease of the buttocks. Staff D then took wipes out of the package two more times with the same gloves and no hand hygiene. Staff D dropped a dirty wipe onto the floor and picked up the wipe and placed it into the garbage. Staff D went and proceeded to clean the resident with wipes pulled from the package. Staff D continued to wipe the resident removing wipes from the container an additional seven more times, only wiping up the center of the resident. No cleaning of the buttocks or thighs observed. Staff D finished cleaning the resident and pulled up the resident's pants. Staff D removed her gloves and helped the resident to the bed without hand hygiene. Staff D adjusted the resident's legs into the bed and then adjusted the resident's pillow. Staff D covered the resident and gave the resident the call light. Staff then entered the bathroom and cleaned up the garbage and the laundry, wearing one glove on the left hand and no glove on the right hand. Staff D replaced the garbage bag, closed the wipe package, and placed the container onto the back of the toilet. Staff D left the bathroom and replaced the alarm on the bathroom door. Staff D left the resident's room and went to the dirty utility hallway to put away the dirty laundry and garbage. No hand hygiene noted throughout the entire observation. During an interview on 11/25/19 at 5:52 PM, the Acting Director of Nursing stated the CNA should have washed her hands when providing care to the resident and when changing her gloves. The	F 880		

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F 880	Continued From page 72 Acting Director of Nursing said she would expect the CNA to change her gloves while providing care and that she should have washed her hands before putting on new clean pants on the resident. The undated policy labeled Handwashing indicated that all employees were to wash their hands at the following times; 1. Before contact with residents and between resident contacts. 2. After contact with a source that was likely to be contaminated with microorganisms. 3. Before gloving and after removal of gloves 4. After handling the resident's belongings.	F 880		

Rec'd 1-2-2020

Pearl Valley Rehabilitation- Lake Park Facility ID: 165445 1304 South Market Lake Park, Iowa 51347 712-832-9548

Provider's Plan of Correction:

Date Survey Completed: December 12, 2019

F000-The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies by Pearl Valley Rehab - Lake Park. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F576-Right to Forms of Communication w/ Privacy

Facility failed to provide the residents access to mail on Saturdays. The facility does and will continue to follow mail delivery requirements per state and federal regulations. Admin, ADON and DON have been educated on the delivery of mail on weekends. Facility will ensure that Saturday mail is scheduled for delivery each weekend by facility designated staff.
Admin, DON or designee will perform random audits of Saturday mail delivery. Audits will occur weekly x4 weeks, biweekly x4 weeks, monthly x 4 weeks and then quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further implementation of system improvement as indicated.

Compliance date of: 12/13/19

F578-Request/Refuse/Discontinue Treatment; Formulate Adv Dir

Facility failed to ensure there was a code status documented for 1 of 16 residents reviewed. The facility does and will continue to follow resident IPOST and code status posting criteria per state and federal regulations. DON, Admin and ADON have been educated on the need for all code status and I Post information to match and to be posted for staff awareness per facility protocols in facility designated location. DON or designee will perform random weekly audits x4 weeks, then biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further implementation of system improvements as indicated. Compliance date of: 12/13/19

F584-Safe/Clean/Comfortable/Homelike Environment

Facility failed to ensure the cleanliness of the Building.

Admin, DON and housekeeping supervisor have been educated on the requirements of providing a clean and home like environment for all residents. Housekeeping has been educated on cleaning windowsills with each deep cleaning of room. Admin or designee will audit cleaning of the resident rooms and windowsills at random times weekly x4 weeks, biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further implementation of system improvement as indicated.

Compliance date of: 12/13/19

F607-Develop/Implement Abuse/Neglect Policies

Facility failed to obtain Department of Human Services (DHS) approval for staff with criminal history to work in the facility for 2 of 5 staff reviewed.
Administrator and DON have been educated on all steps of pre hire criminal background checks prior to hiring new staff. Admin or designee will perform random audits of all new hire paperwork and background checks weekly x4 weeks, biweekly x4 weeks, monthly x4 weeks and then on a monthly basis for the remainder of the year. All findings will be submitted through quarterly QA and QAPI process for further system improvement implementation as indicated.

Compliance date of: 12/13/19

F609-Reporting of Alleged Violations

Facility failed to report a major injury with in twenty-four hours of determining a major injury had occurred for one of one resident reviewed. Facility does and will continue to follow required self-reporting criteria per state and federal regulations. DON, ADON and Administrator have been educated on the requirements of timely self-reporting to DIA for investigation of major injuries and allegations which require self-reporting. Administrator, DON or designee will perform auditing process will occur with each individual major injury within 24/hrs of incident occurrence to assure facility is meeting regulatory compliance for reporting. All findings to be submitted through quarterly QA and QAPI process for further system improvement implementation as indicated.

Compliance date of: 12/13/19

F657-Care Plan Timing and Revision

Facility failed to revise the care plan to demonstrate an accurate picture of the resident's plan of care for 4 of 12 residents reviewed. The facility does and will continue to provide required care plan revision and implementation per facility policy and procedure. DON and MDS have been educated on the care plan revision requirements and facilities policy for care plan implementation and updates. DON or designee will perform random audits on a weekly basis x4 week, biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year.

All findings to be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/13/19

F661-Discharge Summary

Facility failed to develop a discharge summary which included a recapitulation of resident's stay, final summary of resident status and reconciliation of all pre and post discharge medications for one of one closed record Reviewed. The facility does and will continue to follow discharge policy and procedures for all residents being discharged from the facility. DON and MDS have been educated on the requirement of discharge summary and recapitulation of stay for all discharging residents. DON or designee will perform random weekly audits of all discharged resident documentation for completion of discharge summary/recapitulation of stay. Audits will occur on a weekly basis x4 weeks, biweekly x4 weeks, monthly 4 weeks and then quarterly for the remainder of the year. All findings will be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/13/19

F684-Quality of Care

Facility failed to provide adequate assessment and timely intervention for 1 of 12 active residents reviewed. The facility does and will continue to follow bowel assessment and intervention protocols per policies and procedures. Clinical staff educated on the bowel protocol, assessment and following physician orders. DON or designee will monitor Bowel activity documentation and compliance with bowel protocols. DON or designee will perform random audits of bowel activity logs/tracking and compliance with bowel protocols. Audits will occur at random times weekly x4 wks, biweekly x4 weeks and then monthly for the remainder of the year. All findings will be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/13/19

F686-Treatment/Svcs to Prevent/Heal Pressure Ulcer

Facility failed to prevent the development of a pressure ulcer on one resident. The facility does and will continue to assess and implement pressure wound assessments and treatment interventions per the facility policy and procedures. DON and ADON have been educated on the care planning and wound assessment/treatment policy. DON or designee will perform random audits of resident care plans, assessments and treatments on a weekly basis x4 weeks, then to biweekly x4 weeks and
monthly for the remainder of the year. All findings will be submitted through quarterly QA and QAPI processes for further system improvement implementation.

Compliance date of: 01/02/20

F689-Free of Accident Hazards/Supervision/Devices

Facility failed to prevent a resident from falling with the use of a mechanical lift one of one resident reviewed. The facility does and will continue to perform resident transfers per facility policy and procedures. DON, ADON and all clinical staff were educated on the proper use of mechanical lifts for resident transfer. DON or designee will perform random audits of mechanical lift transfers. Audits will occur at random intervals weekly x4 weeks, then to biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year. All findings will be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/30/19

F690-Bowel/Bladder Incontinence, Catheter, UTI

Facility failed to provide aseptic technique while emptying a catheter for one of two residents reviewed. Facility failed to provide aseptic technique while providing perineal cares for one of six residents reviewed. Facility failed to ensure there was a clinical indication for 1 of 2 residents with a urinary catheter.
The facility does and will continue to provide aseptic care to residents with indwelling catheters and provide appropriate diagnosis for utilization of indwelling urinary devices. All clinical staff were educated on proper catheter care per facility policy. DON and ADON were educated on the procedure of proper diagnosis for indicated use of indwelling catheter. DON or designee will perform random catheter care/emptying weekly x 4 weeks, biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year. DON or designee will perform random audits of appropriate diagnosis for indication of indwelling catheters for all residents utilizing indwelling catheters. Random audits to occur monthly x 3 months and then quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/30/19

F697-Pain Management

Facility failed to manage the resident's pain to the extent of the resident's goals and preferences for one of two residents reviewed. The facility does and will continue to perform pain management and assessment per the facility policies and procedures. All clinical staff have been educated on pain management policy and procedure. DON or designee will audit PRN pain medication utilization for required assessment, documentation and implementation. Random audits will occur weekly x 4 weeks, biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/16/19

F726-Competent Nursing Staff

Facility failed to assess a resident following a fall from a mechanical lift resulting in a displaced spiral fracture of the subtrochanteric proximal right femoral diaphyseal for one of one resident's Reviewed. The facility does and will continue to perform appropriate assessment of resident post fall or incident per facility policy and procedures.

All clinical staff were educated on the facility fall protocol, root cause analysis and fall intervention protocols. DON or designee will audit perform random audits of incidents and injuries, investigations and fall prevention implementation per facility policies and procedures. DON or designee will perform audits of all incidents and injuries daily x 2 weeks and then within 48hrs of each occurrence for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12/30/19

F803-Menus Meet Resident Nds/Prep in Adv/Followed

Facility failed to follow the menu to meet the nutritional requirements of the residents.

Facility failed to follow menus for all the residents of the facility. Dietary Supervisor was educated on menu changes and contacting the Dietitian when changes are needed. Dietary Supervisor held an in-service with dietary staff on 12-13-19 regarding requirements of following the menu. All findings will be monitored by the QA Committee on a monthly basis and be presented with QAPI process for further system improvement implementation as indicated.

Compliance date of: 12-13-19

F812-Food Procurement, Store/Prepare/Serve-Sanitary

Facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.

The walls below the dishwasher had been ordered prior to survey. We will replace the wall boards once the material has come by 01/12/20. Staff was educated on 11/25/19 on dating all food, breads included when they are delivered to the building. The plastic cutting boards were thrown away on 11/25/19 and new ones were purchased on 11/26/19. Cutting boards will be monitored monthly for excessive wear. Dietary Manager and staff were educated on 11/25/19 on the safety of dishes and to monitor the excessive wear on the dishes and discard and place with new items when needed. All items will be monitored on a monthly basis by the QA Committee. All findings will be submitted through QAPI process for further system improvement implementation as indicated.

Compliance date of: 1-12-20

F880-Infection Prevention & Control

Facility failed to follow appropriate infection control techniques while providing care for one of twelve residents reviewed. The facility does and will continue to follow infection control policy and procedures to meet the requirements of state and federal regulations. All clinical staff were educated on facility infection control policy and procedures regarding gloving, hand washing and incontinence care. DON or designee will perform random audits of hand washing, gloving and incontinence care weekly x4 weeks, biweekly x4 weeks, monthly x4 weeks and then quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI process for further system improvement implementation.

Compliance date of: 12-30-19