STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. BUILDING _____ B. WING _____	02/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date March 17, 2020 The following deficiencies relate to the facility's annual health survey and investigation of facility reported incident 89153-I, and complaints 88172-C, 89184-C, and 87905-C. Complaints 88172-C, 89184-C, and 87905-C were not substantantiated. Complaint 86903-C and facility reported incident 89153-I was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000	***"This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."*** Correction date is March 17, 2020	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578	1. To correct this deficiency as it relates to resident #51 and #102, the individual's code status has been corrected in the facility electronic health record system and magnet identifier to reflect their current code status as of 2/13/2020 and 2/12/2020 respectively by MDS Coordinator and Social Services. 2. To protect other residents in similar situations, education was given to the Nurse Management Team and Social Services on Advanced Directives on 03/13/2020, or prior to staff members returning to work.	3/17/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Mueller	Administrator	3/16/2020 03/02/2020

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 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to update the advanced directive status for 2 of 31 residents (#51 & #102). The facility reported a census of 107 residents. Findings Include: 1. According to the Minimum Data Set (MDS) assessment tool dated 12/26/19, Resident #51 had diagnoses that included hypertension, anxiety, depression, and end stage renal disease. The MDS documented the resident scored 11 on the Brief Interview for Mental Status (BIMS) test, which meant the resident displayed mild cognitive impairment.	F 578	Continued from page 1 An audit was completed by the DON or designee on 3/16/2020, facility wide to ensure all advance directive statuses are accurate and current. 3. To ensure the problem does not recur, DON or designee will perform 3 random weekly audits using the Advanced Directive Audit Form (see attached). 4. To monitor performance and to ensure solutions are permanent, DON or designee will report the findings from weekly audits to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 578	Continued From page 2 Observation on initial tour at 12:35 PM on 2/10/20, revealed a green dot magnet located on the resident's door frame. Review of the electronic health records (EHR) at 1:11 PM on 2/11/20, revealed the resident's cardiopulmonary resuscitation (CPR) status as Do Not Resuscitate (DNR). A document titled Advanced Directive Information, updated 1/11/13 revealed the resident's daughter's signature with a date of 5/23/16. The form directed staff to provide CPR. The residents CPR status from her signed advanced directive and the status reflected by on magnet on the door frame did not match the DNR code status located in the residents' EHR. 2. According to the Minimum Data Set (MDS) assessment tool dated 2/4/20, Resident #102 had diagnoses that included Congestive Heart Failure, Diabetes, and End Stage Renal Disease. The MDS documented the resident scored 13 on the Brief Interview for Mental Status (BIMS) test, which meant the resident displayed no problems with cognitive impairment. Observation on initial tour at 1:28 PM on 2/10/20, revealed a red S magnet located on the resident's door frame. Review of the electronic health records (EHR) at 10:09 AM on 2/11/20, documented the resident's CPR status as provide CPR (Full Code). An Iowa Physician Orders for Scope of Treatment (IPOST) signed by the residents' daughter and primary care physician on 1/31/20 documented	F 578		

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F 578	Continued From page 3 the resident's CPR wishes as DNR. The residents DNR status from his signed IPOST and the magnet on the door frame did not match the CPR code status in the residents' EHR. A Bethany Lutheran Home Magnet System definitions sheet dated 3/3/16 directed green color = CPR and red color = DNR. An undated Bethany Home Health Care's Clients Rights Concerning Advanced Directives policy directed the facility would communicate directive to all staff participating in client care. During an interview with Staff K, Licensed Practical Nurse (LPN), at 8:02 on 2/12/20, she stated initially she would check in the EHR for the resident's code status. If there was nothing there, she would then look in the front of the resident's clinical record for the signed advanced directive. Staff K LPN, stated the red and green magnets on the doors are not always accurate and she would not look there initially for the residents code status. During an interview with Staff L, LPN, she stated she would check with the magnet located on the residents' door frame to determine the residents' code status, and if there was no magnet, she would then verify code status in the residents' clinical record, the signed advanced directive. During an interview with the Director of Nursing (DON) at 10:00 AM on 2/12/20, she confirmed that the residents EHR, signed advanced directive, and the door magnets should all match and verified in did not at that time. The DON stated the social workers were responsible to	F 578		

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F 578	Continued From page 4 ascertain the residents' code statuses. During an interview with Staff F, Social Worker (SW) at 2:50 PM on 2/12/20, she confirmed the residents EHR, signed advanced directive, and the door magnets did not match. Staff F, SW stated when the facility switched to a different EHR in July 2019, the two former MDS Coordinators were entering that information into the new system. Staff F confirmed that she is responsible for updating the EHR with status code changes and would expect these all areas to match.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580	1. Due to discharge unable to correct this deficiency as it relates to resident #100 and resident #115. 2. To protect other residents in similar situations, education was provided to all floor nursing staff on proper notification to resident, responsible party and primary care provider of a significant change or significant weight loss. Education will be provided by 03/16/2020 or prior to their next scheduled shift.	3/17/2020

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F 580	Continued From page 5 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (Iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify the physician after a change in status and another resident's representative after a significant weight loss for 2 of 31 residents reviewed (#100 & #115). The facility reported a census of 107 residents. Findings include: 1. According to the Face Sheet, Resident #100 had diagnoses that included: dementia with behavioral disturbances, macular degeneration,	F 580	Continued from page 5 3. To ensure the problem does not recur, a 24 hour progress note review will be completed by DON or designee to monitor for appropriate physician and resident representative notification. 4. To monitor performance and to ensure solutions are permanent, findings from the 24 hour progress note review will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 580	Continued From page 6 hypertension and visual hallucinations. The quarterly Minimum Data Set (MDS) dated 10/29/19 documented a Brief Interview of Mental Status (BIMS) score of 02, which indicated severe cognitive impairment. Behaviors documented included hallucinations and delusions. The MDS revealed the resident needed extensive assist of 1 staff with bed mobility and eating and extensive assist of 2 staff for transfers, dressing, and toilet use. The Physician's Telephone Order dated 11/3/19 directed staff to increase the resident's Seroquel to 50 milligrams (mg) twice a day and to decrease the Risperdal to 1 mg at bed time (HS). The Progress Notes documented the following information: a. On 11/3/19, Resident #100's risperidone was decreased and her Seroquel increased. b. On 11/5/19, the resident's head leaned back and she was unable to hold up her head. c. On 11/7/19, the resident slept most of the day, was hard to arouse, acted very confused, and hallucinated a lot. d. On 11/14/19 the resident slept often and had to be coaxed to stay awake for meals. e. On 11/16/19, the resident required a Hoyer lift for transfers and totally dependent on for repositioning. f. On 11/22/19, the physician ordered staff to move the resident from the secure dementia unit due to no longer needing the environment. g. On 12/8/19, staff documented the resident had been sleeping more during the day. The Care Plan revised on 11/3/19 with the	F 580		

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F 580	Continued From page 7 changes in psychotropic medication directed staff to monitor/document/report any adverse reactions. The quarterly MDS dated 1/21/20 documented a BIMS score of 00, which indicated severe cognitive impairment behaviors to include hallucinations and delusions. The MDS revealed the resident totally depended on 2 staff for transfers, dressing, toilet use and eating. The Progress Notes and Physician Orders failed to contain any information to show the staff notified the physician of any increased sleepiness and decline noted after the change in the psychotropics. In an interview on 2/13/20 at 1:18 PM, the Assistant Director of Nursing (ADON) and Director of Nursing (DON) reported they could not find any documentation that show staff notified the physician of the resident's significant change in condition after the Seroquel was increased on 11/3/19. 2. According to the MDS dated 12/13/19, Resident #115 had diagnoses that included cancer and non-Alzheimer's dementia. The MDS documented the resident scored 6 on the BIMS, which meant the resident exhibited severe cognitive impairment. services. The MDS also documented the resident received hospice services and required extensive assist of 1-2 staff for eating, bed mobility, toilet use and personal hygiene. The MDS revealed the resident was not on a weight loss regimen, but had lost of 5% or more of their body weight in the last month and had lost 10% or more in the last 6 months. Clinical record review of weights revealed:	F 580		

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F 580	Continued From page 8 a. 1/2/20 - 107.7 pounds (#) b. 12/24/19 - 109.3# c. 12/19/19 - 110.4# d. 12/5/19 - 116.3# e. 11/5/19 - 124.3# f. 10/2/19 - 127.7# g. 9/6/19 - 134# h. 8/9/19 - 132.8# i. 7/10/19 - 138.9# j. 7/3/19 - 141.1# k. 6/26/19 - 145.4# l. 6/19/19 - 145.4# m. 6/14/19 - 153.3# Review of dietary progress notes showed the residents' primary care provider was notified of significant weight loss with no new orders on 7/3/19, 8/12/19, 10/14/19, 12/9/19, and 12/30/19. Record review revealed the facility notified the residents' responsible party of the significant weight loss on 7/3/19. The facility failed to notify the resident's responsible party of the continued significant weight loss when the resident's primary care provider was notified. During an interview with the Director of Nursing (DON) at 9:00 AM on 2/17/20, she stated the restorative staff obtain the weights and notify the nurse. The DON stated if staff identify a significant weight loss, the nurse is expected to notify dietary, the primary care provider, and hospice. The DON stated the nurse should fax the completed dietary assessment to the residents' primary care provider, notify the residents' representative after the primary care provider returned the fax, even if there were no new orders. The DON stated she would expect	F 580		

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F 580	Continued From page 9 the residents' representative to be notified of any significant weight loss.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584	1. To correct this deficiency as it relates to resident #73, the arm rests on wheelchair were replaced and cushion cleaned by maintenance staff on 2/17/2020. 2. To protect other residents in similar situations, education was provided to staff members regarding wheelchair cleaning schedule and who to report wheelchairs to that are in need of repair. Education provided by 03/16/2020 or prior to staff members next scheduled shift. 3. To ensure the problem does not recur, a weekly wheelchair audit will be performed by DON or designee on 10 random resident wheelchairs to ensure that wheelchairs are clean and in good repair. 4. To monitor performance and to ensure solutions are permanent, findings will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	3/17/202

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F 584	Continued From page 10 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility communication book, and record review the facility failed to ensure 1 of 23 resident's (Resident #73) wheelchairs were clean and free of debris. The facility reported a census of 107 residents. Findings include: According to quarterly Minimum Data Set (MDS) with a reference date of 1/7/20, Resident #73 had a Brief Interview of Mental Status Score of 3, indicating severe cognitive impairment. The MDS indicated Resident #73 required extensive assistance of two staff for bed mobility, transfers and utilized a wheelchair for locomotion. Review of Resident #73's care plan with a revision date of 1/10/20, revealed she used her wheelchair for mobility and was able to propel herself. The care plan directed staff to provide cues for direction as she often needs help to find where to go. Observations on 02/10/20 at 10:39 AM, 02/11/20 at 1:00 PM, 02/12/20 at 10:45 AM, 02/13/20 at 9:16 AM revealed Resident #73's wheelchair needed to be cleaned. The wheelchair had a lot of white, crusty stains on the cushion, hand rests, and foot pedals.	F 584		

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F 584	Continued From page 11 Observation on 02/17/20 at10:40 AM revealed #73's wheelchair arm rests and cushion still needing to be cleaned as it had a lot of white crusty stains. The foot pedals appeared to have been cleaned. Review of the facility's Certified Nursing Assistant (CNA) book revealed a night shift CNA cleaning schedule. The schedule indicated on Tuesdays staff are to clean the wheelchairs of residents in rooms 217 to 224. Resident #73 resides in room 222. During a staff interview on 02/13/20 at 8:30 AM staff were asked who cleans the resident's wheelchairs. Staff O CNA stated the overnight staff are the ones that clean the resident's wheelchairs. When asked if they clean them every night or is there a scheduled, Staff N Licensed Practical Nurse (LPN) stated there is a schedule they follow. Staff P stated if the wheelchairs are really bad anyone can clean them. During a staff interview on 02/13/20 at 12:16 PM the Director of Nursing (DON) stated the overnight shift aides have scheduled days to clean the wheelchairs. The Infection Preventionist stated staff came to her to let her know that arm rests will not come clean with their bleach wipes so are getting shampooed today. She stated they may need to be replaced with arm rests that can be cleaned. When asked what about the foot pedals and cushion, she said that was different.	F 584		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must-	F 606	1. To correct this deficiency as it relates to Staff I, a background check was resubmitted on 2/12/2020. As of	3/17/202

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BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

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F 606	Continued From page 12 §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on employee file review, staff interview and policy review, the facility failed to obtain a record check evaluation from the Department of Human Services regarding a perspective employee's criminal conviction prior to hire, for 1 of 5 employee files reviewed (Staff I). The facility reported a census of 107 residents. Findings included: Staff I's employee file revealed a hire date of 10/14/19. Staff I's employee file on 2/11/20, revealed a Single Contact License & Background Check (SING) form dated 10/3/19. The form revealed	F 606	Continued from page 12 03/02/2020 DHS stated there was no record check evaluation needed. At this time, Staff I was cleared to return to work. 2. To protect other residents from experiencing similar situations, education with Human Resources was completed on or before 3/16/2020 regarding the completion of record checks prior to hire. 3. To ensure the problem does not recur, background check audits are completed on all new hires by Human Resources or designee. 4. To monitor performance and to ensure solutions are permanent, a new hire list will be pulled, monthly, and files for no less than 25% of the new hires from the previous 30 days will be checked by the Executive Director or designee to ensure the background check has been saved.	

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F 606	Continued From page 13 further research required into the staff members criminal history. Further review of the file revealed no request to the Iowa Department of Human Services (DHS) for review of the employee's criminal history and approval to work in the facility. Review of Staff I's Time Card Report forms recorded her first clock in time as 10/14/19 and her last clock in time as 2/6/20. During interview on 2/13/20 at 7:55 A.M., the facility Executive Director and Chief Financial Officer explained the Human Resource Coordinator at the time of Staff I's hire no longer works in the facility and they are unable to locate any paperwork with regard to obtaining approval from DHS for Staff I to work in the facility. She stated they have submitted the paper work for a DHS evaluation and the facility notified Staff I she can no longer work until she is cleared through DHS. Review of a facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy, with a review date of 2/11/19, included direction for staff to screen employees prior to working with residents and included a criminal background check.	F 606	Continued from page 13 Results will be given to the QAPI Committee for 3 months. QAPI Committee will determine if further reporting and or monitoring is to continue.	
	II $500 Upon Receipt			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623	1. To correct this deficiency as it relates to Resident #106, a fax was sent to the long term care ombudsman office on 03/13/2020, stating that this resident discharged from facility.	3/17/202

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F 623	Continued From page 14 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 623	Continued from page 14 2. To protect other residents in similar situations, education was provided to Social Services regarding the new Ombudsman Notification process by 03/16/2020. 3. To ensure the problem does not recur, DON or designee will ensure accuracy of completion of the new Ombudsman Notification Transfer Form, and will be submitted to the Ombudsman Office by the 10th calendar day of every month. 4. To monitor performance and to ensure solutions are permanent, DON or designee will complete Ombudsman Notification audits monthly for 3 months. Audits will be reported to the QAPI Committee during these 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 623	Continued From page 15 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 16 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify an Ombudsman of a resident's discharge from the facility following hospitalization for 1 of 6 residents reviewed for hospitalization (Resident #106). The sample consisted of 31 residents and the facility reported a census of 107 residents. Findings included: An Admission Record dated 2/12/20, documented Resident #106 had diagnoses that included pneumonia, obsessive compulsive disorder and bipolar disorder. A Minimum Data Set (MDS) Assessment tool dated 12/31/19 identified the resident with a Brief Interview Mental Status (BIMS) score of 15, indicative of full cognition. An Incident note Note dated 1/3/20 at 6:42 P.M., revealed staff notified emergency services and transported the resident to a hospital for evaluation. A Bed Hold Notification Form dated 1/3/20,	F 623		

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F 623	Continued From page 17 revealed the resident signed for his bed to be held while hospitalized. A Social Services note dated 1/7/20 at 12:31 P.M., documented Staff F, Social Worker (SW), spoke to the resident and he stated he did not want to hold his bed. The resident's clinical record lacked a second, signed bed hold form with the resident's request to no longer hold his bed at the facility as documented by Social Services on 1/7/20. A facsimile to the State Ombudsman office dated 2/10/20, revealed staff notified the Ombudsman of the resident's transfer to a hospital and documented the resident would return to the facility. Further record review revealed no notification to the Ombudsman regarding the resident's choice not to return to the facility. During interview on 2/13/20 at 8:40 A.M., Staff F stated she had not been aware the resident signed a bed hold form on 1/3/20 with a request for the facility to hold his bed while hospitalized. She reported when she called the resident on 1/7/20, the resident told her he did not want the bed hold, but confirmed no paperwork had been signed. Staff F confirmed the Ombudsman should be notified if a resident is discharged from the facility following hospitalization. During interview on 2/13/20 at 9:30 A.M., the facility Administrator reported the facility lacked a policy for Ombudsman notification in the event of a resident hospitalization.	F 623		

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F 636 SS=D	Continued From page 18 Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 636 F 636	1. To correct this deficiency as it relates to Resident #15 and #44, modified MDSs were completed and updated accurately on 03/11/2020. 2. To protect other residents in similar situations, a data collection tool and peer audit form was created and staff were educated on 3/13/2020. 3. To ensure the problem does not recur, MDS Coordinators will perform 4 peer-to-peer audits weekly for MDS accuracy. 4. To monitor performance and to ensure solutions are permanent, audits will be done by DON or designee on one peer reviewed MDS and one non-peer reviewed MDS weekly for 3 months. Audits will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or auditing is to continue.	3/17/2020

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F 636	Continued From page 19 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to complete an accurate assessment using the Resident Assessment Instrument (RAI) specified by CMS for 2 of 31 residents (Resident #15 and #44) reviewed. The facility reported a census of 107 residents. Findings include: 1. According to the significant change Minimum Data Set (MDS) with a reference date of 3/15/19, Resident #15 did not receive hospice services during the 14 day review period.	F 636		

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F 636	Continued From page 20 According to two quarterly MDS's with reference dates of 5/28/19 and 8/20/19, Resident #15 did not receive hospice services during the 14 day review period. According to a third quarterly with a reference date of 11/12/19, Resident #15 did receive hospice services during the 14 day review period. Review of Resident #15's care plan with a revision date of 12/6/19 documented she had received hospice services. Review of a patient information report from hospice charting revealed a referral date of 3/1/19. Record review revealed resident discharge instructions from the hospital dated 3/4/19, with the following discharge instructions: hospice. Admission physician orders with an admission date of 3/4/19 revealed the admit level of care as hospice. Record review revealed a physician's telephone order dated 3/4/19 that documented ok to follow hospital discharge orders. During a staff interview on 02/13/20 at 12:14 PM, Staff Q MDS Coordinator stated the hospice services should be reflected in the MDS assessments, but reported these been completed before she took the MDS Coordinator position. 2. According to an admission Minimum Data Set with a reference date of 12/09/19, Resident #44 had a Brief Interview of Mental Status Score of 15	F 636		

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F 636	Continued From page 21 indicating no cognitive impairment. The MDS indicated she had received insulin injections for 6 days during the 7 day review period. The MDS listed diabetes mellitus (DM) as a diagnosis. Review of Resident #44's care plan with a revision date of 1/29/20 revealed no documentation related to her diabetes mellitus diagnosis nor does it listed she had received insulin. Record review of Resident #44's chart revealed an Emergency Department (ED) summary with a visit date of 12/3/19 that did not include an order for insulin. Record review revealed a Medication Administration Record (MAR) for December 2019, revealed Resident #44 did not have an order for insulin to be administered during the the MDS review period. Record review revealed Resident #44's physician's order sheet with a date of 1/6/2020 that did not include an order for insulin. During a resident interview on 02/13/20 at 10:06 AM Resident #44 stated she has not received insulin since being in the facility and does not believe they check her blood sugar levels. During a staff interview on 02/13/20 at 10:12 AM the Assistant Director of Nursing (ADON) stated she was unable to find an insulin order in Resident #44's chart and the diagnosis of diabetes but she was going to double check. During follow up interview at 10:55 AM the ADON stated they were not able to find an insulin order for Resident #44.	F 636		

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F 636	Continued From page 22 During a staff interview on 02/13/20 at 11:19 AM Staff D Licensed Practical Nurse (LPN)/MDS Coordinator stated she could not find a definitive answer as to why the MDS was coded that way. She stated she started this position 2 weeks before Resident #44's MDS was due. She stated when she would gather the information do the MDS assessments, she would take a piece of paper and list residents with their information. She wondered if she put someone else's information in her portion of the gathering process. She stated going over her full MDS she noticed some other issues that did not pertain to Resident #44. Staff D stated they have started a new information gathering tool that is one piece of paper per resident.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change assessment within 14 days of the status change	F 637	1.To correct this deficiency as it relates to Resident #100, a Significant Change MDS with an ARD of 11/16/2019 was completed on 03/13/2020. 2. To protect other residents in similar situations, MDS Coordinators attended Resident Assessment Coordinator Certification training from 03/10/2020-03/12/2020. 3. To ensure the problem does not recur, a 24 hour progress note review will be completed by DON or designee to monitor for changes in condition.	3/17/2020

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F 637	Continued From page 23 for 1 of 31 residents reviewed (Resident #100). The facility reported a census of 107 residents. Findings include: The Face Sheet for Resident #100 documented a primary diagnosis of dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 10/29/19 documented a Brief Interview of Mental Status (BIMS) score of 02, which indicated the resident indicating severe cognitive impairment. Behaviors documented included hallucinations and delusions. Her activities of daily living was coded as needing extensive assist of 1 staff with bed mobility and eating and extensive assist of 2 staff for transfers, dressing, and toileting. The Progress Notes dated 10/31/19 documented the resident was started on Bactrim for a urinary tract infection. The Progress Notes dated 11/3/19 documented her risperidone was decreased and her Seroquel increased. The Progress Notes dated 11/5/19 documented that her head was leaning back and she was unable to hold her head up. The Progress Notes dated 11/7/19 documented that she was sleeping most of the day, is hard to arouse, is very confused and hallucinates a lot. The Progress Notes dated 11/14/19 documented resident sleeping often and has to be coaxed to stay awake for meals. The Progress Notes dated 11/16/19 documented the resident is a Hoyer lift and total dependence from staff to reposition. The Progress Notes dated 11/22/19 documented the physician ordered to move the resident out of the secure dementia unit due to no longer needing the environment. The	F 637	Continued from page 23 4. To monitor performance and to ensure solutions are permanent, The nurse management team will meet weekly to review the finding of the daily reports and monitor for significant changes. Significant change assessments will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 637	Continued From page 24 Progress Note dated 12/8/19 documented the resident had been sleeping more during the day. The Care Plan was revised on 11/3/19 with the changes in psychotropic medication and includes an intervention to monitor/document/report any adverse reactions. The Nutrition Dietary Note dated 1/6/20 documented the resident had triggered for a significant weight loss in 180 days. The quarterly MDS dated 1/21/20 documented a BIMS score of 00 indicating severe cognitive impairment and behaviors to include hallucinations and delusions. Her activities of daily living was coded as needing extensive assist of 2 staff for bed mobility and total dependence on 2 staff for transfers, dressing, toileting and eating. The MDS list lacked any documentation of a significant change assessment being completed. Interviewed the MDS Nurse Staff D on 2/13/20 at 12:05 PM and she stated that when she is doing a quarterly the system will identify when she needs to do a significant change in assessment, and if it is missed they will do one after the quarterly. She stated that they follow the RAI guidelines for when to complete a significant change in assessment.	F 637		
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.	F 641	1. To correct this deficiency as it relates to Resident #3, #34, #92 and #100, Electronic Health Records were updated to accurately reflect	3/17/2020

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F 641	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to accurately document medications with diagnoses on the resident assessment for 4 of 31 residents reviewed (Residents #3, 34, 92, and 100). The facility reported a census of 107. Findings include: 1. The Minimum Data Set (MDS) dated 1/28/20 for Resident #3 documented an admission date of 11/1/19 and seven diagnoses: atherosclerotic heart disease, hypertension, cancer, dementia, falls, obesity, and other arthropathies. The MDS stated the resident received no antidepressant medication during the look-back period from 1/22/20 - 1/28/20 and reported no depression diagnosis. The physician's orders summary (POS) dated 1/6/20 revealed Resident #3 had an order dated 11/21/19 for Sertraline 100 mg daily with a diagnosis of depression. The medication administration record (MAR) for January 2020 revealed the resident received Sertraline daily from 1/22/20 - 1/28/20. 2. The MDS dated 12/14/19 for Resident #34 revealed an admission date of 1/23/18 and documented seven diagnoses: dementia without behaviors, depression, anxiety, hypertension, hyperlipidemia, osteoporosis, and hypothyroidism. The MDS reported seven days of insulin injections during the seven day look-back period but did not include a diagnosis of diabetes.	F 641	Continued from page 25 medications with diagnoses on 03/13/2020 by MDS Coordinator. 2. To protect other residents in similar situations, MDS Coordinators attended Resident Assessment Coordinator Certification training from 03/10/2020-03/12/2020. This training includes in depth review of section I (Active Diagnoses) and section N (Medications). 3. To ensure the problem does not recur, MDS Coordinators will perform 4 peer audits weekly for MDS accuracy related to diagnoses and medications. 4. To monitor performance and to ensure solutions are permanent, Audits will be done by DON or designee on one peer reviewed MDS and one non peer reviewed MDS weekly for 3 months. Audits will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or auditing is to continue.	

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F 641	Continued From page 26 The POS dated 1/6/20 revealed the resident had a diagnosis of diabetes with orders dated 3/6/19 for basaglar 5 units at bedtime, 3/6/19 for glimiperide 4 mg daily, and 11/29/19 for Metformin 500 mg twice daily. 3. The MDS dated 1/14/20 for Resident #92 documented an admission date of 5/4/16. The MDS revealed no diagnosis of depression; however, it documented the resident received an antidepressant seven days during the seven day look-back period. The POS dated 1/6/20 showed an order dated 11/3/19 for Mirtiazapine 15mg at bedtime for depression. 4. The MDS dated 1/21/20 for Resident #100 documented an admission date of 9/13/18 and diagnoses of: dementia, macular degeneration, hypertension, visual hallucinations, and irritable bowel syndrome. The MDS revealed the resident received opioids and antidepressants seven days during the seven day look-back period but showed no pain or depression diagnoses. The POS dated 1/6/20 documented orders for Tramadol 50 mg twice daily with a corresponding diagnosis of pain on 11/11/19 and desvenlafaxin 100 mg daily starting 3/13/19 with a diagnosis of depression. On 2/12/20 at 1:40 pm Staff D, MDS Coordinator, reported diagnoses for new residents come from their hospital and/or clinic records. Residents admitted prior to June 2019 had their diagnoses transferred or from Matrix to Point Click Care (PCC) when the switch in electronic health record	F 641		

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F 641	Continued From page 27 systems took place. Nurses write new orders on physician telephone orders (TO) and a copy is reviewed by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) and then dispersed to other staff. When the MDS Coordinators receive the TO's they transcribe the diagnoses into PCC. QMAR is the electronic health record system used by the facility for orders. Pharmacists place the medication orders with diagnoses into QMAR. QMAR does not flow into PCC. The expectation is for all current diagnoses for medications received during the look-back period to be on the MDS. On 2/13/20 at 9:30 am the DON reported she expected staff to code diagnoses accurately on the MDS assessments.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to initiate an antibiotic for 1 of 3 residents (Resident #62) reviewed for respiratory infections. The facility reported a census of 107 residents. Findings include: According to an entry Minimum Data Set (MDS) with a reference date of 1/24/20 Resident #62 re-entered the facility from an acute hospital stay.	F 658	1. To correct this deficiency as it relates to Resident #62, the charge nurse notified the resident's primary care provider of possible medication variance immediately upon discovery on 1/31/2020. A new antibiotic was initiated at this time. 2. To protect other residents in similar situations, education on initiating antibiotic therapy per reflecting physician order will be given to all floor nurses. Education will be given by 03/16/2020 or prior to next shift worked.	3/17/202

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F 658	Continued From page 28 Review of Resident #62's Medication Administration Record (MAR) for January 2020 revealed she had an order for Levofloxacin 500 mg x 10 days, with a written date of 1/18/2020-1/27/2020. There was a second order for Levofloxacin 500 mg x 10 days, with a written date of 1/31/2020-2/4/2020. Review of the MAR revealed the Levofloxacin was not given 1/28/2020-1/30/2020, Resident #62 was not given 3 doses. Record review of Resident #62's Electronic Health Record (EHR) revealed the following progress notes: -1/24/2020 at 2:50 AM an Admission Summary note as a late entry documented the resident returned from the hospital and admitted back to her room. -1/24/2020 at 5:00 PM an order noted as a late entry documented a telephone order from a physician instructing staff to follow hospital discharge instructions. Staff faxed the hospital discharge instructions to the pharmacy and notified Resident #62 of the new orders. -1/31/2020 at 10:36 PM a health status note revealed staff notified Resident #62's physician of a medication variance. Resident #62 did not receive Levofloxacin 500 mg x 10 days ordered on 1/24/20 (the readmission date). Staff informed the physician the resident had no adverse effects from this variance, and the physician directed staff to give Levofloxacin 500 mg po daily x 5 days. -2/4/2020 1:00 PM an order note documented the	F 658	Continued from page 28 3. To ensure the problem does not recur, DON or designee will perform weekly audits on all antibiotic orders to ensure timely initiation. 4. To monitor performance and to ensure solutions are permanent, antibiotic order audits will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or auditing is to continue.	

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F 658	Continued From page 29 resident returned from an appointment with her physician with an order to continue Levofloxacin 500 mg daily X 5 days. Record review revealed the following documentation: -Review of a hospital discharge summary with a date of 1/24/20 at 12:58 PM revealed a discharge diagnosis of pneumonia and acute bronchospasm. The summary included an order for levofloxacin 500 mg 1 tablet by mouth daily for 10 days. -Re-admission physician orders dated 1/24/20 at 2:50 pm revealed resident admitted with pneumonia and the following antibiotic order: Levofloxacin 500 mg daily x 10 days. -Physician telephone order dated 1/24/20 at 8:20 PM revealed staff are to follow hospital discharge instructions. -Follow-up appointment on 2/4/2020 and the physician made the following note: since patient did not receive Levofloxacin after hospital discharge, she needs to complete full course of antibiotic. The physician wrote a new order for Levofloxacin 500 mg daily for a total of 10 days. A 5 day script to continue the Levofloxacin was sent to the pharmacy. During an interview on 02/10/20 at 11:30 AM Resident #62 was asked if she knew about missing her antibiotics after her hospitalization. She stated they did not start her antibiotic right away when she came back from the hospital. She stated they waited 2 or 3 days later to start her Levofloxacin. Resident #62 stated her physician	F 658		

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F 658	Continued From page 30 had to order it longer because it was missed. When asked why she was hospitalized she stated she had pneumonia. During a staff interview on 02/13/20 at 12:18 PM the Assistant Director of Nursing (ADON) started the Levofloxacin was initially stated before Resident #62 went to the hospital. When Resident #62 was hospitalized the medication was put on temporary suspension. When she came back to the facility with the new orders for the Levofloxacin, the pharmacy resumed the original order and the order just fall off the MAR. The ADON stated the nurse that approved the new order probably saw the current order, thought it was the new order from Resident #62's recent hospitalization and not the old one that was started prior to being sent to the hospital. The ADON stated she did not think pharmacy had entered the new order after they received it.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686	1. Due to discharge unable to correct this deficiency as it relates to resident #115. 2. To protect other residents in similar situations, eduction provided to all charge nurses on providing necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing by 03/16/2020 or prior to next shift worked.	3/17/2020

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F 686	Continued From page 31 by: Based on clinical record review and staff interview, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 1 residents reviewed for pressure ulcers. (Resident #115). The facility reported a census of 107 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 12/13/2019, Resident #115 had diagnoses that included: cancer and non-Alzheimer's dementia. The MDS documented the resident had scored a 6 on the Brief Interview for Mental Status (BIMS), which meant the resident experienced severely impaired cognition. The MDS coded the resident required extensive assist of 2 staff for bed mobility, toilet use, and personal hygiene, and depended totally on staff for transfers. A nurses' note dated 12/31/2019, revealed a 3.0 X 2.9 centimeter (cm) unstageable pressure injury to the resident's coccyx. The MDS identified the following descriptions of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis	F 686	Continued from page 31 3. To ensure the problem does not recur, a 24 hour progress note review will be completed daily by DON or designee to monitor changes in skin integrity. 4. To monitor performance and to ensure solutions are permanent, the nurse management team will meet weekly to review the finding of the daily reports and monitor for changes in skin integrity. Pressure ulcer status and treatments will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 686	Continued From page 32 presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but 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. Stage IV is 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 is full thickness loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. A Care Plan with initiation date 6/19/19, identified the resident had an unstageable pressure injury to their coccyx. The resident scored a 10 on the Braden Scale for predicting pressure sore risk dated 10/20/2019. A score of 10 meant the resident was at high risk for developing a pressure ulcer. Progress notes, skin/wound entries, documented: a. On 11/19/19: staff documented no new skin issues at this time. b. On 11/23/19 staff completed a daily skin check with no new skin issues identified. c. On 11/24/19 staff completed a daily skin check with no new skin issues identified. d. On 11/29/19 staff documented no new skin issues at this time.	F 686		

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F 686	Continued From page 33 e. On 12/13/19 staff documented no new skin issues at this time. f. On 12/21/19 documentation revealed the resident continued with open area to coccyx. g. On 12/25/19 staff documented no new skin issues at this time. h. On 12/26/19 staff documented no new skin issues at this time. i. On 12/29/19 staff documented no new skin issues at this time. j. On 12/31/19 resident noted to have unstageable pressure injury to coccyx Review of Hospice documentation revealed the following entries: a. On 11/26/19 - A facility nurse informed the hospice nurse that the area on the resident's coccyx is slightly improving: staff to continue venalex ointment. b. On12/30/19 - A nurse documented the wound on the resient's coccyx appears to have worsened and wound nurse at the facility will assess this week and make recommendations c. On 1/5/20 - hospice nurse provided education to the residents Medical Power of Attorney for Healthcare regarding a Kennedy ulcer Clinical record review revealed telephone order dated 11/20/19. The physician dorected staff to apply Venalex ointment (used to promote wound healing and treat ulcers) to coccyx/buttocks three times a day and as needed until resolved. Record review failed to provide assessment of skin impairments related to the 11/20/19 order and of the open area to coccyx from progress note dated 12/21/19.	F 686		

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F 686	Continued From page 34 A skin assessment sheet dated 12/31/19 noted unstageable area to coccyx 3.0 x 2.9 x 0.1cm. Eschar to wound bed and wound edges pink. During an interview with Staff R Registered Nurse (RN) at 10:37 AM on 02/17/20, she stated she remembered she wrote the order for Venalex ointment, however, area was only red at that time and not open. Staff R stated it was a good chance the resident's Medical Power of Attorney (MPOA) requested the ointment. Staff R stated MPOA was difficult to please even though she was an advocate for the resident. Staff R stated MPOA would state facility did not notify her of things, however, confirmed the facility did. Staff R stated resident was checked and changed every 2 hours and treatment done as ordered. Staff R stated the residents primary care provider and and hospice nurse were aware of skin concerns. During an interview with Staff O Certified Nurse's Aide (CNA) at 10:49 AM on 2/17/20, she stated she was aware the resident had an open area on her bottom, however, did not know when became opened. Staff O stated the only time she saw the area open it looked freshly open. Staff O stated the nurses would do a treatment in the morning prior to getting the resident up. Staff O stated the resident was laid down between meals, and was the last one up and first one down for meals. Staff O stated she did not get up for meals, maybe just a couple days before she passed. At that time, the staff would check, change, and reposition the resident every 1-2 hours. During an interview with Staff S Certified Medication Aide (CMA) at 10:52 AM on 02/17/20, she stated the resident had an open area at the end of her life. Staff S stated the area started out	F 686		

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F 686	Continued From page 35 as a red area and eventually opened. Staff S stated she was unsure how long area was opened. Staff S stated the resident was up for meals, last one up and first one down. The CMA stated between meals, the staff would check, change and reposition the resident. The CMA stated the resident stayed in bed very few times for meals, due to MPOA stated if the resident had not gotten up the facility staff did not feed her. Staff S denied that the facility did not feed the resident. Staff S stated she was unsure how long area was opened. During an interview with Staff N RN at 11:11 AM on 2/17/20, she stated the area on the residents' coccyx started as a red area and she is unsure of when it opened. Staff N stated resident was gotten up for meals as able. The RN stated she was not exactly sure of when the resident stopped eating or drinking, however, at that time staff would check, change and reposition. Staff N stated when the charge nurse identified skin issues they would notify the residents' primary care provider, obtain the treatment, notify family, and hospice if resident on hospice. Staff N stated the nurses were to initiate the skin sheet and notify skin nurse by voice mail or email. During an interview with Staff T RN Wound Nurse at 11:30 AM on 2/17/20, she stated she did not know when the area to the residents' coccyx got worse or changed from when macerated area was documented as resolved on 10/30/19. The Wound Nurse stated she was notified on 12/31/19, that the resident had an ulcer and when she assessed the area she was alarmed at the current wound condition. Staff T stated the nurses and the CNA's notify her of skin issues, or if the current areas have gotten worse. Staff T stated	F 686		

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F 686	Continued From page 36 she was unsure of why the order was wrote on 11/20/19, possibly the nurse was being proactive. Staff T stated a nurse informed her the area to the residents' coccyx was possibly a Kennedy ulcer per hospice, however, stated she had not talked with hospice in regards to this. During an interview with the Director of Nursing (DON) at 11:40 AM on 2/17/20 she stated she was unaware of when the red area initially opened. The DON stated when skin issues are identified, the nurses are expected to have started a skin sheet. The DON stated the Wound Nurse does weekly rounds and provides follow up. The DON stated she would expect if an area is worse the nurse would call the residents primary care provider, hospice, and send email or call the wound nurse to update her.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689	1. To correct this deficiency as it relates to Resident #70 and #93, wheelchair bags for foot pedals were placed on back of wheelchairs and verified on 3/13/2020. For Resident #3, scoop mattress applied to bed on 12/23/2019.	3/17/2020

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F 689	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to provide adequate nursing supervision to prevent accidents from hazards for 3 of 5 residents reviewed. (Residents #3, #70 & #93). The facility reported a census of 107 residents. 1. According to a quarterly Minimum Data Set (MDS)assessment tool dated 1/7/2020, Resident #70 had a diagnosis of dementia and a Brief Interview of Mental Status (BIMS) score of 6 indicating she experienced moderately impaired cognition. The MDS documented Resident #70 required extensive assistance of 1 person for bed mobility and locomotion around the facility and extensive assistance of 2 staff for transfers locomotion in her room and used a wheelchair. Review of Resident #70's care plan with a revision date of 1/10/20 identified the resident as at risk for falls. In an observation on 02/12/20 at 12:19 PM, Staff C (Certified Nursing Assistant) CNA pushed the resident in her wheelchair down the 100 hall from the dining room. The wheelchair had no foot pedals attached, and Resident # 70 's feet barely touched the floor. 2. According to a quarterly MDS dated 1/14/20, Resident #93 used a wheelchair for mobility. The MDS documented she demonstrated severely impaired cognitive skills, required extensive assistance of 2 staff for bed mobility, totally depended on one staff or locomotion around the facility.	F 689	Continued from page 37 2. To protect other residents in similar situations, staff education given to all nursing employees to prevent accidents and hazards by 03/16/2020 or prior to next worked shift. 3. To ensure the problem does not recur, environmental safety audits will be done by DON or designee on 10 random residents weekly. 4. To monitor performance and to ensure solutions are permanent, environmental safety audit results will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/ or monitoring is to continue.	

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F 689	Continued From page 38 The resident's care plan with a revision date of 1/27/20 revealed she had a history of falls prior to coming to the facility and directed staff she required total assistance with locomotion. Observation on 02/12/20 at 12:37 PM, revealed Staff C had pushed the resident in her wheelchair down the 100 hall from the dining room to her room. Resident #93's foot pedals were on her wheelchair, but her right foot was not resting on a foot pedal, it was resting behind it with her toes pointing toward the floor. During a staff interview on 02/13/20 at 7:15 AM, Staff C stated she did assist Resident #70 in her wheelchair without foot pedals yesterday and should not have. She stated the resident usually propels herself but she wanted to help get her to her room. She stated Residents should have foot pedals on. During a staff interview on 02/13/20 at 7:25 AM Staff M Licensed Practical Nurse (LPN) stated foot pedals should be used on wheelchairs when assisting residents. She also stated even if the resident is displayed intact cognition, staff should still apply and use foot pedals. During a staff interview on 02/13/20 at 12:24 PM the Director of Nursing (DON) stated every resident needs foot pedals on their wheelchairs if they are being assisted by staff. 3) The admission Minimum Data Set (MDS) dated 11/5/19 documented the resident scored a 6/15 for the Brief Interview of Mental Status, which meant the resident demonstrated severe cognitive impairment,. The MDS documented she required extensive assist of 2 staff for bed mobility, transfers, dressing and toilet use and	F 689		

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F 689	Continued From page 39	F 689		

had a history of falls one month prior to admission to the facility. The MDS also documented the resident had no impairment in her functional range of motion of her upper or lower extremities.

The Care Plan dated 11/10/19 documented the resident as at risk for falls and directed staff to keep frequently used items in reach.

The Progress Notes dated 12/23/19 documented the resident was found in her room lying on her right side. The resident stated her phone had been ringing but the bedside table was not in reach, and when she tried to reach for it she fell off the bed and landed on her right side. The notes documented the right leg was stiffer with complaints of right knee pain. The physician ordered an x-ray, which revealed a right patella (kneecap) fracture. The physician subsequently ordered an orthopaedics referral when notified of the x-ray results.

The Fall Assessment dated 12/23/19 at 5:10 PM documented the new intervention was to assist the resident to her recliner in the afternoon and to place the bedside table within reach.

The Care Plan revised 12/23/19 documented new fall interventions to keep her cell phone on the bedside table next to the bed when she is in bed and a scoop mattress was put in place. A second intervention added was to offer her to sit in her recliner after meals in the morning and afternoon.

The Orthopedic Clinic Note dated 12/27/19 documented there were no signs of an acute fracture.

Interviewed the Director of Nursing on 2/12/20 at

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F 689	Continued From page 40 12:05 PM and she stated that she expects the bedside table, phone, call light and water to all be in reach at all times. Interviewed the aide assigned to the resident's hall on 2/12/20 at 2:30 PM and aide Staff E stated that she is expected to keep the resident's belongings in reach to help prevent falls.	F 689		
F 880 SS=E	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	F 880	1. To correct this deficiency as it relates to Residents #15, #42, #109, #111, Staff A, B, G and N, DON or designee provided direct education to staff members A, B, G and N by 03/16/2020 or prior to next worked shift. 2. To protect other residents in similar situations, all nursing staff were assigned an additional education regarding infection prevention and control on 03/16/2020. 3. To ensure the problem does not recur, 3 random infection audits will be performed weekly for 3 months by DON or designee. 4. To monitor performance and to ensure solutions are permanent, infection audits will be reported to the QAPI Committee for 3 months. The	3/17/2020

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F 880	Continued From page 41 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 880	Continued from page 41 QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 880	Continued From page 42 interview, the facility failed to assure appropriate infection control practices for 4 of 8 resident's observed (Residents #15, #42, #109, and #111). The facility reported a census of 107 residents. Findings include: 1. According to a Diagnosis Report form dated 2/12/20, Resident #109's diagnosis included diabetes mellitus, acute osteomyelitis of the right ankle and foot, cellulitis of the right lower limb and chronic ulcer of the right foot. A Physician's Orders form dated 2/12/20, included orders for Timolol Maleate, 0.5% eye drops, instill 1 drop into right eye 2 times a day. During observation on 2/12/20 at 7:05 A.M. Staff G, Registered Nurse (RN), prepared to administer Resident #109's Timolol eye drops. She obtained the eye drops in a package/box from a med cart, entered the resident's room and placed the box of eye drops on a night stand without a barrier. Staff G entered the resident's bathroom, washed her hands, donned gloves, picked up the box with her left gloved hand, removed the eye drop bottle with her right gloved hand, and placed the box back down on the night stand without a barrier. Staff G held a kleenex in her left gloved hand, administered the Timolol eye drop and handed the resident the kleenex she held to dab his eye if necessary. Staff G removed her gloves, placed the eye drop bottle in the box and set the box on a glass shelf above the sink near the resident's bathroom toilet. Staff G washed her hands, donned gloves, obtained the resident's urinal nearly full of urine and emptied the urine in the	F 880		

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F 880	Continued From page 43	F 880		

resident's bathroom toilet. Staff G removed her gloves, washed her hands, picked up the Timolol eye drops in a box, carried the box to a med cart and sat the box on top of the med cart without a barrier. She unlocked the med cart and placed the Timolol eye drops and box in a drawer next to other residents boxes of medications.

2. According to a Diagnosis Report form dated 2/12/20, Resident # 42's diagnosis included weakness, diabetes mellitus and chronic obstructive pulmonary disease.

A Physician's Orders form dated 2/12/20, revealed the resident's medications included fluticasone spray, 2 sprays in each nostril daily, spiriva capsules, 180 milligrams, inhale contents of 1 capsule via device daily and symbicort inhaler, inhale 2 puffs two times a day.

During observation on 2/12/20 at 7:20 A.M., Staff G obtained the resident's fluticasone nose spray in a box, spiriva inhaler and symbicort inhaler in a box out of a med cart and placed them on top of a med cart with a barrier. Staff G picked up the fluticasone nose spray and inhalers without a barrier, carried the medications to the resident's room and placed them on a bedside table without a barrier. Staff G entered the resident's bathroom, washed her hands and donned gloves. Staff G handed the fluticasone nose spray to the resident, observed the resident administer the nose spray to herself and placed the nose spray back in the box on the bedside table without a barrier. Staff G handed the spiriva inhaler to the resident, observed the resident administer the spiriva to herself and placed the inhaler directly on the bedside table without a barrier. Staff G then handed the symbicort inhaler to the resident,

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F 880	Continued From page 44 observed the resident admininster the resident to herself, attempted to place the symbicort back in it's box and the box fell on the floor. Staff G left the box on the floor and handed the resident a glass of water. Staff G removed her gloves, washed her hands and picked up the symbicort box off of the floor. She carried all of the above described medications to a med cart, placed the medications and boxes on top of a med cart without a barrier, unlocked the med cart and placed the medications in drawers in the med cart, next to other resident's medications. During interview on 2/12/20 at 10:45 A.M., the facility Infection Preventionist confirmed the facility expected nursing staff to use a plastic barrier under medications and medication boxes when used away from a med cart, for infection control prevention. 3. According to a quarterly Minimum Data Set (MDS) with a reference date of 11/12/19, Resident #15 had a Brief Interview of Mental Status (BIMS) score of 5 indicating cognitive impairment. The MDS documented Resident #15 required extensive assistance of 2 staff for bed mobility and dressing. The MDS also documented she had an indwelling catheter with a diagnosis of neurogenic bladder. Review of Resident #15's care plan, with a revision date of 1/28/20, revealed she had a catheter due to a diagnosis of neurogenic bladder Observation on 02/12/20 at 1:32 PM revealed Staff A Certified Nursing Assistant (CNA) and Staff B CNA provided peri care and catheter cares. jessica completed cares by using a different surface of the wipe with each new area	F 880		

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cleansed, using her right hand. With her right hand Staff A grabbed a new wipe to cleanse the peri-area and discarded the wipe. She then grabbed another with her right hand then placed it back in the clean bag used as a barrier between the bed and the supplies. STaff A removed her gloves, used hand sanitizer, donned a new pair of gloves, picked up that wipe and used it to cleanse the catheter tubing that was extending from the resident.

During a staff interview on 02/13/20 at 12:22 PM the Director of Nursing (DON) stated staff should have grabbed a new wipe, that is what is taught. The Assistant Director of Nursing (ADON) stated when staff grabbed the wipe after completing cares, her gloves were considered dirty.

4. Entry Form for Resident #111, with a completion date of 2/4/20, documented the resident was admitted to the facility on 2/4/20, from an acute hospital. The diagnoses listed in the electronic health record included Parkinson's and cognitive impairment.

During initial record review at 1:25 PM on 2/10/20, revealed the resident was admitted to the facility with a stage 1 and stage 2 pressure ulcer to his right and left buttocks.

During an observation at 7:25 AM on 12/13/20, Staff N Registered Nurse (RN) applied the daily treatment to the residents' pressure ulcers. Staff N RN washed her hands and applied gloves and proceeded to cleanse the residents' right and left buttocks, including the rectal area. Once Staff N cleansed the areas, she did not remove her gloves, wash her hands or apply new gloves. The RN proceeded to apply the paste to the residents' pressure ulcers on the right and left buttock. After

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F 880	Continued From page 46 she applied the paste, the RN removed her gloves and washed her hands. Staff N RN, failed to change her gloves when going from dirty to clean, after washing the wound and prior to applying the paste. During review of the February 2020, treatment administration record, revealed treatment to right and left buttocks was to apply phytoplex z-guard paste topically to pressure areas twice daily until healed. Phytoplex z-guard is a skin protectant paste. During an interview with Staff N RN at 7:34 AM on 2/13/20, she stated she should have changed her gloves after cleansing the residents wound, before she applied the paste. During an interview with the Director of Nursing (DON) at 2:35 PM on 2/13/20, she stated she would expect nursing staff to change gloves between dirty and clean, after cleansing the wound and prior to apply the paste.	F 880		