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	165264	A. BUILDING _____ B. WING _____	01/15/2020

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QHC MITCHELLVILLE, LLC	114 CARTER STREET SW MITCHELLVILLE, IA 50169

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F 000 V KM	INITIAL COMMENTS Correction date: 2/21/20 The following deficiencies relate to the annual health survey and investigation of complaints #87138, #87231, #87463, #87534, #87567, #87579, #87673, #87677, and #87724. Facility reported incidents #87736 and #87945 were not substantiated. See Code of Federal Regulations 42CFR Part 483, Subpart B-C.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the assessment failed to accurately reflect the resident for 2 of 17 sampled (Residents #34, #39). The facility reported a census of 44. Findings include: 1. A Minimum Data Set (MDS) for Resident #34 dated 8/26/19 documented diagnosis of renal insufficiency, dementia and paraplegia. The BIMS showed a score of 15 out of 15 indicating intact cognition. A MDS dated 11/26/19, documented diagnosis of renal insufficiency, dementia and pressure ulcer. The Brief Interview for Mental Status (BIMS)	F 641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/15/

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 641	Continued From page 1	F 641		

showed the resident was unable to be done indicating resident is rarely or never understood.

A Care Plan intervention dated 11/26/19 directed Resident #34 enjoyed socializing in his room and will remain oriented to person, place, situation and time through

Observation on 12/30/19 at 11:00 a.m., revealed Resident #34 alert and had clear speech. Resident #34 stated things were going okay for him and agreed to visit later.

During an interview on on 12/31/19 at 10:00 a.m., the Assistant Director of Nursing (ADON) stated she did not know why the BIMS would not have been done for resident #34. She stated the BIMS is completed by the admission nurse initially and then all further BIMS assessments are completed by the Activities Director. Furthermore the ADON stated the BIMS assessment is to be completed with all comprehensive and quarterly reviews.

A Progress Note dated 12/31/19 at 11:24 a.m., documented the staff completed the BIMS assessment and reflected Resident #34 hard of hearing and instead of accurately repeating the words sock, blue and bed, Resident #34 repeated fox, blue and debt. The Activity Director signed the assessment.

During an interview on 1/2/20 at 2:00 p.m., the ADON stated she followed up with the Activities Director after the conversation on 12/31/19. The Activity Director had no knowledge to why Resident #34's BIMS was not completed with the 11/26/19 assessment.

The facility failed to accurately reflect Resident

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F 641	Continued From page 2 #34's cognitive status on the 11/26/19 assessment. 2. The MDS assessment dated 11/8/19 documented Resident #39 displayed independent decision-making and had no memory impairment. The assessment documented he had diagnoses that included peripheral vascular disease, hypertension, diabetes mellitus, hyperlipidemia, arthritis, Parkinson's disease, generalized muscle weakness and difficulty walking. The MDS also documented Resident #39 had no range of motion (ROM) in either his upper or lower extremities. Review of the Resident #39's Electronic Health Record revealed no additional ROM assessments. During an observation and resident interview on 12/31/19 on 9:41 a.m., Resident #39 stated and demonstrated that he could not fully straighten his fingers on his left hand upon request. During interview on 1/14/20 at 9:35 a.m., the ADON stated when assessing a th Resident's ROM, she asks the Nurse Aides during cares and observes if there is a ROM concern for a particular resident. She did not utilize a standardized ROM assessment, just experience over the years. When assessing ROM limits in a resident's hands, she had the resident do wrist	F 641		

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F 641	Continued From page 3 circles, move their wrists up and down and watch them make a fist. At 9:45 a.m., Resident #39 sat at the table in the dining room. Upon request with ADON present, Resident #39 could not straighten his left fingers. The ADON stated Resident #39 could not fully straighten his fingers and the resident's left hand limitations did not seem to affect his activities of daily living, so she never coded the limitations. The Resident Assessment Instrument 3.0 Manual for assessing functional limitation in ROM in upper extremities (including shoulder, elbow, wrist and fingers) directed the facility staff to instruct the resident to make a fist and then open the hand. With the resident seated in a chair, instruct him or her to reach with both hands and touch palms to the back of the head. Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair. The manual instructed to code 0, no impairment, if the resident has full functional ROM on the right and left side of their upper/lower extremities.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		

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F 655	Continued From page 4 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 655		

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F 655	Continued From page 5 Based on clinical record review and staff interviews, the facility failed to develop and implement an accurate baseline care plan for 1 of 4 sampled (Resident # 23) who smoked. The facility reported a census of 44. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/6/19 documented Resident #23 had impaired memory, moderately impaired cognition, and displayed verbal behaviors. Resident #23 required one staff to assist with transfers, used a walker and wheelchair, had limited range of motion to both upper and lower extremities on one side of his body, and did not walk. The Nursing Notes documented Resident #23 entered the facility at 12:00 p.m. on 10/24/19. At 3:58 p.m., the staff provided re-orientation with each conversation as Resident #23 thought he was in jail. The Care Plan initiated on 10/28/19 documented a focus area of smoking and directed the staff to allow Resident #23 to smoke outside with his family per facility policy, encourage to attend activities to help provide distraction from smoking, ensure the oxygen turned off while smoking or using electronic cigarette, and monitor and provide for changing needs. An Incident Report dated 10/27/19 at 5:41 p.m., documented a visitor yelled for a nurse to respond outside. The nurse responded and found Resident #23 on the ground. Resident #23 reported he attempted to reposition himself and slid out of the wheelchair. Resident #23 reported a lady helped him back into the chair. The report	F 655		

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F 655	Continued From page 6 revealed no injuries. During an interview on 1/9/20 at 9:35 a.m., Staff H, (Licensed Practical Nurse) reported Resident #23 had a code alert necklace at the time of the fall to call for help. Resident #23 required supervision to smoke after the fall. Staff H could not recall if Resident #23 had the code alert necklace when he fell outside. During an interview on 1/9/20 at 9:59 a.m., the Assistant Director of Nursing stated she remembered Resident #23 used a Smart code alert necklace until he fell outside, but it's not listed on his care plan. She thought she wrote direction to staff to use it, but could not remember where. She reviewed the October 2019 Nursing communication book sheets and did not see mention of the code alert necklace.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		

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F 656	Continued From page 7 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide a comprehensive care plan for three of seven residents reviewed (#36, 23, 35) for . The facility identified a census of 44 current residents. Findings include: 1. Resident #35 had a Minimum Data Set (MDS) assessment with a reference date of 11/29/19. The MDS identified the resident with short term and long term memory problems. The MDS indicated Resident #35 independent for bed	F 656		

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F 656	Continued From page 8	F 656		

mobility and locomotion on the unit, and limited assistance of one staff person for transfer, toilet use, and personal hygiene. The MDS further documented the resident with an indwelling catheter and always continent of bowel. The MDS further documented the resident had not wandered. The resident's diagnoses included hypertension, heart failure, diabetes, and cardiorespiratory conditions.

A Wandering Risk Assessment completed on 11/21/19 identified the resident scored an 8 which indicated a moderate risk for wandering. Specifically the assessment identified the resident disoriented x 2 spheres, behaviors of loss of self-control and experiencing feeling of anger/fear of abandonment, was admitted within the last month, had early dementia and was taking antidepressants and anti-anxiety medications.

A care plan initiated on 11/25/19 failed to identify a risk for elopement and wandering behaviors.

A progress note dated 11/21/19 documented the resident was admitted to the facility following an inpatient psychiatric hospitalization and had received medication intramuscular injection (IM) prior to leaving the hospital for agitation and aggression.

A progress note dated 11/29/19 at 10:17 AM documented the resident wanted to leave and was stopped inside of the facility walking towards the door. Resident stated his family put him here. Oder received for wandergurard to be placed.

A progress note dated 12/7/2019 at 8:45 PM documented the resident reported that he has a ride coming and he will be leaving tonight, it was

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F 656	Continued From page 9	F 656		

further documented the ride showed up at 10:30 PM, resident refused to talk to daughters when contacted and was talked into not leaving and staying at the facility after calmed down.
In an interview on 1/8/19 at 4:00 PM with the Administrator, Assistant Director of Nursing (ADON), and a Corporate Representative elopement concerns were discussed. The ADON confirmed that the resident had a wanderguard bracelet, the resident had cut it off, and the facility had not yet reapplied because she felt the resident would just cut it off again. The ADON confirmed the resident had not been care-planned for wander/elopement risk and interventions not identified before or after had attempted to leave with a friend, and no new assessment of wandering risk had been completed. Further interview on 1/14/2020 at 9:40 AM the ADON reported the resident had cut off his wander-guard bracelet on 1/3/20 with a butter knife. The ADON further reported the resident had agreed on 1/8/2020 to have the wanderguard replaced for safety. The ADON confirmed the resident did not have a wanderguard alarm from 1/3/2020 to 1/8/2020. The Administrator stated would have expected staff to go to the door that had alarmed and visually check the exit when they had not witnessed someone leaving and caused the door to alarm.

Findings include:

2. A Minimum Data Set (MDS) dated 11/6/19, documented Resident #23 had no active diagnosis in the past 7 days. A Brief Interview for Mental Status (BIMS) recorded a score of 8 out of

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F 656	Continued From page 10	F 656		

15 indicating a mild cognitive impairment. Resident required limited assist of 1 for bed mobility and personal hygiene. Resident required extensive assist of 1 for transfer and toilet use. The MDS showed an admission date of 10/24/19.

A Medical Diagnosis sheet created on 11/5/19, recorded a diagnosis of traumatic brain injury.

An Order Summary Report with active orders dated 1/15/2020, revealed Seroquel (an anti psychotic drug) was ordered on 10/24/2019.

A care plan initiated on 10/28/19 for Resident #23, lacked a plan for anti psychotic drug use.

On 1/15/2020 at 10:31 a.m., the Assistant Director of Nursing concurred that antipsychotic medication was not and had not been on Resident #23's comprehensive care plan. ADON stated this should have been part of this resident's care plan.

Findings include:

3. According to the Minimum Data Set (MDS) assessment dated 12/1/19, Resident #36 had a diagnosis of depression. The assessment documented she received daily antipsychotic and antidepressant medications.

The Order Summary Report dated 1/6/20 instructed staff to administer Effexor XR 50 milligrams (mg) twice a day for depression

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F 656	Continued From page 11 starting 12/9/19 and Seroquel 25 mg every night for a recurrent major depressive disorder starting 11/18/19. Review of the resident's Care Plan with a target date of 12/15/19 revealed no documentation of psychotropic medication use or any intervention regarding the medication use. During interview on 1/14/20 at 10:59 AM, the ADON (Assistant Director of Nursing) reviewed the resident's care plan and stated she could not see any interventions related to the resident's psychotropic medications. The ADON stated she would expect to see listing of the psychotropic medications, to administer them as ordered, the reasons for the medications and side effects to watch for. She knows psychotropic medications triggered on the most recent CAA (Care Assessment Area report) and planned to add the information and interventions. Review of the CAA report included with the 12/1/19 MDS assessment showed the resident received psychotropic medications. Page 4 of the CAA report documented the psychotropic drug use would be addressed in the resident's care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		

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F 657	Continued From page 12 (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 observations, staff interviews and record review, the facility failed to review and revise the comprehensive care plan for 1 of 17 sampled (Resident #34). The facility reported a census of 44. Findings include: A Minimum Data Set (MDS) assessment dated 11/26/19, documented Resident #34 had diagnoses of malnutrition, renal insufficiency, dementia and pressure ulcer. The Brief Interview for Mental Status (BIMS) unable to complete as rarely or never understood. Resident #34 required extensive assistance of 2 staff for bed mobility and extensive assistance of one staff for dressing and personal hygiene.	F 657		

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F 657	Continued From page 13 A Care Plan dated 11/14/19 revealed Resident #34 had impaired skin integrity and directed the staff to encourage to turn every 2 hours and educate on the importance of repositioning when refusing. The Weekly Pressure Ulcer Record documented Resident #34 had a wound with an onset of 8/29/19. A Progress Note dated 8/29/19, documented Resident #34 had a darkened area on left gluteal fold and a skin tear on the left buttocks. The Note revealed an order for a wound care consultation. A Progress Notes dated 9/2/19, documented Resident #34 transported to the Emergency Department and received intravenous antibiotics. Resident #34 had an appointment to see the wound care doctor on 9/6/19. A Progress Note dated 9/3/19, documented Resident #34 had an order for an oral antibiotic for 7 days. The note documented Resident #34 had decubitus ulcers (pressure ulcers) on both buttocks. A Progress Note dated 9/6/19, revealed the wound care doctor saw Resident #34 and continued to receive an antibiotic for buttock wounds. On 12/30/19 at 5:46 p.m., Staff A (Nurse Aide) stated Resident #34 does not allow repositioning. Staff A stated she did reposition resident at 3:45 pm. Staff B (Nurse Aide) informed Staff A that she (Staff B) repositioned Resident #34 at 2:00	F 657		

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F 657	Continued From page 14 pm. On 12/31/19 at 9:53 am, Staff B Nurse Aide) stated the staff turn Resident #34 and at times Resident #34 had combative behaviors. Staff A said she did not Resident #34's room all morning and she did provide repositioning. Staff B denied informing Staff A that she repositioned resident at 2:00 p.m. on 12/30/19. Staff B repeated she never goes in Resident #34's room. During an interview on 12/31/19 at 10:03 a.m. the Assistant Director of Nursing (ADON) stated the Care PLan directed to turn Resident #34 every 2 hours. However, Resident #34 refused most of the time. During an interview on 12/31/19 at 10:20 a.m., Resident #34 stated he had not been repositioned that morning. Resident #34 did not know the last time the staff turned him. During an interview on 1/20/19 at 11:00 a.m., the ADON stated Resident #34's care plan was not updated as it should have been. The ADON stated a RN had made the change and had educated staff. The facility failed to update Resident #34' Care Plan with the identification of a pressure ulcer on 8/29/19.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		

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F 677	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident interviews, the facility failed to provide assistance with bathing, grooming, and repositioning for 3 of 3 sampled (Residents #8, #39 and #94). The facility reported a census of 44. Findings include: 1. The Minimum Data Set (MDS) assessment dated 10/5/19 documented Resident #8 displayed independent decision-making and had no memory impairment. The assessment documented he required the assistance of two staff for bathing. The resident's diagnoses included an amputation below the resident's left knee and anxiety. The MDS also documented Resident #8 required surgical wound care. The Order Summary Report dated 1/9/20 recorded instruction beginning 7/10/19 for the resident to continue with showers three times a week every Monday, Wednesday and Friday. The resident's Care Plan with a target date of 10/2/19 did not contain instruction for provision of the resident's showers. During an interview on 12/30/19 at 3:16 p.m., Resident #8 stated he is supposed to get a shower every other day, but they set them up on Monday Wednesday and Friday instead. He stated that on 12/23/19, he missed his shower and he heard they sent the shower girl home. He received a shower the next day, but it messed up the schedule.	F 677		

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Review of Resident #8's Bath & Skin reports 11/1/19 to 1/6//20 revealed omissions in his showers on 12/16/19 and 12/24/19. Review of the Progress Notes and the facility's Resident Absence sign out sheets identified he was in the facility on both days.

2. The MDS assessment dated 11/8/19 documented Resident #39 displayed independent decision-making and had no memory impairment. The assessment documented he had diagnoses that included peripheral vascular disease, hypertension, diabetes mellitus, hyperlipidemia, arthritis, Parkinson's disease, generalized muscle weakness and difficulty walking. The MDS also documented Resident #39 required the assistance of one staff to meet his personal hygiene needs.

Review of the Care Plan updated on 12/24/19 revealed Resident #39 required assistance of one staff for showers and should be encouraged to do so 2 times per week.

During observation and interview on 12/31/19 at 7:34 a.m. Resident #39 sat in a chair in the dining room. His face unshaven. The resident stated he had a shower Monday and would be shaved later in the day. At 9:23 a.m., Resident #39 remained unshaven. He stated he should be shaved every other day, but will often go two weeks without a shave. It depends on who is giving the showers.

During observation and interview on 1/6/20 at 12:15 p.m., Resident #39 sat in a wheelchair in the dining room, with his face unshaven. The resident stated he had not been shaved in week and tried to do it himself with the electric razor but

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couldn't get it done. The observation revealed longer facial hair on his neck and spiky shaved patches on his cheeks.

3. The MDS assessment dated 11/13/19 revealed Resident #94 had intact memory and cognition. The MDS indicated Resident #94 required extensive assistance of two staff person with bed mobility and dressing, and total dependence for transfer, toilet use, and bathing. The MDS further documented was always incontinent of bowel and bladder. Resident #94 had diagnoses of hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. The MDS indicated the resident assessed as at risk of developing pressure ulcers.

The Care Plan failed to directed the staff concerning showers.

During an interview on 1/2/20 at 3:45 p.m., Resident #94 stated the staff failed to give her a shower yesterday (Wednesday 1/1/202) because there was no clean mechanical lift sling. Resident #94 reported being upset, and stated "it's just not right". Resident #94 reported the last shower on Saturday. Resident reported the shower person said she couldn't do it today either.

Review of Resident #94's Bath & Skin reports since admission 10/31/19-1/7/2020 revealed omissions in showers on 11/2/19, 11/6/19, 11/9/19, 11/13/19, 11/16/19, 11/21/19, 11/23/19, 11/30/19, 12/4/19, 12/7/19, 12/16/19, 12/21/19, 12/24/19, 1/1/20, and 1/4/20.

During an interview on 1/7/20 at 1:05 p.m., the

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F 677	Continued From page 18 Assistant Director of Nursing (ADON) reviewed the bath and skin reports for Resident #94 and could only find documentation for 11/21/19, 11/27/19, 12/11/19, 12/14/19, and 12/28/19. The ADON confirmed the expectation that resident is to receive two showers per week. The ADON further stated that mechanical lift slings not being available has been a problem and may have contributed to Resident #94 failing to get showers. The ADON stated would expect staff to provide shower at a later date if sling unavailable when shower scheduled.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interviews, the facility failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 4 sampled (Resident #94 and #34). The facility failed to implement	F 686		

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interventions to promote healing of Resident #94's Stage II pressure ulcer and failed to prevent Resident #2 from developing a Stage II pressure ulcer while in the facility. The facility failed to implement interventions to promote healing of Resident #34's Stage IV pressure ulcer. The facility reported a census of 44.

Findings included:

1. The Minimum Data Set (MDS) assessment dated 11/13/19 revealed Resident #94 admitted to the facility on 10/31/19 with intact memory and cognition. Resident #94 required extensive assistance of two staff person with bed mobility and dressing, and total dependence for transfer, toilet use, and bathing. Resident #94 always had bowel and bladder incontinence. Resident #94 had diagnoses of hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. Resident #94 gad a risk of developing pressure ulcers and no pressure ulcers present. Resident #94 utilized a pressure-reducing device for bed, application of nonsurgical dressings, and application of ointments/medications.

The MDS identified the following Stages of Pressure Ulcers:

a. Stage I-An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperatures (warmth or coldness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may

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F 686	Continued From page 20 appear with persistent red, blue, or purple hues. b. Stage II-Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead skin tissue). May also present as an intact or open/ruptured blister. c. Stage III- Full thickness tissue loss. Subcutaneous fat may be visible but the bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. d. Stage IV-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable-Slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar. A Baseline Care Plan completed on 10/31/19 directed the staff to turn every two hours and place a bariatric specialty mattress on the bed. The care plan documented no current pressure ulcer and identified a skin concern of shearing gluteal fold (crease separating the buttocks form the thigh) related to moisture. The care plan further documented the resident as unable to turn over by self in bed. A Non-Pressure Skin Condition Report sheet dated 10/31/19 documented staff noted shearing to the Left gluteal fold due to incontinence upon admission. The wound measured 2 centimeters (cm) (length) by 0.5 cm (width) by 0.1 cm (depth) with a scant amount or serosanguineous (watery,	F 686		

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clear) exudate (fluid from a wound). The staff notified the Physician and Resident #94. The sheet revealed a wound care consult requested and planned to see tomorrow morning. The sheet revealed no further assessments of the area after 10/31/19.

A Wound Treatment Plan sheet dated 11/1/19 revealed the Wound Nurse Consultant visited Resident #94 but did not assess the buttock wound due to Resident #94 being up in her wheelchair. The staff reported the area slightly excoriated and requested a wound paste. Resident #94 utilized an electric wheelchair for mobility with a foam cushion. The Wound Nurse ordered a treatment to cleanse the buttock wound with wound cleanser and apply wound paste every shift and as needed.

A Wound Treatment Plan sheet dated 11/15/19 documented Resident #94 visited by the Consultant Wound Nurse. The Wound Nurse unable to assess the buttock wound due to Resident #94 being up in the wheelchair. The staff reported the buttock looking better with application of wound paste. The Wound Nurse did not alter the treatment to the wound.

A Wound Treatment Plan sheet dated 11/22/19 documented the Wound Nurse Consultant visited Resident #94. The Wound Nurse unable to assess the buttock wound as Resident #94 up in the wheelchair. The staff informed the Wound Nurse Consultant of concerns with the current treatment. Resident #94 inquired about what cream should be used for buttock wound. The Wound Nurse provided education that without assessment, wound care cannot be properly answered now. The staff did not voice concerns

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F 686	Continued From page 22 related to the current treatment to the buttocks. An Encounter Note dated 12/6/19 documented the Wound Nurse Consultant unable to assess the buttock wound as Resident #94 sitting up in the wheelchair. The Wound Nurse asked Resident #94 about her bottom and she reported both pressure and moisture. Resident #94 currently does not have an air mattress or an overlay. An Encounter dated 12/13/19 documented the Wound Nurse Consultant assessed Resident #94's Stage II sacral pressure wound. The area measured 7 cm (length) by 2.3 cm (width) by 0.1 cm (depth). The Wound Nurse mechanically debrided the wound. The Wound Nurse noted a foam cushion in the wheelchair. However, no air mattress or an overlay on bed and required staff assistance for repositioning. The Wound Nurse ordered to obtain an air mattress for the bed and change foam cushion in her chair to a pressure reduction (Roho or Equagel) cushion. The Wound Nurse ordered Triad to the left buttock wound twice a day and do not remove cream between applications. The Wound Treatment Plan dated 12/19/19 documented the Triad ordered, took some time to get from pharmacy, and just arrived today. The left buttock Stage II pressure area measured 4 cm (length) by 11.5 cm (width) by 0.1 cm (depth). The Wound Nurse noted a new Stage II pressure ulcer to the right buttock that measured 0.2 cm (length) by 0.3 cm (width) by 0.1 cm (depth). The etiology pressure and shearing. The Wound Nurse recommended cleansing both wounds with cleanser of choice, apply triad paste, do not remove all cream between applications and take	F 686		

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F 686	Continued From page 23 a break from briefs when able. A Wound Treatment Plan dated 1/2/20 documented the Wound Nurse ordered Occupational Therapy to evaluate wheelchair for pressure points and noted this had been requested and not completed and Roho or equagel cushion to wheelchair and noted this had been requested and not completed. Observation on 1/9/20 at 9:45 a.m., revealed the Wound Nurse Consultant completed an assessment and measured Resident #94's wounds. The Wound Nurse stated the staff informed her Resident #94's buttocks improved and no longer open. The Physical Therapist joined to assist with repositioning. Resident #94 stated she was not turned last night on the overnight shift. Resident #94 reported they never turn me on the night shift. The left buttock pressure ulcer measured 7.0 cm (length) by 10.0 cm (width) by 0.1 cm (depth). The buttock pressure sore measured 14.0 cm (length) by 6.0 cm (width) by 0.1 cm (depth). The Wound Nurse stated the buttocks had not improved in in fact had deteriorated. The wound Nurse noted the air loss mattress placed on the bed, but noted that the foam cushion remained in the wheelchair. The Physical Therapist stated she did not receive a referral to evaluate for the cushion. During an interview on 1/6/20 at 11:01 a.m., the Assistant Director of Nursing, (ADON) stated she reviewed the wound sheets and could not find any wound sheets that included measurements of Resident #94's wounds. The ADON reported	F 686		

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Resident #94 admitted with non-pressure wounds and was at risk of developing pressure ulcers. The ADON stated the facility failed to implement interventions to prevent pressure ulcers. Further stated the resident is non-compliant with laying down during the day and the facility was aware of this prior to her admission and this had not changed. The ADON reported she would expect the staff to offer to reposition or lay down, turn, and reposition every two hours when in bed. The ADON stated the staff they did not have access to the electronic record. Therefore, they could not look at the Care Plans. The ADON confirmed Resident #94 was not added to the bedside care plan, referred to as the cheat sheet, since her admission on 10/31/19.

A 300 Hall Cheat Sheet provided by the ADON on 1/2/19 failed to list Resident #94 and direct care needs.

During an interview on 1/7/20 at 1:05 p.m., the Acting Director of Nursing (DON) stated Resident #94 reported staff had not been turning or repositioning her in bed, especially at night. The DON reported an expectation of staff to turn or reposition the residents every two hours when in bed and to offer to lay down during the day. The ADON stated the facility obtained a low air loss mattress for Resident #94 as of 1/6/20.

2. The MDS assessment dated 11/26/19 documented Resident #34 had diagnoses of malnutrition, renal insufficiency, dementia, and pressure ulcer of the right buttock. Resident #34 had severe cognitive impairments. Resident #34 required extensive assist of two staff for bed mobility, and total dependence of one staff for

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toilet use. The MDS indicated Resident #34 did not transfer during the observation period. Resident #34 had one Stage IV pressure ulcer.

The Care Plan dated 9/11/19 directed the staff to transfer Resident #34 with a total mechanical lift. The Care Plan updated 11/22/19 directed the staff to implement a low air loss mattress on his bed. Resident #34 had a diagnosis of paraplegia.

The initial Weekly Pressure Ulcer Record sheet dated 8/29/19 revealed Resident #34 had a 4 by 2 (unknown measurement) right ischial skin tear.

A Progress Note dated 8/29/19, documented a darkened area on left gluteal fold and a skin tear on the left buttocks. An order for a wound consult obtained.

A Progress Note dated 9/2/19, documented Resident #34 transferred to the emergency room and returned. While at the emergency room, Resident #34 received intravenous antibiotics. Resident #34 had an appointment set up on 9/6/19 for a Wound Specialist.

A Progress Note dated 9/3/19, documented an order for an antibiotic by mouth for 7 days.

A Progress note dated 9/6/19, revealed Resident #34 seen by the Wound Care Specialist and continued to receive an antibiotic for buttock wounds.

A Progress Note dated 9/12/19, documented Resident #34 continued to have pressure area on right buttock and treatment completed.

A Progress Note dated 9/17/19, documented

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F 686	Continued From page 26 Resident #34 transferred to the hospital for evaluation of sepsis (an infection in the blood stream) and urinary tract infection. A Progress Note dated 11/13/19, documented Resident #34 rested well all night. The facility completed an Admit/Readmit Screener on 11/13/19. A hospital Nutrition Assessment dated 11/7/19, documented Resident #34 required increased nutrient needs for wound healing and Resident #34 had a moderate nutrition risk. A Dietitian Recommendation sheet dated 10/9/19 lacked an assessment for Resident #34. On 1/2/20 at 4:31 p.m., the Assistant Director of Nursing (ADON) stated the facility lacked Dietitian assessments for Resident #34. The ADON explained the facility had four different Dietitians in a short period of time at this likely contributed to the lack of assessments.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		

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F 688	Continued From page 27 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interviews the facility failed to ensure staff completed range of motion exercises as recommended by Physical and Occupational Therapy for 1 of 2 sampled (Resident #94) who had limited range of motion. The facility reported a census of 44. Findings include: 1. Resident #94 had a Minimum Data Set (MDS) assessment with a reference date of 11/13/19. The MDS identified Resident #94 had intact memory and cognition. Resident #94 required extensive assistance of two staff with bed mobility and dressing, and total dependence for transfers, toilet use, and bathing. Resident #94 always had bowel and bladder incontinence. The MDS documented diagnoses of hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. The MDS identified no upper extremity functional limitation in range of motion and impairment on both sides of the lower extremities. The MDS documented Resident #94 and staff believed the resident had capability of increased independence in at least some activities of daily living. The Recommended Restorative Care Program communicated to the Restorative Aide by the by	F 688		

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F 688	Continued From page 28 the Occupational Therapist on 12/4/19 directed the following exercise program 3 to 5 times per week with an on ongoing duration: a. Dowel exercise (1-3# dowel) in all planes x 2 sets of 10-15 repetitions. b. Purple therapy band exercises in all planes x2 sets of 15 repetitions. c. Pulley with 10 pound weight A review of the December 2019 Restorative Notes revealed the staff offered Resident #94 restorative exercises zero times from December 1, 2019 to December 13, 2019. The Restorative Notes documented Resident #94 refused restorative exercises on 12/14/19. The staff offered and completed exercises on 12/13/19, 12/18/19, 12/23/19, 12/26/19, and 12/27/19. During an observation on 1/2/20 at 10:25 a.m., revealed the Occupational Therapist (OT) and Physical Therapist (PT) in room with family to observe the family provide a one assist transfer as a plan to discharge Resident #94 home. PT educated resident on importance of continued participation in restorative exercises to strengthen core muscles and increase upper extremity strength. Resident #94 stated that staff had failed to consistently offer her exercises, further stating that the Restorative Aide had not offered because she reported the resident had been asleep. Resident #94 directed that staff need to wake her up, as it is imperative to her being able to discharge home. During an interview on 1/2/20 at 11:15 a.m., Staff D (Restorative Aide) provided restorative	F 688		

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F 688	Continued From page 29 documentation and confirmed restorative care delayed to Resident #94 for 9 days after initiated on 12/4/19. Staff D further stated it shouldn't take that long and explained that she had failed to enter it timely. Staff D confirmed the program is to be offered 3-5 times weekly and had cited that she gets pulled in to cover nursing shortages and there is no restorative coverage on the holidays. Additionally Staff D admitted that if the resident is sleeping she doesn't attempt to wake. During an interview on 1/2/20 at 11:35 a.m, the Physical Therapist expected the Restorative Program to start right away and would not expect a nine day delay in program initiation, further stating program is very important for Resident #94. Additionally, the Physical Therapist would expect staff to wake the resident and offer or re-approach at a later time. In an interview on 1/2/20 at 11:40 a.m., the Assistant Director of Nursing (ADON) stated she had only pulled the Restorative Aide to work the floor once in December. The ADON further stated would expect the staff to wake the resident and offer the restorative exercises.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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by:
Based on clinical record review, observation, and interviews, the facility failed to provide adequate supervision for smoking and to prevent an elopement for 4 of 4 sampled (Residents #7, #23, #93 and #94). The facility reported a census of 44.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 11/6/19 documented Resident #23 had moderately impaired cognition, displayed verbal behaviors and had no wandering behaviors. Resident #23 required assistance of one staff for transfers, did not walk, used a walker and wheelchair, and had limited range of motion to both upper and lower extremities on one side of his body.

The Medical Diagnosis sheet dated 1/2/20 revealed Resident #23 had a diagnosis of traumatic brain injury.

The Care Plan dated 10/28/19 directed the staff to allow Resident #23 to smoke outside with his family per facility policy, encourage attending activities to distract from smoking, and ensure oxygen off while smoking or using electronic cigarettes. The Care Plan documented Resident #23 at high risk for injury related to impaired mobility and directed the staff to assess decision making ability, muscle strength and balance, assure non-skid, well fitting footwear when up, assure that call light in reach at all times (does not always use), assure glasses used correctly, and clear the environment of unnecessary objects.

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The Wandering Risk Assessment dated 10/24/19 revealed Resident #23 had a moderate risk to wander.

The Electronic Medical Record failed to contain an elopement risk assessment.

The Nursing Notes documented Resident #23 entered the facility at 12:00 p.m. on 10/24/19. At 3:58 p.m., staff provided re-orientation as Resident #23 thought he was in jail.

An Incident Report dated 10/27/19 at 5:41 p.m., documented the staff responded to a visitor yelling for assistance outdoors. The staff responded outside and found Resident #23 in his wheelchair. Resident #23 reported he attempted to reposition himself in the wheelchair and slid to the ground. Resident #23 stated a lady helped him back into the chair. Staff noted no injuries following the incident.

During an interview on 1/7/20 at 3:43 p.m., the Community Member report she arrived in the facility parking lot on 10/27/19 and heard groaning. The Community Member found Resident #23 on the ground right outside the front door. The Community Member looked in the window for staff and did not see anyone. Resident #23 asked her to help him back in the chair, so she did after asking if he hurt anything. The Community Member told the staff she had to help him up off the ground. The Community Member found Resident #23 outside the smoking area and thought he must have gone through the gate at the smoking area. The Community Member reported the gate to the smoking area was unlocked and it was unlocked all the time.

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During interview on 1/7/20 at 3:37 p.m., Staff H (Licensed Practical Nurse) remembered on 10/27/19, they found Resident #23 outside the front door, about ten feet from the door and on the concrete walkway. She stated the alarms are always set to on and she cannot remember that any alarms sounded. Resident #23 reported he exited the facility from the front door. Observation of the front door revealed two metal and glass push doors with the second door alarmed with a deactivation code. Staff H stated Resident #23 did not wear an alarming device. Staff H recalled telling Resident #23 not to go outside the front door to smoke, but to use the patio instead.

During interview on 1/8/20 at 11:35 p.m., Staff M (Registered Nurse) recalled the incident. Staff M did not know how Resident #23 exited the facility, with help possibly from a visitor, as he went out the front door. A visitor entered the facility and stated help needed outside. Staff H and Staff M found Resident #23 outside in the wheelchair. Resident #23 informed them a visitor put him back in the chair. Staff M stated this was her first time working with Resident #23 and he could not keep his feet on his wheelchair pedals at that time. Staff M stated that no alarms went off.

Review of the facility's Daily Schedule dated 10/27/19 revealed three Nurse Aides worked from 2:00 p.m. to 10:00 p.m. Interviews with the CNAs revealed the following information:

a. On 1/8/20 at 11:47 p.m., Staff N stated that she did not know Resident #23 went out the front door and she heard it from a family member later. She stated Resident #23 was always agitated then. She could not recall when she last saw the

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resident before he fell outside. Staff N stated the patio gate is locked at all times now but before the survey, it was not.

b. On 1/9/20 at 9:12 a.m., Staff M stated she did not work Resident #23's hall and had no knowledge that he fell in front of the facility. At the time, the door to the smoking patio had no alarm. She remembered Resident #23 had independent smoking privileges and utilized a fall alert necklace. However, Resident #23 did not call staff all the time and at times sat outside a long time without asking to come in.

c. On 1/8/20 at 12:20 p.m., Staff Q reported Resident #23 had the ability to go where he desired when he desired. Staff Q did not recall the last time he/she saw Resident #23 before he fell outside. She stated in the last two to three months, the patio alarm to the smoking area was not alarmed and the patio gate had no lock.

Observation on 1/8/20 at 1:00 p.m. revealed the facility sits on a residential street with a speed limit of 25 miles per hour (mph). There were 13 surveyor steps from the front door to the parking lot and 25 steps from the sidewalk to the road. From the sidewalk to parking lot, a non-handicapped accessible 4 inch drop off at smoker ' s patio gate, and a handicapped accessible sidewalk at the front door. The facility sat at the south edge of town, one block north of a highway through town. Approximately ¼ mile south of town on the highway, the speed limit increased 45 mph.

The State Climatologist reported on 10/27/19 at 5:40 p.m. an outside temperature of 45 degrees, winds from the northwest, low clouds and no

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precipitation.

During an Environmental tour on 1/8/20 at 1:10 p.m., the Maintenance Director reported he checked all the exit doors and alarms on Friday and documented the checks. The exits were alarmed. Each of the 3 Halls had a non-Wanderguard exit door at the end of each halls. The alarm down the 100 hall had a chime alarm when checked. The sound quiet instead of a loud siren alarm. The Maintenance Director reported that staff change the sound if the door needed used by the funeral home. All other alarms functioned properly. Continued observation and interview revealed an adjacent door to the dining room to the west, which led to a patio area enclosed with a chain link fence. The fence had an unsecured gate. The gate opened by lifting a latch, either from inside or outside of the gate. The Maintenance Director reported the gate previously locked. A previous Administrator directed him to unlock the gate six months ago, as it was a fire exit. The dining room exit door opened by pushing on the door and required only very light pressure to open. The Maintenance Director stated the latch was removed so that the residents could let themselves back in from the outside smoking area. The door contained a Wanderguard alarm and had a key pad in the upper right area of the door frame to deactivate the alarm.

Resident #23's elopement and observations throughout the survey resulted in findings of Immediate Jeopardy for the facility. The facility abated the Immediate Jeopardy situation on 1/8/20 through the following actions:

a. Placement of a combination lock on the gate to

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F 689	Continued From page 35 the smoking patio. b. Placement of signs on the front and patio doors to remind visitor to not permit a resident to follow them out. c. Placing secondary alarms in a permanent position so that staff could not change the tone. d. Staff re-education the elopement policy and additional education as needed. e. Revision of the smoking policy to eliminate independent smoking. f. Review of the resident elopement binder. g. Initiation of audits. h. Educating residents on changes to the smoking policy. i. Update and revise care plans for residents who smoke. j. Provision of an all-staff meeting to reinforce the changes listed above. 2. A Minimum Data Set (MDS) dated 11/6/19 documented Resident #23 had moderate cognitive impairments. Resident #23 required limited assist of one staff for bed mobility and personal hygiene and extensive assist of one for transfers and toilet use. A Medical Diagnosis sheet created on 11/5/19, recorded a diagnosis of traumatic brain injury.	F 689		

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A Smoking Safety Screen dated 12/30/19 at 11:22 a.m., documented Resident #23 screened as safe to smoke and the facility to store his lighter and cigarettes. Furthermore, it stated Resident #23 may smoke independently so long as he is in his wheelchair and follows the facility smoking policy regarding storage of smoking materials and plan of care put in place. It documented the team decision was that resident is safe to smoke without supervision with the rationale that the risk versus benefit for resident to smoke independently as he has behavioral outburst when not able to smoke alone.

A Care Plan intervention dated 10/28/19, directed staff to allow Resident #23 to smoke outside with family per facility policy. An update on 12/30/19 stated resident was able to smoke independently as long as he adheres to the policy of storage and stays in his wheelchair during smoke breaks. An update dated 12/31/19 documented the resident often forgets to keep smoking material locked at nurses station. This intervention directed staff to check with resident when he comes in from smoking to ensure smoking materials turned in per policy and remind him if he argues that it is safer to have the materials locked up versus on his person.

An observation on 12/30/19 at 1:08 p.m. revealed Resident #23 outside smoking in his wheelchair with other residents.

During an observation and interview on 12/30/19 at 2:17 p.m., Resident #23 stated the staff provide 1 to 2 cigarettes at a time at the desk and staff try to take his lighter. Resident #23 showed that he had his lighter on him at this time in his room.

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F 689	Continued From page 37 During an observation on 12/30/19 at 4:00 p.m., Staff G (Nurse Aide) revealed 3 packs of cigarettes and 1 lighter locked in the medication room. A pack of cigarettes contained Resident #23's name. An undated List of Residents Who Smoke, provided by the facility, listed 7 residents who smoke. The list contained Resident #23's name. During an interview on 12/30/19 at 4:28 p.m., Staff G stated the facility updated Resident #23's care plan and he could now smoke on his own. During an interview on 12/30/19 at 4:33 p.m., the Nursing Home Administrator (NHA) stated the staff store all residents' smoking supplies in the medication room. The NHA stated she confiscated one lighter earlier that day. During an interview on 12/30/19 at 4:36 p.m., the Assistant Director of Nursing (ADON) verified that only 3 packs of cigarettes were present in the medication room and this was not all of the residents' smoking materials. The NHA and ADON both stated all cigarettes are to be kept in the medication room. ADON stated Resident #7 is the only resident that keeps their own cigarettes. The ADON stated Resident #23 should not have a lighter. ADON stated the residents who smoke signed a new policy. The ADON stated the staff know to get smoking supplies back from the residents as they hand the supplies to the residents prior to them going outside to smoke. The ADON then said that the residents do not always get their smoking supplies from staff, so the staff would not always know which residents are to return smoking	F 689		

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supplies. Upon exiting the medication room, Resident #23 asked to go outside to smoke. Resident #23 had a lighter on his person attached to a cord. The staff did not intervene to retrieve the lighter.

During an interview on 12/31/9 at 11:10 a.m., the ADON stated that all smoking materials, including cigarettes were in the nursing medication room.

A Resident Smoking Policy signed on 10/29/19 directed the staff to store smoking materials, including lighters in the medication cart or the medication room. The ADON reported Resident #23's daughter signed the policy.

The facility failed to provide adequate supervision for Resident #23 by not ensuring smoking materials did not remain on his person.

3. The MDS assessment dated 10/4/19 documented Resident #7 had diagnoses of diabetes, paraplegia and depression. Resident #7 had no cognitive impairments. Resident #7 required extensive assistance of two staff for bed mobility and total dependence of two staff for transfers.

A Smoking Safety Screen dated 10/9/19, documented the resident was safe to smoke independently (without supervision) and the facility needed to store his lighter and cigarettes.

On 10/29/19, Resident #9 signed the Resident Smoking Policy. The policy directed staff to store smoking materials including lighters in the medication cart or the medication room.

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F 689	Continued From page 39 A Care Plan dated 1/15/19 direct Resident #7 refuses to allow staff to keep his smoking materials and that he is cognitive to keep items on his person at all times. An updated on 2/1/19 directed the staff to allow Resident #7 to smoke unsupervised and not to have any smoking supplies on him. Observation on 12/30/19 at 4:00 p.m., Staff G (Nurse Aide) revealed 3 packs of cigarettes and 1 lighter stored in the locked medication room. Noted Resident #7 did not have a pack of cigarettes or lighter in the medication room. An undated List of Residents Who Smoke listed 7 residents who smoke. The list contained Resident #7's name. During an interview on 12/30/19 at 4:33 p.m., the Nursing Home Administrator (NHA) stated all residents' smoking supplies are stored in the medication room. The NHA stated she confiscated one lighter earlier that day. On 12/30/19 at 4:36 p.m., the Assistant Director of Nursing (ADON) verified that only 3 packs of cigarettes were present in the medication room and this was not all of the residents' smoking materials. The NHA and ADON both stated all cigarettes are to be kept in the medication room. ADON stated the only resident that keeps his own cigarettes is Resident #7. The ADON stated the staff know to get smoking supplies back from the residents as they hand the supplies to the residents prior to them going outside to smoke. The ADON then said that the residents do not always get their smoking supplies from staff, so the staff would not always know which residents are to return smoking supplies.	F 689		

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F 689	Continued From page 40 On 12/31/9 at 11:10 a.m., the ADON stated that all smoking materials, including cigarettes were in the nursing medication room. During an interview on 1/2/20 at 11:12 a.m., Resident #7 stated he obtains his smoking supplies from the staff and returns them to the nurse's station after smoking. Observation on 1/2/10 at 11:14 a.m. Staff H (Licensed Practical Nurse) unlocked the medication room and located a basket that contained Resident #7's lighter and cigarettes. Observation on 1/2/20 at 3:45 p.m., revealed Resident #7 obtained his cigarettes from the nurse's station and went outside and smoked. Resident came up to surveyor afterwards to report that he had returned his smoking supplies to Staff H. The facility failed to provide adequate supervision for Resident #7 by not ensuring smoking materials did not remain on his person. 4. The MDS assessment dated 11/13/19 documented Resident #94 had no cognitive impairments. Resident #94 required extensive assistance of two staff for bed mobility and dressing, and total dependence for transfers, toilet use, and bathing. Resident #94 had diagnoses of hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. A Care Plan dated 11/29/19 identified Resident #94 smoked and directed the staff to allow to smoke unsupervised and may light own cigarette,	F 689		

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F 689	Continued From page 41 but understands per the smoking policy all smoking materials are stored at the nurse's station. A Smoking Safety Screen dated 10/31/19, documented Resident #94 safe to smoke without supervision. On 10/31/19, Resident #94 signed a Resident Smoking Policy. The policy directed staff to store smoking materials including lighters in the medication cart or the medication room. During an observation on 12/30/19 at 1:19 p.m., revealed an unknown staff assisted Resident #94 with his coat. Resident #94 proceed out dining room door to the smoking area in an electric wheelchair. Resident #94 remove a pack of cigarettes and lighter from a purse she had on her lap. Resident observed to smoke cigarettes and return inside when finished. Resident #94 reported she carried cigarettes and lighter in her purse at all times. 5. The MDS assessment dated 11/29/19 documented Resident #35 had short term and long-term memory problems. The MDS indicated Resident #35 independent for bed mobility and locomotion on the unit, and limited assistance of one staff person for transfers, toilet use, and personal hygiene. Resident #35 had diagnoses of hypertension, heart failure, diabetes, and cardiorespiratory conditions. A Wandering Risk Assessment completed on 11/21/19 identified Resident #35 scored an "8" which indicated a moderate risk for wandering.	F 689		

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F 689	Continued From page 42 The assessment revealed Resident #35 disoriented, behaviors of loss of self-control, experienced a feeling of anger/fear of abandonment, admitted within the last month, had early dementia, and receiving antidepressants and anti-anxiety medications. A care plan initiated on 11/25/19 failed to identify a risk for elopement and wandering behaviors. A Progress Note dated 11/21/19 documented Resident #35 admitted to the facility following an inpatient psychiatric hospitalization and received an intramuscular injection prior to leaving the hospital for agitation and aggression. A Progress Note dated 11/29/19 at 10:17 a.m. documented Resident #35 wanted to leave and approached the doors. The staff intervened. Resident #35 stated his family put him here. The staff obtained an order a Wanderguard (alarm device). A Progress Note dated 12/7/2019 at 8:45 p.m. documented Resident #35 reported he had a ride and planned to leave that night. The ride showed up at 10:30 p.m. The staff contacted Resident #35's family and Resident #35 refused to talk to them. The staff convinced Resident #35 to stay at the facility. During an observation on 1/8/19 at 1:05 p.m., a visitor exited the front door. Staff G (Medication Aide) responded to the door alarm. Staff G looked at the control panel and identified the front door alarmed and stated, I didn't see who left. Staff G then observed the visitor get into a car out the front window and stated, Oh-that is who. Staff G reset the alarm. Staff G failed check the exit or door to assure a resident did not exit the	F 689		

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F 689	Continued From page 43 facility. During an interview on 1/8/19 at 4:00 p.m., with the Administrator, Assistant Director of Nursing (ADON), and a Corporate Representative discussed elopement concerns. The ADON confirmed Resident #35 had a Wanderguard bracelet but cut it off, and the facility had not yet reapplied because she felt the resident would just cut it off again. The ADON confirmed Resident #35 failed to wear a Wanderguard from 1/3/2020 to 1/8/2020. The ADON confirmed the Care Plan failed to address the wander/elopement risk and interventions after an attempted to leave with a friend. During an interview on 1/14/20 at 9:40 a.m., the ADON reported Resident #35 cut off the Wanderguard bracelet on 1/3/20 with a butter knife. The ADON further reported the resident had agreed on 1/8/2020 to have the Wanderguard replaced for safety. The Administrator stated she would have expected staff to go to the door that had alarmed and visually check the exit when they had not witnessed someone leaving. 6. The MDS assessment dated 12/30/2019 documented Resident #93 had severe cognitive impairments. Resident #93 admitted to the facility 12/26/2019. Resident #93 required limited assistance of one staff person for bed mobility and locomotion on and off the unit and extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. Resident #93 had diagnoses of dehydration and Non-Alzheimer's dementia.	F 689		

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F 689	Continued From page 44 A Wandering Risk Assessment completed on 12/26/19 identified Resident #93 scored a "5" which indicated a moderate risk for wandering. The assessment revealed Resident #93 disoriented, forgetful/short attention span, admitted within the last month, independent, and dementia with psychosis. A Care Plan dated 12/31/19 identified wandering behaviors related to diagnosis of Alzheimer's, delusional disorder, and anxiety manifested by wandering behavior. The Care Plan directed staff to provide redirection, will not be injured due to wandering, monitor and provide for changing needs and Wanderguard bracelet, staff to check placement and function every shift and every 3 months. During an observation on 12/30/19 revealed Resident #93 confused and asking to go home. Resident #93 had a Wanderguard bracelet in place and a chair alarm. Resident #93 asked what she was doing at the facility and wanted to know her husband's location. Resident #93 self-propelled the wheelchair with her feet about the facility without staff assistance. Resident #93 observed in the dining room where other residents independently exited the facility through a door to the smoking area. The dining room exit door had a buzzer alarm that sounded as residents exited the door. The door failed to contain a Wanderguard alarm. Observation on 12/31/18 at 9:15 a.m., Resident #93's Family reported she just admitted and had confusion. While at home, she went outside and could not find her way home from the neighbor's house.	F 689		

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F 689	Continued From page 45 During an observation on 1/8/20 at 11:25 a.m., revealed Resident #93 sitting at a dining room table next to the dining room exit door doing a puzzle with a fellow resident. Resident #93 voiced a desire to go home and wanted to know when her husband was coming.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		

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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 observation, clinical record review and resident and staff interview, the facility failed to ensure a resident who entered the facility without an indwelling catheter was not catheterized and unless medically necessary and failed to properly care for and change catheters as ordered for 3 of 8 sampled (Resident #12, #35, #94) with catheters. Resident #94 developed a urinary tract infection. The facility reported a census of 44.

Findings include:

1. Resident #94 had a Minimum Data Set (MDS) assessment with a reference date of 11/13/19. The MDS identified the resident with intact memory and cognition. The MDS indicated Resident #94 required extensive assistance of two staff person with bed mobility and dressing, and total dependence for transfer, toilet use, and bathing. The MDS further documented the resident without an indwelling catheter and always incontinent of bowel and bladder. The resident's diagnoses included hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. The MDS further documented the resident assessed as at risk of developing pressure ulcers, with no pressure ulcers present.

A Baseline Care Plan dated 10/31/19 revealed

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Resident #12 used briefs, unable to turn over by self in bed and dependent on staff for bed mobility and transfers.

During an interview on 12/30/19 at 10:00 a.m., Resident #94 confirmed she had not had an indwelling catheter on admit to the facility but had incontinence. Resident #94 reported the staff failed to changing her brief as needed. She reported they just do not have enough staff, especially on the evening and overnight shift. The staff do not change or turn her in the night. Resident #94 reported a wound on her bottom that developed at the facility that is not getting better. The staff had suggested she ask for an indwelling catheter, so she asked for one. Observation at this time revealed the resident seated in electric, reclining wheelchair with indwelling catheter collection bag visible, laying on its side on the soiled wheelchair footrest, with no barrier between the collection bag and the footrest. Footrest contained food debris and stains from dried fluids. Additionally, catheter bag observed to be in contact with the residents feet and no cover on the drainage bag.

Observation on 12/30/19 at 1:19 p.m. revealed Resident #94 located in her power wheelchair in the main dining room. The catheter drainage bag and tubing on the footrest with no bag cover.

A Physician Notification sheet faxed on 12/9/2019 revealed the staff requested an order for a urinary catheter due to a non-healing wound on the buttock (incontinence related). The Physician approved the order.

A Physician Notification sheet faxed on 12/16/19 revealed the staff informed the Physician

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F 690	Continued From page 48 Resident #94 had size 16 urinary catheter placed last week. The staff requested a larger catheter due to the catheter tubing kinking when up in the wheelchair which in turn caused sediment to build up in the line. The Physician approved the order. During an interview on 1/6/2020 at 11:01 a.m., the Assistant Director of Nursing, (ADON) stated Resident #94 agreed to the catheter and planned to for documentation of an assessment for the need for catheter. However, no documentation provided. The ADON confirmed Resident #94 received education regarding the risks involved with catheter placement by the Wound Nurse after the catheter was already in place. The ADON stated the Physician was involved in the decision to place catheter. The ADON stated would expect the urinary catheter drainage bag to be in a privacy bag, which were available at the facility, and not be laying on the footrest or the floor. During an interview on 1/7/2020 at 1:05 p.m., the Acting Director of Nursing (DON) stated the resident had approached her about putting a catheter in. The DON stated this bothered her but she obtained an order from the physician. The DON further stated the Wound Nurse did not seem bothered by the fact a catheter was inserted for an intervention to heal pressure wound. However, the DON did not discuss the catheter with the Wound Nurse before they obtained the order. The DON stated she was not sure the staff were not repositioning Resident #94 at night because they had two staff at night, or if it was because the staff did not want to. The DON stated had not attempted or considered the removal of the catheter.	F 690		

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During an interview on 1/9/2020 at 9:30 a.m., the Wound Nurse Consultant stated that she had become aware on 12/19/19 that the facility ad inserted a catheter at Resident #94's request. The Wound Nurse reported Resident #94 informed her that she had requested the catheter the staff were not changing her. The Wound Nurse reported the catheter was not necessary for wound healing and there was more risk involved with having a catheter than not having a catheter.

During a phone interview on 1/13/2020 at 3:30 p.m., the Physician stated he was unaware that measures to prevent and heal pressure areas on the residents buttocks, recommended and ordered by the wound nurse consultant had not been implemented prior to requesting and order for a urinary catheter. The Physician stated the urinary catheter had now been discontinued, but would have expected to be informed.

The facility reported did not have a policy specific to catheter care when requested by surveyor.

A Progress Note dated 1/11/2020 documented the resident complained of burning with urination. Believes she might have a bladder infection. Physician notified and urinalysis for culture as indicated ordered.

A urine lab result report dated 1/14/2020 documented a urine specimen obtained on 1/13/2020 had culture results of greater than 100,000 gram negative rods (bacteria).

A Progress Note dated 1/15/20 revealed the staff received an order for an antibiotic.

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F 690	Continued From page 50 2. The MDS assessment dated of 11/29/19 documented Resident #35 short and long-term memory problems. The MDS indicated Resident #35 independent for bed mobility, and limited assistance of one staff person for transfer, toilet use, and personal hygiene. The MDS documented Resident #35 had an indwelling catheter and always continent of bowel. Resident #35 had diagnoses of hypertension, heart failure, diabetes, and cardiorespiratory conditions. Observation on 12/30/19 at 10:12 a.m., revealed Resident #35 sitting in his room with the supra pubic catheter bag laying on the floor. The bag filled half way up the bag. The floor contained a stick substance and had a urine odor. The drainage bag had no cover. 3. The MDS assessment dated 6/3/19 documented Resident #12 had diagnoses that included neurogenic bladder and quadraplegia. Resident #12 had no cognitive impairments. The MDS documented Resident #12 had an indwelling urinary catheter. The Care Plan dated 6/19/19 directed the staff to change Resident #12's catheter as ordered, monthly, and as needed. The Order Summary Report dated 7/10/19 directed staff to change the 16 French urinary catheter every 30 days starting on the 27th and as needed. During an interview on 1/6/20 at 9:05 a.m., the Assistant Director of Nursing (ADON) indicated the staff documented catheter changes on the Treatment Administration Record (TAR).	F 690		

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F 690	Continued From page 51 Review of Treatment Administration Records, the Medication Administration Records, and Progress Notes for July 2019, August 2019 and October 2019 revealed a lack of documentation to show the staff changed the catheter. During an interview on 1/13/20 at 3:30 p.m., Resident #12's Physician stated he did not think the lack of catheter changes had a negative outcome.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and interviews the facility failed to ensure a resident had the necessary supplies to maintain a clean and sanitary Continuous Positive Airway Pressure (C-PAP) device for 1 of 1 sampled (Resident #8) for respiratory care and services. The facility reported a census of 44. Findings include: 1. The Minimum Data Set (MDS) assessment dated 10/5/19 documented Resident #8 displayed independent decision-making and had no	F 695		

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memory impairment. The resident's diagnoses included an amputation below the left knee and anxiety.

The Order Summary Report dated 1/9/20 revealed Resident #8 had an order for a C-PAP device at hour of sleep every night.

The Care Plan dated 10/2/19 identified Resident #8 utilized a C-PAP machine while sleeping and informed staff the resident would notify staff when he needed equipment for the machine from the medical supply company.

During an 12/30/19 at 3:03 p.m., Resident #8 stated he takes care of his own C-PAP machine but does not receive clean supplies to do so. The resident stated he had not had a clean filter for six months or clean tubing for at least the last four months.

During an interview on 1/7/20 at 1:26 p.m., Resident #8 stated he should get supplies routinely for cleaning and changing the C-PAP machine from the medical supply company where he bought the machine. Resident #8 talked to the the Assistant Director of Nursing (ADON) about it, most recently a couple of months ago, but had not received new supplies. Observation of the C-PAP filter revealed a build up of a gray substance. Resident #8 reported no recent respiratory infections.

During interview on 1/13/20 at 1:20 p.m., the ADON stated the facility ordered Resident #8's C-PAP supplies through a local medical supply company. Resident #8 cleaned his own machine and informs staff when he needs supplies but it had been awhile since he let her know of the

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F 695	Continued From page 53 need for supplies. The ADON checked the Electronic Record and called the supply company and reported the facility ordered C-PAP supplies in April of 2019. The ADON stated the resident did not have a system to monitor for the need to order supplies. During an interview on 1/13/20 at 1:47 p.m., Resident #8 stated that he understood the C-PAP supplies would be ordered routinely. The previous Director of Nurses told him that. The medical supply company staff told him to change all the filters and tubing every three to four months. During an interview on 1/13/20 at 1:58 p.m., with the Medical Supply Company staff revealed the C-PAP device manufacturer recommended changing out the filter every month, the tubing every three months and the mask every six months.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		

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F 725	Continued From page 54 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interview, the facility failed to ensure the resident's needs were met in a timely manner for 3 of 17 sampled (Resident #8, #12, #94). The facility reported a census of 44. 1. The Minimum Data Set (MDS) assessment dated 11/13/19 revealed Resident #94 had no cognitive impairments. Resident #94 required extensive assistance of two staff with bed mobility and dressing, and total dependence for transfers, toilet use, and bathing. The MDS further documented always incontinent of bowel and bladder. Resident #94 had diagnoses of hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. During an interview on 1/2/20 at 3:45 p.m., Resident #94 reported she never gets turned at night. Resident #94 reported waiting 20 minutes up to an hour for staff to respond to the call lights. However, not when surveyors are here. The staff informed Resident #94 last night that they only had one Nurse Aide.	F 725		

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F 725	Continued From page 55 During an interview on 1/7/20 at 1:45 p.m., the acting Director of Nursing (DON) stated reported she was aware that call lights are not answered timely and often take too long. The DON feels there is not enough staff. The DON stated staff are rude and disrespectful and ignore residents requests for help. During an interview on 1/7/20 at 1:05 p.m., the Assistant Director of Nursing (ADON) stated the residents reported the staff are not repositioning them every two hours as is the expectation. 2. The MDS assessment dated 6/3/19 documented Resident #12 had diagnoses that included neurogenic bladder and quadriplegia. Resident #12 had no cognitive impairments and required two staff to assist with bed mobility, transfers, and toilet use. Review of the Care Plan dated of 6/19/19 documented Resident #12 utilized a catheter and required assistance with transfers. During interview on 1/13/20 at 2:30 p.m., Resident #12 stated that twice over the previous weekend, she did not receive timely help after incontinence. On 1/10/20, she activated her call light and asked to be changed after bowel incontinence. She was told staff needed to get help, but no one would come. Resident #12 stated turned the call light on again, staff turned it off and did not return; this happened repeatedly. She finally received assistance to change at 10:30 p.m. and she started asking for help at 5:30 p.m. On 1/12/20, Resident #12 stated she had a bowel movement after receiving a laxative and put her call light on for assistance. A female Nurse Aide answered and told her the only Nurse	F 725		

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F 725	Continued From page 56 Aide was male and that she wouldn't want a male to take care of her, would she? The resident told her she didn't care, but they didn't help. At 10:00 p.m., the night shift staff arrived and helped her. She stated she initially requested help around 7:00 p.m. Resident #12 had a clock within view her bed. Review of the Progress Note dated 1/12/20 at 7:29 a.m. revealed she received Milk of Magnesia (a laxative). 3. The MDS assessment dated 10/5/19 documented Resident #8 displayed independent decision-making and had no memory impairment. Resident #8 required assistance of two staff for toilet use and bathing. Resident #8 had diagnoses of left below the knee amputation and anxiety. The MDS documented Resident #8 required surgical wound care. During interview on 12/30/19 at 3:19 p.m., Resident #8 stated that sometimes agency staff watch TV in residents' rooms and they can't see call lights. Two days ago on the evening shift, he waited 45 minutes for the staff to respond to his call light. Resident #8 had a hard time not peeing himself and that he needed help with everything...dressing, bathroom, etc. Observation at the time of the interview revealed a clock within view of the resident's bed.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		

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F 758	Continued From page 57 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interviews and clinical record reviews, the facility failed to limit as needed psychotropic drugs including anti-psychotic drugs to 14 days without physician rationale for 2 of 4 sampled (Residents #19 and #23). The facility reported at census of 44.

Findings include:

1. A Minimum Data Set (MDS) dated 10/28/19, documented Resident #19's diagnoses included anxiety disorder, depression, bipolar disorder and psychotic disorder. A Brief Interview for Mental Status (BIMS) revealed the resident was not completed. This resident was independent for bed mobility, personal hygiene, transfer and toilet use.

An Order Summary Report dated 1/15/20, showed an active order for Lorazepam (an anti anxiety medication) to be given as needed (PRN) every 24 hours. This medication showed an order date of 12/12/19.

On 1/15/2020 at 10:31 a.m., the Assistant Director of Nursing (ADON), revealed there were no pharmacy recommendations regarding the PRN Lorazepam nor were there any physician's orders giving rationale to continue the PRN Lorazepam. ADON stated understanding of PRN psychotropic medications (including anti anxiety drugs) needed a 14 day stop date or rationale for continuation. ADON stated the facility had neither

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a stop date nor continuation rationale for Resident #19's PRN Lorazepam.

On 1/15/2020 at 3:33 p.m., the Pharmacist Consultant concurred the PRN Lorazepam was current, was not ordered with a discontinue date. The Pharmacist Consultant stated this order should have been discontinued after 14 days. She stated, she had not done the monthly pharmacy review for the month of December, therefore recommendations had not been given. The Pharmacist Consultant did not know if the primary care provider was aware of the 14 day PRN regulation.

The Psychotropic Drug Use Policy dated 1/2019, stated PRN Anti-anxiety orders must have a 14 day stop date, unless written with a clinical rationale and expected duration of use.

2. Minimum Data Set (MDS) dated 11/6/19, documented Resident #23 had no active diagnosis in the past 7 days. A Brief Interview for Mental Status (BIMS) recorded a score of 8 out of 15 indicating a mild cognitive impairment. Resident required limited assist of 1 for bed mobility and personal hygiene. Resident required extensive assist of 1 for transfer and toilet use.

An Order Summary Report dated 1/15/2020, showed an active order for Seroquel (an anti-psychotic medication) to be given PRN every 12 hours. This medication showed an order date of 10/24/19.

An Admission Medication Review dated 10/24/19, stated Please advise a 14 day stop is required for PRN Quetiapine (Seroquel).

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F 758	Continued From page 60 On 1/15/20 at 10:31 a.m., the ADON stated there was no discontinuation date ordered on the PRN Seroquel for Resident #23. The ADON concurred there should have been and the PRN Seroquel should not have been given for more than 14 days without physician orders. The ADON stated there were no pharmacy recommendations since the admission recommendations, nor had there been any physician order regarding the PRN Seroquel. On 1/15/20 at 3:33 p.m., the Pharmacist Consultant stated she was unaware that Resident had an order for PRN Seroquel. She stated she looks at the pharmacy's system called QS1. The Pharmacist Consultant stated the facility's system and the pharmacy's system must not talk with each other. She did not view the order on her system so could not give recommendations on this medication. She concurred that the PRN Seroquel should have been discontinued after 14 days. The Psychotropic Drug Use Policy dated 1/2019, directed PRN anti-psychotic orders must have a 14 day stop date with no exceptions.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)	F 801		

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F 801	Continued From page 61 This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-	F 801		

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F 801	Continued From page 62 (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on document review and staff interviews, the facility failed to employ a qualified person to serve as the director of food and nutrition services in the absence of a full-time dietitian and ensure sufficient scheduled consultations from a qualified dietitian to provide adequate oversight and support to the department. The facility identified a census of 44.. Findings include: During an interview on 12/30/19, at 9:21 a.m., the Dietary Account Manager reported she is in charge of the facility's foodservice department, and is employed through a contract with a	F 801		

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professional services group. She reported she has been employed in the facility since August 2019. The Dietary Account Manager acknowledged she is not currently a Certified Dietary Manager (CDM) but has completed the course that qualifies her to take the certification exam, which is scheduled for 1/24/19. She acknowledged she had completed a Certified Food Safety Protection Professional program (CFPP - ServSafe) at one time but confirmed she let it expire.

During an interview on 12/30/20, at 9:35 a.m., the Dietary Account Manager reported their current contracted dietitian comes weekly. She reported she does not really interact with her or dietary staff and stated "she barely talks to us".

During an interview on 1/02/20, at 1:05 p.m., the Administrator reported their current facility dietitian had previously been contracted through the facility but when the contracted dietary services group came on board, part of their service included dietetic services. She explained the facility wanted to keep their current dietitian so she is now contracted by dietary service group to provide services at the facility.

During an interview on 1/02/20, at 1:15 p.m., the Dietary Account Manager confirmed the contracted dietitian does not conduct any activities in/with the foodservice staff including education, observation of meal service, food handling or environment/sanitation checks.

During an interview on 1/02/20, at 1:10 p.m., Assistant Director of Nursing (ADON) reported the contracted dietitian completes a report with of activities conducted on each visit and provides

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her with a copy. She reported her activities include completion of resident assessments and she documents recommendations, significant weight changes identified, etc. The ADON reported she does not recall any documentation of any activities related to the foodservice department. Review of the the past few months of the reports confirmed documentation of clinical nutrition activities and nothing related to the foodservice department.

During an interview on 1/02/20, at 1:15 p.m., the Dietary Account Manager, reported the contracted dietitian uses her computer to access the resident's electronic health record but confirmed the dietitian does not consult with her regarding any foodservice activities including education with her or dietary staff, observation of meal service/food handling, environment/sanitation checks, etc.

Review of an email from the District Manager of the contracted foodservice company, dated 1/2/2020 identified the facility's Dietary Account manager's start date as "on or about 9/9/19".

Review of a document dated 7/30/19 revealed the Dietary Account Manager successfully completed a Nutrition & Foodservice Professional Training course which qualifies her to take the CDM/CFPP certification exam.

Review of a document dated 11/7/19 identified the dietary account manager received confirmation of a testing appointment to take the Certified Dietary Manager/Certified Food Protection Professional Credentialing Examination on 1/24/19.

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F 801	Continued From page 65 Review of a policy titled "Professional Staffing", revised 9/2017, revealed in part "... If the qualified dietitian ... is not employed full time, a director of food and nutrition services who meets the necessary qualifications will be employed ... A qualified director of food and nutrition services is one who: is a certified dietary manager ... ". Review of a document titled "Dietitian Services Agreement", dated 9/23/19, revealed in part " ... Consultant shall maintain Facility's dietary functions pursuant to this Agreement in compliance with applicable laws and regulation and assist Facility in providing ... meals ... in a palatable and appetizing manner and under safe and sanitary conditions for a reasonable cost ... Consultant shall provide guidance and training to the Food Service Director and dietary staff as required, ... shall inspect all areas of the dietary department, including, but not limited to, sanitation, equipment functioning, food service operations and compliance with applicable federal, state and local laws. Consultant shall be available at various mealtimes to observe dining operation ... The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires an employee with supervisory and management responsibility and the authority to direct and control food preparation and service must be a certified food protection manager.	F 801		
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-	F 803		

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F 803	Continued From page 66 §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; §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, document review, menu review and staff interviews the facility failed to follow the planned menu portion sizes and textures for residents on all diet types. The facility identified a census of 44 residents. Findings include: 1. During an interview on 12/30/19, at 11:30 a.m., the Dietary Account Manager reported the original planned menu for today had been replaced with a resident choice meal, which included turkey, dressing, mixed vegetables (corn and peas) and	F 803		

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peaches, pears or vanilla pudding for dessert. She reported the menu was taken from Wednesday this week, with the exception of serving vegetable mix instead of the identified Brussel sprouts Wednesday, and serving assorted dessert instead of cheesecake. The Dietary Account Manager reported the portion sizes would be the same for the meat, vegetable and dressing as identified on Wednesday and their standard fruit/vegetable serving is 1/2 cup. The Dietary Account Manager reported a printed tray slip identifies the main menu items and portion sizes for each resident, which is served, unless a resident asks for something else ahead of time or they are aware of a dislike. She reported the alternates for the lunch meal would be some leftover chicken and noodles and peas.

Review of the planned Week 2 menu, approved the contracted dietitian, revealed a 1/2 cup serving of fruit and pudding when served as part of the meal. The tray slips for Wednesday lunch (which is being served today) identified a 1/2 cup serving of vegetable and bread dressing.

Observation of lunch meal service on 12/30/19, from 11:45 a.m. through 1:05 p.m. revealed the peaches, pears and pudding dished into small disposable, plastic cups with lids for all residents. The cups with fruit contained 2 or 3 slices and the cups with pudding appeared about 1/2 full.

Following lunch meal service, on 12/30/19, at 1:15 p.m., requested the Dietary Account Manager measure the contents of one of the remaining plastic, disposable cups. All of the small cups of fruit had been used so she measured a pudding cup. She obtained a #12 scoop (equivalent to approximately 1/3 cup) and

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F 803	Continued From page 68 emptied the pudding into it, which did not quite fill the scoop. The Dietary Account Manager acknowledged she did not know for sure how much a #12 scoop yielded in cups but should be 4 ounces (oz)/1/2 cup because it's labeled 4 ounces (oz). The Contracted Dietary Services District Manager confirmed the result of measurement failed to provide a 1/2 cup serving and the small, disposable plastic cups should not be used for portioning menu items. The Dietary Account Manager reported the cups are only used for room trays, however the observation revealed they had been used for all residents regardless of eating in their room or in the dining room. During the Resident Council meeting on 12/30/19, beginning at 2:00 p.m., 7 of 7 residents reported sometimes they don't get much for supper and the menu posted is not always followed. The group reported the small, disposable plastic cups are routinely used for fruit, baked beans, coleslaw, pudding, etc which might contain 3 pieces of fruit or only a few bites. They reported the small, disposable plastic cups are used for all residents, whether it's a room tray or in the dining room. The residents agreed it happens more frequently at the evening meals, but sometimes at lunch too. The residents reported they did not pick the "resident choice" meal today and not sure who requested the items. They commented they would not chose the items served and definitely wouldn't pick pudding or fruit for dessert. The residents all agreed they have shared their concerns regarding the frequent occurrences of the menu not being followed and small portions but it continues until "you" show up, in reference to the survey team.	F 803		

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F 803	Continued From page 69 During an interview on 12/30/19, 5:00 p.m., the Dietary Account Manager confirmed she now understood the small, disposable plastic cups, labeled 4 oz, indicated a fluid ounce measurement and would not hold a 1/2 cup. During random resident interviews on 12/31/19, at 7:15 a.m., two residents requested to share comments on their meal service. Both residents complained the posted menu is not always followed and don't know of the menu change until they receive their plate. They reported it happens more frequently at the dinner meal but sometimes occurs at lunch also. They complained some of the food items, for example fruit, pudding, cole slaw and baked beans, are served in little plastic cups, and commented it's only about 2 bites and sometimes items are omitted, with no replacement. During an interview on 12/31/19, at 3:50 p.m., the Dietary Account Manager confirmed the night staff had been using the small, disposable plastic cups routinely at the evening meal and dished up the fruit and pudding for Monday lunch and she used them for all residents at the Monday lunch meal. She again confirmed the serving in the cup did not provide the identified menu portion of 1/2 cup. 2. Review of the planned menu for the dysphagia diets at the Week 2 dinner meal, on 12/30/19, revealed it identified a 1/2 cup of pureed fruit salad for the dysphagia mechanical diet and the dysphagia puree diet and a 1/2 cup of ground fruit salad for the dysphagia advanced diets. The dinner meal also identified coleslaw as the vegetable.	F 803		

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Review of an untitled facility report, dated 12/30/19, revealed a current list of resident diet orders. The report identified 4 residents on a dysphagia mechanical diet and 3 residents on a dysphagia puree diet.

Observation of dinner meal service on 12/30/19, from 5:32 p.m. to 6:15 p.m., revealed Staff I, Cook and Staff K, Dietary Aide, assigned to serve the dinner meal and the Dietary Account Manager remained in the kitchen to assist. The Dietary Staff served 4 of 4 residents observed, on a dysphagia mechanical diet, regular texture fruit salad and served 2 of 2 residents observed, on a dysphagia puree diet, applesauce. All of the residents received broccoli for a vegetable instead of cole slaw.

During an interview on 1/2/20, at 7:25 a.m., the Dietary Account Manager confirmed the menu, for dinner on 12/30/19, had not been followed for the dysphagia diets, as the tray slips identified an altered texure of fruit salad and reported she had not noticed the texture differences for the dysphagia diets identified on the tray slips.

During an interview on 1/02/20, at 11:38 a.m., the Dietary Account Manager reported she has a form to document substitutes and had recorded the substitutes made at the lunch meal on Monday. She acknowledged she had not been routinely documenting menu changes on the form.

During an interview on 1/02/20, at 11:45 a.m., the Dietary Account Manager provided a copy of the substitution log she completed on Monday that identified the substitution made for Monday and Wednesday lunch but identified the main entree

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F 803	Continued From page 71 only and not the substitutions for the vegetable and desserts, nor did it identify the menu change for Monday dinner, which substituted broccoli for coleslaw. Review of a facility policy titled "Menus", revised 9/17, revealed in part " ... A menu substituion log will be maintained on file ...".	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff and resident interviews, the facility failed to prepare and provide routine alternative menu options and palatable food to the residents. The facility reported a census of 44 residents. Findings include: During the Resident Council meeting on 12/30/19, at 2:00 PM, 7 of 7 residents agreed they have had ongoing complaints with the food quality and food temperatures and have shared their concerns but it doesn't seem to change. They commented the hot food is often "cold" and sometimes the food quality is not good and provided examples such as the vegetables may	F 804		

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be over or undercooked, meat dry and hard to chew. The group agreed the "cold" food did not just apply to room tray as they generally eat in the dining room. The group reported it is generally worse at dinner, but today at lunch, they reported the turkey was dry and the dressing soupy and not good. The residents also expressed concerns regarding the lack of alternate choices, and again reported the problem is generally worse at dinner but occurs at lunch sometimes too.

Review of the Resident Council Meeting minutes from 9/27/19, 10/30/19 and 11/27/19. The minutes from 9/27/19 identified cold food as an old business concern and undercooked food as new business concern. The only remedy identified on the form titled "Resident Council Department Concerns and Corrections", dated 9/27/19, identified the statement "Checked, changed cooks" and the yes/no question to identify potential need for further action lacked a response. The minutes from 10/30/19 identified food cold and not cooked through and a new business concern of cold food. The form titled "Resident Council Department Concerns and Corrections", dated 10/30/19, identified the statement "Talked w/staff and did training, have new cooks" and the yes/no question to identify potential need for further action lacked a response. The Administrator signed both forms on the same date. The minutes from 11/27/19 identified food is served cold as old business.

During an interview on 12/31/19 at 3:50 p.m., the Dietary Account Manager reported she had heard some complaints about food quality and food temperatures She reported they had a problem with a night cook, whom is no longer employed, and believed he had contributed to the complaints

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at the dinner meal. She reported she has looked at the food temperature at the time of service, which are good and is not sure why the temperatures are not holding. The Dietary Account Manager reported she has also worked on timing in the kitchen, as far as dishing quickly to get the plates out and passed to residents but confirmed she has not looked at the speed of which the room trays are passed, because the Certified Nurse Aids (CNA's) pass them. She reported she does one test tray monthly for Quality Assurance.

During an interview on 1/2/20, at 3:00 p.m., the Dietary Account Manager confirmed the documentation identified on the "Resident Council Department Concerns and Corrections", for 9/27/19 and 10/30/19 as the only steps taken to alleviate the residents concern with food palatability. She reported one of the dinner cooks seemed to be part of the problem with food quality and the cook is no longer employed and she provided her dietary staff with education regarding food temperatures.

2. Observation of the dinner meal on 12/30/19, from 5:05 p.m. to 6:15 p.m., revealed Staff I, Cook, assigned to serve the dinner meal. Upon completion of meal service requested a test plate of the main dinner meal items including baked fish portion and french fries but unable to taste the broccoli, as all of it had been served. The taste of fish portion revealed a somewhat warm taste but the french fries were hard (unable to pierce with a fork), barely warm and unpalatable.

During random resident interviews on 12/31/19, at 7:15 a.m., two residents requested to share comments on their dinner meal last night. One

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resident reported it was "terrible" and described the french fries as cold and hard, broccoli mushy and the fish looked like it was done, but tasted barely warm. The second resident agreed, the french fries were cold and hard, the broccoli mushy and the fish barely warm. The second resident reported her current admission is her second, as she returned about 6 months ago, and the foodservice has been not been good since her return. She reported she buys a small supply of her own food each month in case she doesn't get enough to eat because the food is not good. Both residents reported they don't usually have alternates to chose from. They acknowledged they can ask for a peanut butter sandwich but sometimes, especially at night, may not get it.

3. Observation on 12/31/19, beginning at 7:30 a.m., revealed the Dietary Account Manager prepared to serve the breakfast meal and began dishing meals for the room trays. Staff L, Dietary Aide, took the first cart of 5 trays to the nurses station and returned to the kitchen. The Dietary Account Manager began to dish the meals for the second room tray cart, and surveyor requested a test tray for the second cart. The Dietary Account Manager dished the test tray at 7:42 a.m., and Staff L, Dietary Aide, took the room tray cart, with 5 more resident meals, to the nurses station. The first cart remained at the nurses station. At 7:57 a.m. a Certified Nurses Aide (CNA) took the second cart and began passing the meals. The test tray remained on the second cart for testing after all the resident trays served on both carts. The CNA began passing the meals from the first cart at 8:05 a.m. and the last meal passed at 8:17 a.m. Evaluation of the test tray began at 8:18 a.m., with a second surveyor, as the Dietary

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F 804	Continued From page 75 Account Manager remained busy serving the dining room. The milk measured 53.9 degrees and both parties agreed it tasted warm. The sausage measured 95.7 degrees, scrambled eggs measured 93.7 degrees and both parties agreed the items tasted barely warm and not at a preferable temperature. The temperature of the bacon and toast not measured but both parties tasted them and the bacon and toast tasted cool and the bacon hard to chew. During a random resident interview on 12/31/19, at 08:30 a.m., a resident seated in the dining room eating breakfast requested to share her comments about food concerns. She reported she had recently admitted here following a stay at another long-term care facility to be closer to her family. She reported the meal service is "awful". The resident described the french fries at supper last night as cold and hard, the broccoli mushy and described the fish portion as "ok" and commented at least it was a little warm. She reported the dinner meals are the worst and believed the dietary staff needed more supervision and training. The resident reported concerns the facility does not offer routine options for alternates and added occasionally there might be an alternate choice at lunch but not at supper. She reported if they can get anything it's a peanutbutter and jelly sandwich. IV. Observation on 12/31/19, beginning at 12:08 p.m., revealed the Dietary Account Manager prepared to serve the lunch meal and began dishing room trays. Requested she add a test tray to the second cart after dishing all the resident meals, with the main menu items of teriyaki pork, green beans, steamed rice in addition to the alternate roast beef and chicken breast. At 12:13	F 804		

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p.m. the first cart of 5 trays taken to the nurses station by the contracted Dietary Services District Manager. At 12:14 p.m., the Dietary Account Manager started dishing meals for the second cart. She dished the test plate at 12:19 p.m. and the second cart left the kitchen and placed at the nursed station. A CNA delivered the last resident meal at 12:30 p.m. and test tray evaluation proceeded with the contracted Dietary District Manager. The temperature of the pork measured 143.6 and tasted warm, with an acceptable flavor, but had a dry texture, making it more difficult to chew. The contracted Dietary District Manager described the green beans as lacking flavor and both parties agreed the temperature tasted warm but could be hotter. The chicken breast measured 124 degrees. Both parties agree the chicken lacked any seasoning and the meat very dry, difficult to chew and unpalatable. The contracted Dietary District Manager commented the process of passing trays seemed lengthy and identified the need to perhaps change the process to doing each tray individually, rather than several on cart.

During an interview on 12/31/19, at 3:50 p.m. the Dietary Account Manager reported residents can ask for alternative menu items such as soup, cold meat and peanutbutter sandwiches but acknowledges they do not post a daily planned alternate and do not have an alternative menu item list available or posted for residents so they are aware of the variety of options. She confirmed they don't have a planned alternate for the evening meal but usually do for the lunch meal.

During an interview on 1/2/20, at 10:30 a.m., the contracted Dietary District Manager reported their accounts usual practice would be to have an "always available" type menu that would include

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F 804	Continued From page 77 the availability of certain alternative items upon request such as hamburgers/cheeseburgers, soup, salad/chef salad, grilled cheese and sandwiches. Review of a facility policy titled "Test Trays", revised February 2015, revealed in part "... An audit tool to evaluate the ... qualitative aspects of the meal. Data should be reviewed to identify any patterns of deficient practice that would trigger a quality improvement project. Frequency: Eight times per month using alternating meals, days and diet plans ... Testing includes the following criteria: Temperature of foods ... Quality and Preparation ... Missing items or substitutions ...	F 804		
F 812 SS=F	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	F 812		

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F 812	Continued From page 78 by: Based on observations, document review, policy review and staff interview the facility staff failed to maintain the kitchen in a clean and sanitary manner, maintain required food temperatures and store and serve food under sanitary conditions to reduce the risk of contamination to food and food-borne illness. The facility identified a census of 44 residents. Findings include: I. Observation of the kitchen, during the initial environment tour, on 12/30/19, beginning at 9:21 a.m. identified the following concerns with adequate cleaning and intact surfaces: 1. The perimeter of the kitchen floor showed a build up of debris and grime around the entire perimeter, especially under and around equipment. The floor under the dishmachine appeared as if it had some repair done with the floor tiles gone and a rough concrete-looking surface which resulted in a build up of dust/debris/grime. Three floor tiles surrounding a floor drain, near the east wall, had the corners worn through. The tiles, near the left side of the steamtable, had worn through in an area approximately 2" X 1/2". The tiles at the north end of the milk cooler had a worn area approximately 6" X 3". There were several areas of the floor that had small pieces of a tile missing or had become cracked and chipped up. 2. The dishroom area had compromised areas on the east wall by the hand sink and behind a metal storage rack, resulting in a non-intact surface that would not allow for adequate cleaning. The wall behind the hand sink, had an area above it that	F 812		

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F 812	Continued From page 79 appeared as if a soap dispenser had been mounted and removed which left small holes and had torn the top surface of the wall covering exposing the fiberboard underneath. The wall behind the metal storage rack had areas on the wall that appeared as it it had a shelf attached and subsequently removed, which left holes in the wall and tore the top layer off the wall covering, exposing the fiberboard underneath. 3. The ceiling above the dishmachine had a large area of bubbled and peeling paint. The vent above the dishmachine had multiple areas of missing paint. 4. The floor fan in use, near the west kitchen entrance and facing toward the dishmachine area, showed a very heavy accumulation of dirt on the outside and inside surfaces, including the blades. A second fan, mounted on the wall near the east window, also showed a heavy accumulation of dirt on the outside and inside surfaces, including the blades. 5. The pole, by the steamtable, had multiple areas of chipped and missing paint creating a non-intact surface that would not allow for adequate cleaning. 6. The east wall, around the window, showed multiple concerns. The air condition, mounted under the window, had been sealed for the winter, but the area of wall to the left of it, under it, the cord itself, and the plug-in were soiled with food splatters and dust/dirt build up. The hand sink had a gap between the wall and the caulk and the wall paneling that extended from the floor and about half way up the wall, had come loose and gapped away from the wall.	F 812		

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F 812	Continued From page 80 7. The kitchen ceiling had a long crack at the joint of the wall and ceiling with peeling/chipped paint. The crack extended approximately the entire length of the 3 compartment sink. An additional T-shaped ceiling crack in the area of the steamtable and a food preparation counter also had some cracked and peeling paint. 8. A metal storage shelf, next to the stove stored a green and a tan cutting board with worn surfaces such that the hard plastic, intact surface gone across the majority of the boards resulting in a surface that would be unable to be adequately cleaned and sanitized. 9. A metal storage shelf, next to the stove stored a tan colored non-stick skillet with multiple areas of non-stick coating worn off resulting in a surface unable to be adequately cleaned and sanitized. During an interview on 12/31/20, at 3:50 p.m., the Dietary Account Manager acknowledged the cleaning and environment concerns in the kitchen. She confirmed both fans were very dirty and reported they do not use the wall fan and usually don't use the floor fan, which had been in use upon entering the kitchen for this interview. She shut it off and reported they only use it when the dish room floor is wet, which appeared dry at the time. The Dietary Account Manager reported the maintenance department is responsible for cleaning the fans but they can not be taken apart to clean so she wants them discarded. She reported maintenance is supposed to be taking the wall mounted fan down and discarding both of them. She also reported maintenance is supposed to be working on the wall by the air conditioner, including taking the hand sink out,	F 812		

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along with the soap and paper towel dispenser, cleaning up the area under the air condition, including the cord and plug-in and acknowledged the wall paneling is soiled and loose from wall. She reported the plan also included having maintenance replace the wall covering . The Dietary Account Manager reported sweeping and mopping are on the daily cleaning list but acknowledged the floor lacked adequate cleaning around the perimeter and under equipment and acknowledged the non-intact areas of the east dishroom wall.

During an interview on 1/02/20, at 8:20, a.m. the Maintenance Director reported the kitchen fans are not on their cleaning schedule and are the kitchen's responsibility. He had not been aware of any planned changes in the kitchen near the east wall window and reported the Dietary Account Manager mentioned to him just this morning about cleaning the air conditioner cord and plug in. He confirmed he had no knowledge of any plan to remove the hand sink and replace the wall covering on the east wall, near the air conditioner.

During an interview on 1/02/20, at 10:30 a.m., the contracted Dietary District Manager confirmed the environmental concerns identified with the floor, ceiling, fans (have been removed from the kitchen), cutting boards and skillet. He acknowledged the floor could use "more attention to detail" referring to the build up around the perimeter.

The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires non-food contact surfaces of equipment that are exposed to splash, spillage or food soiling be

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F 812	Continued From page 82 constructed of a corrosion-resistant, nonabsorbent and smooth material and the surfaces must be free of unnecessary ledges, projections and crevices and designed and constructed to allow easy cleaning. The surfaces of nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to avoid the accumulation of dust, dirt, food residue and other debris. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires materials for indoor floor, wall and ceiling surfaces be constructed and installed so they are smooth, durable and easily cleanable for areas were food operations are conducted. II. Observation as part of the initial kitchen environment tour, 12/30/19, at 9:40 a.m., revealed the Centaur refrigerator stored an undated, unlabeled container of gravy. The Dietary Account Manager reported she had made it earlier that morning for use at lunch, however the container felt completely cold. The refrigerator also stored an undated, unlabeled container of roast beef , pork and beans and a plastic bag with two sausage patties. During an interview at the time, the contracted Dietary Account Manager acknowledged the items should be labeled and dated. The Arctic air refrigerator stored 6 thawed 6 ounce (oz) Hormel orange nutritional juice drink without a date to identify when thawed. The product label identified it should be used within 14 days of thawing. During an interview at the time, the Dietary Account Manager reported she did not realize the product needed to be used in a certain timeframe and unsure when they had been placed in the refrigerator to thaw.	F 812		

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F 812	Continued From page 83 The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires time/temperature control for safety of certain foods (TCS), which include: an animal food that is raw or heat-treated, a plant food that is heat-treated or consists of raw seed sprouts, cut melons, cut leafy greens, fresh cut tomatoes or mixtures of fresh cut tomatoes. The TCS foods must be marked with a date the items are stored and a label to identify the contents. III. Observation on 12/30/19, at 12:35 p.m., revealed the Dietary Account Manager planned to begin preparation of the pureed menu items for the pureed meal needed at lunch. She reported they puree the items at the time staff are ready to begin assisting the resident. The Dietary Account Manager pureed the turkey with nectar thickened milk, obtained from refrigeration She pureed the peas and dressing with nectar thickened water, obtained from refrigeration. The Dietary Account Manager put each of the pureed items in a bowl, as they were prepared, placed them on a cart, and at 12:58 p.m., she instructed Staff I, Dietary Aide, to take the items to the dining room. Staff I proceeded toward the kitchen door and at the point of the doorway, requested a measurement of the temperature of the items. The Dietary Account Manager placed a thermometer in the pureed turkey, which measured 98 degrees and she reported it would need to be heated. She placed all 3 items in the microwave and at 1:02 p.m. she measured the temperature of the turkey at 115 degrees. She placed the items back in the microwave for approximately a minute and at 1:04 p.m. measured the turkey at 135 degrees, the peas at 155.3 degrees and the dressing at	F 812		

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F 812	Continued From page 84 116 degrees. At the end of meal service on 12/30/19, at 1:07 p.m. requested the Dietary Account Manager measure the temperature of the remaining meal items served at lunch. All of the remaining items measured at least the minimum required hot holding temperature of 135 degrees or above except the ground turkey, which measured 122 degrees and the Dietary Account Manager confirmed it should be hotter. Observation on 12/30/19 from 5:23 p.m. to 6:15 p.m. revealed Staff J, Cook, assigned to serve the dinner meal. At the conclusion of meal service, requested a measurement of end temperatures of the remaining meal items. All of the remaining items measured at the minimum required hot holding temperature of 135 degrees or above, except the french fries which measured 123 degrees. During an interview on 1/02/20, at 10:30 a.m., the contracted Dietary District Manager reported the expectation for hot food is 140 degrees or above and cold food 41 degrees or below, hot foods stored on the steamtable should remain at least 140 degrees or above during service and all reheated items should be 165 degrees or above. Review of a document titled "Service Line Checklist", used to record the daily food temperatures at each meal identified the holding temperature guidelines for hot food at 135 degrees or above, cold food at 41 degrees or below and reheating guidelines for mechanically altered foods at 165 degrees for 15 seconds. Review of a facility policy titled "Food:	F 812		

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Preparation", revised 9/2017, revealed in part "... when reheated, food will be rapidly heated to 165 degrees F ... All foods will be held a at appropriate temperatures, greater than 135 degrees F (or as state regulation requires) for hot holding ... All TCS (Time/Temperature Control for Food Safety) foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a "prepared date" ..."

The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires TCS foods be held for service at 135 degrees or above or 41 degrees or below.

IV. Observation on 12/30/19, at 5:43 p.m., revealed the Dietary Account Manager donned gloves but failed to wash her hands and proceeded to make 2 sandwiches, for a resident request. She handled the bread, ham and cheese packages, obtained the slices needed for the sandwiches, resealed the packages and returned them to the refrigerator. She put the sandwiches together and placed them on the plates with the gloved hands.

Observation on 12/31/19, at 12:04 p.m. revealed Staff L, Dietary Aide, began preparation of requested cold meat sandwiches. She obtained a cutting board and loaf of bread from storage racks and sliced ham and cheese from the refrigerator. Staff L donned gloves but failed to wash her hands first. She handled the packages of ham, bread and cheese slices with her gloved hands and took the slices of ham, bread and cheese from the packages and placed them on a cutting board. She resealed the packages, put the

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packages back in the refrigerator and put the sandwiches together, touching the sandwich items with the gloved hands.

Observation on 12/31/19, 7:25 a.m., revealed the Dietary Account Manager in the kitchen and working on breakfast preparation and buttered toast with her bare hands and placed more slices of toast in the toaster. She carried 6 slices over to the steamtable, returned to the toaster and buttered 8 more slices and carried them to the steamtable for meal service.

During an interview on 12/31/19, at 3:50 p.m. the Dietary Account Manager identified the expectation for glove use when handling ready to eat food included dietary staff needed to wash hands before putting gloves on and sticking to one task and would require a change in gloves if they touched other surfaces. She confirmed she handled toast this morning with bare hands when buttering and placing in steam table and that she shouldn't have.

During an interview on 1/02/20, at 11:45 a.m., reported she could not find a policy specific to glove use but reported all current staff had watch a glove usage video, from the corporate training site, which instructs them to wash hands, don gloves, stick to a single task, then remove gloves and wash hands.

Review of a facility policy titled "Food: Preparation", revised 9/2017, revealed in part "... All staff will practice proper hand washing techniques and glove use ..."

Review of a policy titled "Meal Distribution", revised 9/2017, revealed in part " ... Proper food

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F 812	Continued From page 87 handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires food employees may not contact ready-to-eat foods with their bare hands and must wash hands prior to donning gloves and use single-use gloves for only one task, such as working with ready-to-eat food and used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on facility record review, identification of deficient practices during the current annual survey and staff interview, the facility failed to maintain a Quality Assessment and Performance Improvement (QAPI) program that addressed current concerns at the facility. The facility reported a census of 44. Findings include: The facility's QAPI program documented the purpose was to utilize all staff, residents and others to continually look at everything we do so	F 867		

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as to enhance environments and outcomes to improve our residents' quality of life. A Guiding Principal, #3, instructed the quality of care and quality of life of our residents is a direct outcome of the QAPI. The scope of listed areas included dementia care and services, dining services, activities programs, infection control, nursing services, environmental services and staff satisfaction.

During interview on 1/15/20 at 10:45 a.m., the Administrator identified current QAPI projects included resident food, most recently discussed on 12/23/19. The facility purchased new plate covers and insulators to help with food temps, purchased a new oven and shifted out room trays to earlier delivery. The facility was also working on Agency (temporary) staff usage and the need to get the right staff in place. The facility also discussed resident aggression issues with the Medical Director and he is looking into possible med changes. Those were the big projects right now. The facility also had a high water bill lately; they found some leaks in toilets and sinks and that issue was discussed in QA. When asked about smoking alarm use (turned off), the Administrator stated she just recently became aware of that and could not recall ever being told. A couple of months ago, they came in and learned night shift had turned the front door alarm off, they started immediate education and it sounds routinely now.

The annual health survey and investigation of 12/30/19 to 1/15/20 resulted in eight quality of care deficiency recommendations, four dining deficiency recommendations and one infection control deficiency recommendation.

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F 880	Continued From page 89	F 880		
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 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 90 (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 observation, staff interview and facility policy review, the facility failed to ensure staff followed infection control practices for 1 of 17 sampled (Resident #94). The facility identified a census of 44 residents. Findings include: 1. Resident #94 had a Minimum Data Set (MDS)	F 880		

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F 880	Continued From page 91 assessment with a reference date of 11/13/19. The MDS identified the resident with intact memory and cognition. The MDS indicated Resident #94 required extensive assistance of two staff person with bed mobility and dressing, and total dependence for transfer, toilet use, and bathing. The MDS further documented was always incontinent of bowel and bladder. The resident's diagnoses included hypertension, renal failure, anxiety, depression, chronic pain, lymphedema, and morbid obesity. The MDS indicated the resident assessed as at risk of developing pressure ulcers, with no Stage 1 or higher pressure ulcers present. The MDS identified no upper extremity functional limitation in range of motion and impairment on both sides of lower extremities. Additionally the MDS documented both the resident and staff believe the resident is capable of increased independence in at least some activities of daily living. Observation on 12/30/19 at 4:50 p.m., revealed Staff P (Nurse Aide) and Staff N (Nurse Aide) observed as Staff P completed wound treatment to areas on Resident #94's buttocks. Staff P assisted resident to turn onto her right side and with a gloved hand cleansed in a circular motion to remove layer of pink colored cream/ointment that covered the buttocks. Staff P obtained a second wipe and with the same gloved hand cleansed between the buttocks and with the same wipe then continued in a circular motion over the Stage II pressure areas. Staff P disposed of the wipe and with the same gloved hand opened the resident's bedside drawer and obtained what was identified by Staff P as a compound cream ordered to be applied to buttocks and wounds. Under constant	F 880		

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F 880	Continued From page 92 observation with the same gloved hand Staff P used his index finger and his middle finger to dip into the compound container and obtained a swipe of compound and applied it in a back and forth motion over the buttocks that were observed to be red and excoriated with blood spots noted on the bed linens. With the same gloved hand, Staff P again dipped his index and middle finger into the compound container and obtained another swipe of compound which he was observed to apply to the residents buttocks. Staff P removed his gloves but failed to wash or sanitize his hands. The staff rolled Resident #94 on the left side. Staff N dipped two fingers into the same compound container and applied to the the compound to Resident #94's buttocks without cleansing the area. Staff N with same gloved hand dipped two fingers into the compound container and obtained another swipe of compound and applied it to the open and excoriated areas of the buttocks and upper thigh. Staff N removed gloves and sanitize hands prior to transferring Resident #94 to her wheelchair. During an interview on 1/7/20 at 1:30 p.m., the acting Director of Nursing (DON) stated an expectation of staff to change gloves and perform hand hygiene when going from dirty to clean, and perform hand hygiene with every glove change. Additionally, would not expect staff to use soiled gloved fingers to obtain compound cream from container and would expect staff to use a single use wooden applicator to obtain from container.	F 880		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0615	A. BUILDING: _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC MITCHELLVILLE, LLC	114 CARTER STREET SW MITCHELLVILLE, IA 50169

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 104	50.7(4) 481- 50.7 (10A,135C) Additional notification 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, " elopes " means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This Statute is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to report an elopement for 1 of 1 sampled (Resident #23) to the Department of Inspections and Appeals as required by Iowa Administrative Rule 50.7(4). The facility reported a census of 44. Findings include: The Minimum Data Set (MDS) assessment dated 11/6/19 documented Resident #23 had moderately impaired cognition and displayed verbal behaviors. Resident #23 required assistance of one staff for transfers, did not walk, used a walker and wheelchair, and had limited range of motion to both upper and lower extremities on one side of his body. The Medical Diagnosis sheet dated 1/2/20 revealed Resident #23 had a diagnosis of traumatic brain injury.	N 104		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0615	A. BUILDING: _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC MITCHELLVILLE, LLC	114 CARTER STREET SW MITCHELLVILLE, IA 50169

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 104	Continued From page 1 The Care Plan dated 10/28/19 directed the staff to allow Resident #23 to smoke outside with his family per facility policy, encourage attending activities to distract from smoking, and ensure oxygen off while smoking or using electronic cigarettes. The Wandering Risk Assessment dated 10/24/19 revealed Resident #23 had a moderate risk to wander. The Electronic Medical Record failed to contain an elopement risk assessment. An Incident Report dated 10/27/19 at 5:41 p.m., documented the staff responded to a visitor yelling for staff assistance outdoors. The staff responded outside and found Resident #23 in his wheelchair. Resident #23 reported he attempted to reposition himself in the wheelchair and slid to the ground. Resident #23 stated a lady helped him back into the chair. Staff noted no injuries following the incident. During interview on 1/7/20 at 3:37 p.m., Staff H (Licensed Practical Nurse) reported the staff found Resident #23 outside the front door on the concrete walkway, about ten feet from the door. Staff H stated the alarms are always on and she cannot remember that any alarms sounded. During an interview on 1/8/20 at 11:35 p.m., Staff M (Registered Nurse) reported a visitor summoned the staff outside to assist Resident #23. Staff M had no knowledge how Resident #23 ended up outside. On 1/9/20 at 10:10 a.m., the Administrator reported the staff had no knowledge Resident #23 exited the facility. The Administrator report	N 104		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0615	A. BUILDING: _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC MITCHELLVILLE, LLC	114 CARTER STREET SW MITCHELLVILLE, IA 50169

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N 104	Continued From page 2 she did not report the elopement to the Department.	N 104		

This Plan of correction and the individual responses to each F tag are written solely to maintain certification with Medicare and Medicaid programs and as required are submitted as credible allegation of compliance. These written responses do not constitute an admission of noncompliance with any requirement. Mitchell Village Care Center wishes to preserve our right to dispute these findings in their entirety should any remedies be imposed and in any legal or administrative proceedings.

- F 641 Mitchell Village Care Center reasonably ensures that the assessment must accurately reflects the resident's status which includes BIMS and range of motion.

1.

- R #34 BIM score was reassessed on 12/31/2019
- R #39 Range of Motion was reassessed on 2/14/2020

2.

- All residents requiring a BIMS assessment may be affected
- All residents with a functional limitation in range of motion may be affected
- A facility wide audit was completed on all residents to ensure BIMS were completed
- A facility wide MDS audit was completed on all residents

- An MDS checklist which includes ROM and BIMS was created and will be utilized upon admission, quarterly assessment, yearly assessment, and if a change in condition were to occur

3.

- On 1/2/2020 and again on 2/10/20 and ongoing Activities/Social Services Designee was educated on completion of BIM assessments that must be completed on admission, during quarterly evaluation, yearly evaluation, and upon a change in condition
- On 2/18/20 and ongoing the ADON/MDS designee was educated on completion of MDS assessment and utilization of MDS checklist

4.

- The DON or designee will complete weekly audits on completion of MDS assessment, including BIMS and Range of Motion for 12 weeks and compliance reviewed by the QA committee quarterly

5. Compliance date: 02/21/20

- F 655 Mitchell Village Care Center Reasonably ensures a comprehensive care plan (baseline) is developed and implemented for each resident to meet professional standards of quality care.

1.
- R #23 was discharged from facility on 2/3/2020

2.
- All residents in the facility may be affected
- All residents that smoke may be affected

- An audit of baseline care plans was completed on all new admissions including residents that choose to smoke

- A baseline care plan tool was developed and will be placed in the communication book upon a new resident admission.

3.
- On 02/18/20 and ongoing MDS, charge nurses, and CNAs were educated on the new baseline care plan tool and where to locate it.

4.
- The DON or designee will complete weekly audits on completion of baseline care plan for 12 weeks and compliance reviewed by the QA committee quarterly

5. Date of Compliance: 02/21/20

- F 656 Mitchell Village Care Center reasonably ensures the devolpment and implementation of comprehensive care plans which includes risk for elopement and wandering behaviors, the use of antipsychotic drugs, and the use or interventions regarding the use of psychotropic medication.

1.
   - R #35 care plan was reviewed and revised to include risk for elopement and wandering behaviors
   - R #23 resident discharged from the facility on 2/3/2020
   - R #36 care plan was reviewed and revised to include the use and interventions regarding the use of psychotropic medication

2.
   - All residents that have the risk for elopement or wandering may be affected
   - All residents who use antipsychotic or psychotropic drugs may be affected
   - A facility wide audit of the care plans for residents that have a high risk for elopement or wandering as well as for residents that use antipsychotic or psychotropic drugs was completed
   - A care plan checklist tool was developed

3.
   - On 02/18/20 and ongoing MDS/ADON was educated on the new care plan checklist

4. The DON or designee will complete weekly audits on completion of care plan checklist for 12 weeks and compliance reviewed by the QA committee quarterly

5. Date of compliance: 2/21/20

- F657 Mitchell Village Care Center reasonably ensures the revision and review of all comprehensive care plans including, the identification of a pressure ulcer.

1.

- R#34 – Read and revised care plan to accurately reflect skin condition which is currently intact

2.

- All residents with pressure sores may be affected
    - A facility wide audit of the care plans for residents with pressure ulcers was completed

A skin integrity process was developed which includes review and revision of care plan

3.

- On 2/18/20 and ongoing MDS/ADON, Skin nurse, and DON were educated on the new skin integrity process which includes the review and revision of care plans

4.

- DON or designee will complete weekly audits on completion of the skin integrity process and care plan revision for 12 weeks and compliance reviewed by the QA committee quarterly

5.

- Date of compliance: 2/21/20

- F677 Mitchell Village Care Center reasonably ensures that a resident who is unable to carry out activities of daily living receive the necessary services, which include assistance with bathing, grooming, and repositioning.

1.
   - R#8 – Read and revised care plan to include the instructions and provision of showers and has been receiving scheduled showers.
   - R#39 – Resident bathing and shaving schedule was reviewed and resident is currently receiving appropriate ADL care (i.e. shaved).
   - R#94 – Resident successfully discharged home on 1/16/2020
2.
   - All residents who are dependent with ADLs may be affected
   - A facility wide audit of care plans for residents who are dependent with ADLs was completed
   - A new shower sheet was developed which includes scheduled baths and shaving
   - Audit mechanical lift slings to ensure appropriate number available for care
3.
   - On 2/18/20 ADON/MDS, Skin Nurse, and CNAs were educated on the new shower sheet which includes the scheduled baths and shaving
4.
   - DON or designee will complete weekly audits on completion of the shower sheets which includes scheduled baths and shaving for 12 weeks and compliance reviewed by the QA committee quarterly
5.
   - Date of compliance: 2/21/20

- F686 Mitchell Village Care Center reasonably ensures that a resident receives care consistent with professional standards of practice to prevent pressure ulcers, including providing care to promote healing, prevent infection, and prevent new pressure ulcers from developing.

1.

- R#94 – Resident successfully discharged home on 1/16/2020
- R#34 – Read and reviewed dietitian recommendations to accurately reflect nutrient needs for wound healing, which is currently none as skin is intact.
- R#2 – reviewed medical record and he has no history of developing a stage 2 pressure ulcer while at facility

2.

- All residents in the facility with pressure ulcers may be affected
- A facility wide skin assessment was completed on all residents on 2/5/2020
- A skin integrity process was developed which includes review and revision of care plans, as well as weekly meetings with the facility dietician.
- A weekly skin integrity/nutrition action team meeting will be conducted to review all skin conditions in the facility. This meeting will include the registered dietician.

3.

- On 01/24/2020 and ongoing the ADON/MDS, Skin Nurse, CDM and Dietician were educated on the new skin integrity process which includes the review/revision of care plans, review of weekly skin sheets/documentation from wound nurse, as well as weekly meetings with the facility dietician.

4.

- DON or designee will complete weekly audits on completion of the skin integrity process and care plan revision for 12 weeks and compliance reviewed by the QA committee quarterly

5.

- Date: February 7, 2020

- F688 Mitchell Village Care Center reasonably ensures that a resident who enters the facility without limited range of motion does not experience a decrease in range of motion, including the completion of staff lead motion exercises as recommended by Physical and Occupational Therapy.

1.

- R#94 – Resident successfully discharged home on 1/16/2020

2.

- All residents with limited range of motion may be affected.
- A restorative program audit was completed for every resident with limited range of motion.
- A restorative program book was created to ensure prompt start of care following a discharge from therapy.

3.

- On 2/18/20 and ongoing Restorative Aide, and Therapy Staff were educated on the new restorative program book which includes documentation of refusals.

4.

- DON or designee will complete weekly audits on completion of restorative program calendar and documentation of refusals for 12 weeks and compliance reviewed by the QA committee quarterly

5.

- Date: 2/21/20

- F689 Mitchell Village Care Center reasonably ensures that a residents environment remains free of accident hazards and that each resident receives adequate supervision, including supervision while smoking and to prevent an elopement.

1.

- R#94 – Resident successfully discharged home on 1/16/2020
- R #23 - Resident discharged from the facility on 2/3/2020
- R #7 – Smoking materials collected and placed in the medication room
- R#93 – Patio secured to ensure safety if resident were to exit into the smoking area

2.

- All residents in the facility may be affected
- A facility wide door alarm audit was completed to ensure all door alarms were functioning
- A smoking materials audit was completed to ensure that all smoking material had been collected
- A daily door alarm audit was created to ensure door alarms were functioning, the patio area was locked, and that staff members were responding to door alarms appropriately.
- Visible signs were placed on the front door and patio door to remind visitors to not permit a resident to follow them out of the facility.
- The secondary alarms were super glued so that the sound settings of the alarms could not be changed.
- The smoking policy was revised so eliminate independent smoking at the facility.
- The resident elopement binder was reviewed
- Resident care plans were updated to the specifics of the new smoking policy (i.e. supervised smoking)

3.

- On 1/8/20, 2/7/2020, and ongoing all staff members were educated on the elopement and door alarm policies
- On 1/8/20, 2/7/2020, and ongoing Charge nurses were trained on the daily door alarm and patio audit
- On 1/9/20 and ongoing residents were educated on changes to the smoking policy

4.

- Administrator or designee will complete weekly audits on completion of door alarm audits for 12 weeks and compliance reviewed by the QA committee quarterly

5.

- Date: February 7, 2020

- F690 Mitchell Village Care Center reasonably ensures that residents who enter the facility continent of bladder remain so, including ensuring that residents are not catheterized unless it is medically necessary and will be changed as ordered.

1.

- R#94 – Resident successfully discharged home on 1/16/2020
- R #35 – Catheter bag has been placed in dignity bag and is off of the floor
- R #12 – Has been receiving catheter changes per physician order

2.

- All residents in the facility may be affected
- A review was completed for all residents with catheters to ensure they are medically necessary
- An audit of residents with catheters to ensure proper diagnosis for catheter use was completed
- The facility catheter policy was rewritten to include the use of dignity bags, the changing of catheters, as well as an appropriate diagnosis that needs to be in place prior to placing a catheter
- A facility audit was completed on the number of dignity bags available to ensure adequate supply

3.

- On February 7, 2020 and ongoing all nurses and CNAs were educated on the new catheter policy that included the use of dignity bags, the changing of catheters, as well as the diagnosis required prior to placing a catheter.

4.

- DON or designee will complete weekly audits on following the catheter policy for 12 weeks and compliance reviewed by the QA committee quarterly

5.

- Date: February 7, 2020

- F695 Mitchell Village Care Center reasonably ensures that residents with respiratory care needs are met, including having the necessary supplies to maintain a sanitary C-PAP device.

1.

- R#8 – Has received new C-PAP supplies and will be reordered monthly

2.

- All residents using C-PAPs may be affected
- An audit was completed of all residents using C-PAPs
- The dates of when to reorder C-PAP supplies for the resident were placed on the MAR and will be provided and changed.

3.

- On 2/18/20 and ongoing the ADON was educated on the ordering schedule that included placing the C-PAP supplies on the resident MAR, and will be changed.

4.

- DON or designee will complete monthly audits on C-PAP supplies to ensure available and changed for 4 months and compliance reviewed by the QA committee quarterly

5.

- Date of compliance: 2/21/20

- F725 Mitchell Village Care Center reasonably ensures sufficient nursing staff with appropriate competencies and skill sets, including meeting resident needs in a timely manner.

1.
   - R#8 – Call light is being responded to in a timely manner per resident's needs (i.e toileting, dressing, etc.)
   - R#12 – Call light is being responded to in a timely manner and remains on until need is met (i.e toileting, dressing, etc.)
   - R#94 - Resident successfully discharged home on 1/16/2020
2.
   - All residents in the facility may be affected
   - All call lights are being responded to in a timely manner and remain on until the needs of the resident are met
   - Call light audits have been completed to determine the amount of time it takes staff to answer them.
3.
   - On 2/18/20 and ongoing all staff were educated that anyone can answer a call light and were informed about the acceptable timeframe they have to answer the light.
4.
   - DON or designee will complete weekly audits on call lights for 12 weeks and compliance reviewed by the QA committee quarterly
5.
   - Date of Compliance: 2/21/20

- F758 Mitchell Village Care Center reasonably ensures that residents do not receive psychotropic drugs pursuant to a PRN order unless medically necessary, and limits as needed psychotropic drugs to 14 days without physician rationale.

1.
   - R# 19 – Order for Lorazepam has been reviewed by resident physician and rationale form has been completed per physician recommendation.
   - R# 23- Resident discharged from the facility on 2/3/2020
2.
   - All residents in the facility who receive psychotropic drugs may be affected
   - Chart review audits of all residents who receive psychotropic drugs was completed.
   - The pharmacist will review PRN psychotropic medications monthly and make recommendations as needed.
   - Physician rational form was developed for appropriate documentation for continued use of PRN psychotropic medications
3.
   - On 2/18/20 and ongoing ADON/MDS and all floor nurses were educated on how to use the physician rational forms and the importance of adhering to the 14 day PRN policy for psychotropic drugs.
4.
   - DON or designee will complete weekly audits on rational forms and PRN medications for 12 weeks and compliance reviewed by the QA committee quarterly
5.
   - Date of compliance: 2/21/20

- F801 Mitchell Village Care Center reasonably ensures sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including employing a qualified person to serve as the director of food and nutrition services when the dietitian is absent and to ensure sufficient consultations from a qualified dietitian.

1.

- Dietary Account Manager – Manager has passed her exam and is currently designated as a certified dietary manager.

2.

- All residents in the facility may be affected
- The duties and responsibilities of the dietician were reviewed
- A weekly cleaning checklist was created for the kitchen via the CMS pathway

3.

- On 2/18/20 and ongoing the Dietician and CDM were educated on the importance of leadership in the kitchen as well as of attending the nutrition meetings.
- On 2/18/20 and ongoing the ADON, CDM, and dietician were educated on the duties and responsibilities of the dietician.

4.

- Administrator or designee will complete monthly audits on weights for 3 months and compliance reviewed by the QA committee quarterly

5.

- Date of compliance: 02/21/20

- F803 Mitchell Village Care Center reasonably ensures that the nutritional needs of residents are met, including following a planned menu portion sizes and textures for residents on all diet types.

1.
   - The certified Dietary Manager has ensured that the portion sizes and textures for residents have been consistent with their diet type

2.
   - All residents in the facility may be affected
   - A review of the weekly menu spreadsheet shows which scoop is needed in order to serve the proper food portion
   - An audit of the kitchen occurred in order to ensure that the kitchen had the proper equipment (i.e. scoops) needed to serve appropriate serving sizes.

3.
   - On 2/18/20 and ongoing the CDM and dietary staff were educated on menu substitutions, scoop sizes, correct portions, use of disposable dishes, not following the menu and diet textures, and use of weekly menu spreadsheet.

4.
   - Administrator or designee will complete tray audits weekly and compliance reviewed by the QA committee quarterly

5.
   - Date of compliance: 2/21/20

- F804 Mitchell Village Care Center reasonably ensures that food and drink is palatable, including preparing and providing routine alternative menu options.

1.
   - The certified Dietary Manager has ensured that residents are receiving palatable food (i.e. temperature) and receiving alternative menu options upon request
2.
   - All residents in the facility may be affected
   - A test tray audit was completed to ensure that plates were palatable and that alternative menu options were available.
   - The alternative menu options will be posted alongside the daily menu
   - Residents will be given the opportunity to fill out a questionnaire regarding food temperature and availability of alternate menu options
3.
   - On 2/18/20 and ongoing the CDM and dietary staff were educated on plate presentation, food temps, food palatability, accurately posting the menu, providing alternates, and posting the alternates.
4.
   - Administrator or designee will complete tray audits and menu audits at least 8 times per month and compliance reviewed by the QA committee quarterly
5.
   - Date of compliance: 2/21/20

- F812 Mitchell Village Care Center reasonably ensures food safety requirements including, maintaining the kitchen in a clear and sanitary manner, requiring food temperatures and store and serve food under sanitary conditions to reduce the risk of contamination to food and food-borne illness.

1.

- The certified Dietary Manager has ensured that the kitchen is clean and that food has been kept under sanitary conditions.

2.

- All residents in the facility may be affected
- The kitchen was deep cleaned in order to decrease the risk of food-borne illness.
- The kitchen is scheduled to be deep cleaned monthly
- All kitchen appliances are placed on a cleaning schedule and foods are to be labeled with the date made and contents of the container.
- The dating and labeling of food is assigned as a task to be completed daily by the cook

3.

- On 2/18/20 and ongoing the CDM and dietary staff were educated on handwashing and food preparation, food labeling, and food temperatures.

4.

- Administrator or designee will complete review and update cleaning schedules at least once per week and compliance reviewed by the QA committee quarterly

5.

- Date of Compliance: 2/21/20

- F867 Mitchell Village Care Center reasonably ensures that quality assessment and assurance is met including, the identification of deficient practices and to maintain a QAPI program that addresses the current concerns at the facility.

1.

- The Administrator has ensured that the deficiencies cited in survey have been addressed.

2.

- All residents in the facility may be affected
- Facility wide audits have been occurring on practices that have been identified as deficient as well as any new business
- A QAPI action team has been assembled and meets once per month to discuss any deficient practices in the building.

3.

- On February 17, 2020 and ongoing all department heads have been educated on the QAPI program

4.

- Administrator or designee will complete QAPI audits at least once per week and compliance reviewed by the QA committee quarterly

5.

- Date of Compliance: 2/21/20

- F880 - Mitchell Village Care Center reasonably ensures that an infection prevention and control program be in place, including ensuring that staff follow infection control practices.

1.

- R#94 - Resident successfully discharged home on 1/16/2020

2.

- All residents in the facility may be affected
- Facility wide pericare audits have been conducted to ensure infection control protocol is being followed.
- Facility wide handwashing and hand hygiene audits have been conducted.

3.

- On February 18, 2020 and ongoing CNAs and Nurses were educated on pericare and hand hygiene when going from dirty to clean.

4.

- DON or designee will complete pericare and hand hygiene audits at least once per week and compliance reviewed by the QA committee quarterly

5.

- Date of Compliance: 2/21/20

- N 104- Mitchell Village Care Center reasonably ensures that when a resident elopes from the facility it is reported to the director or the director's designee.

1.

- R# 23- Resident discharged from the facility on 2/3/2020

2.

- All residents in the facility may be affected..
- Facility wide alarm audit has shown that all door alarms are functioning correctly
- Updated facility smoking policy to include only supervised smoking
- Staff now have access to a "Who to call" sheet that tells them who to call in case a particular situation were to arise.
- Posters are hung with the 2 hour abuse reporting law and the contact information for the administrator and director of nursing.
- Reviewed the elopement policy to ensure a proper definition for elopement was present

3.

- On February 7, 2020 and ongoing staff members were educated on thus use of the "who to call sheet" as well as the location of the abuse reporting sheets with administrative personnel's contact information.
- On February 18, 2020 and ongoing staff members including the DON and Administrator were educated on the facility elopement policy

4.

- Administrator or designee will complete incident report audits and compliance reviewed by the QA committee quarterly

5.

- Date of Compliance: 2/21/20