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	165181	A. BUILDING _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK RAPIDS HEALTH CENTRE	703 SOUTH UNION ROCK RAPIDS, IA 51246

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F 000	INITIAL COMMENTS Ammended upon further review on September 2, 2020. A COVID-19 Focused Infection Control Survey and investigation of complaints #91059-C, #90582-C and incidents #91541-I, #89339-I, #90509-I, #92094-I and #89545-I was conducted by the Department of Inspection and Appeals on July 28-August 11, 2020. The facility was found to not in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Complaint #91059 and incidents #91541, #89339, #90509 and #92094 were substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.)	F 000		
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	F 580		

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

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F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that 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 immediately notify the physician and resident representative of an incident resulting in a change of condition for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 37 residents. Findings include:	F 580		

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According to the Minimum Data Set (MDS) assessment dated 4/16/20, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility and transfer. The resident's diagnoses included malignant neoplasm of the prostate.

A Progress Note by Staff M, Licensed Practical Nurse (LPN) dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in his wheel chair (w/c). When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt, and application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg orally (PO) given, with staff to monitor.

The clinical record lacked documentation the facility notified the resident's physician or family/resident representative of the incident and new onset pain.

The Progress Notes dated 6/6/20 at 6:45 a.m. documented awaiting Hospice to return phone call regarding resident's left ankle, swollen & painful to touch. The prior nurse stated the resident's left side of foot hit while moving the resident via w/c through a doorway with no noticeable injury after the occurrence.

In a Witness Statement dated 6/5/20 Staff D,

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F 580	Continued From page 3 Certified Nursing Assistant (CNA) stated she pushed the resident out of the dining room after lunch and the left side w/c foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it. During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away. She did not know if she turned too sharp or what happened. During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated they did not have an incident report for the incident or physician and family notification until a later date, At 4 p.m. DON stated she expected the physician and the family would be notified as soon as possible after an incident occurred. During an interview on 8/5/20 at 11:57 a.m. Staff M stated if not documented, she did not notify anyone (of the incident). An Incident/Accident Management policy reviewed 11/19 included verifying notification of the physician and responsible party.	F 580		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 604		

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The resident has a right to be treated with respect and dignity, including:

§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

§483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to provide adequate assessment, evaluation, and documentation for the use of a seatbelt restraint for 1 resident reviewed (Resident #4). The facility reported a census of 37 residents.

Findings include:

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According to the Minimum Data Set (MDS) assessment dated 5/12/20, Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living including bed mobility, transfers, ambulation, dressing, and toilet use. The resident's diagnoses included seizure disorder. The MDS indicated the resident did not use a trunk restraint in the chair.

A Physical Therapy Evaluation and Plan of Treatment with a start of care date 11/11/19 documented the resident had a manual wheelchair (w/c) with restraints for safety,

An Occupational Progress Report with a start date of 11/11/19 identified a goal the resident would be able to buckle/unbuckle the w/c (belt) in 3/5 trials to promote increased independence during w/c management. On discharge 1/21/20 the resident could buckle/unbuckle in 3/5 trials.

The Care Plan revised 12/3/19 identified the resident at very high risk for falls related to (r/t) seizures and involuntary movements revised 12/3/19. The interventions included:
a. See restraint plan of care. The resident needed a safety seat belt on when in the w/c due to seizures and movements. All staff were to monitor and check the resident every 1-2 hours and as needed (PRN), in the w/c and bed due to seizures and safety needs.
The restraint plan of care included:
b. The resident needed and used a seat belt when in the w/c as a physical restraint r/t safety and protection from falls and injuries with seizures and movements.

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c. Discuss and record with the resident/family/caregivers, the risks and benefits of the restraint, when the restrains should/would be applied, routines while restrained and any concerns or issues regarding restraint use.

d. Ensure valid consent on the chart prior to initiating restraint.

e. Evaluate the restraint use when up in the w/c daily: Evaluate/record continuing risks/benefits of the restraint, alternatives to restraint, need for ongoing use, reason for restraint use (due to safety when in w/c seat belt with seizures and involuntary movement to protect from falls out of w/c and safety).

f. The resident needed hourly toileting and PRN while restrained to promote continence.

g. The resident needed the seat belt restraint applied when in the w/c and released every 30 minutes or repositioned every hour to bed. Document restraint use and release as per facility protocol.

h. The resident needed opportunities for restraint-free time and physical activity daily. The resident would be restrained with the seat belt in the w/c only when up for meals and with w/c use. Check every 30 minutes and unbuckle and reposition out of the w/c into bed every hour.

The clinical record lacked documentation regarding restraint use and release.

During an observation on 8/4/20 at 8:20 a.m. the resident returned from the dining room with the w/c seatbelt buckled. The resident stated she could not unbuckle the seatbelt. She said some days she could.

During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated when they 1st

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F 604	Continued From page 7 evaluated the resident, she could unbuckle the seatbelt herself. She did not know if/when they reevaluated that. She said they had no restraint documentation (despite the care plan calling for it) for the seatbelt. She said they are now in the process of getting a physician's order for the restraint. At 4 p.m. the DON stated they did not do an evaluation of the seatbelt since therapy (1/21/20). They had no documentation (since then) of the resident's ability to unbuckle the seatbelt herself. The facility Restraint Management policy 4/2013 documented the restraint would be re-evaluated for the use of the restraint at least quarterly or with a change of condition during the care management meeting.	F 604		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		

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not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview the facility failed to update the care plan to reflect clear and correct directions for resident's care for 2 of 6 residents reviewed (Resident #1 and #5). The facility reported a census of 37 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 6/12/20, Resident #1 had highly impaired hearing with no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for activities of daily living (ADL's) including bed mobility, transfer, and toilet use. The resident's diagnoses included a fracture and malignant neoplasm of the prostate.

The current Care Plan identified the resident with self care deficit related to (r/t) altered balance revised 1/7/16. The interventions included
a. The resident required up to limited assist with toileting. The resident would toilet self and ask for assist if needed.
b. The resident was independent with

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wheelchair (w/c) pivot transfers in his room.
c. The resident was independent with bed mobility. Provide assist as needed.
d. The resident required total assistance with transfers.

The Care Plan gave conflicting information on the resident's needs for ADL assistance and in contrast to the MDS assessment.

During an observation on 7/30/20 at 12:30 p.m. Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) and Staff G, CNA transferred the resident to bed with the total mechanical lift.

During an interview on 8/5/20 at 12:40 p.m. the Director of Nursing stated they had identified a problem with updating care plans.

2) According to the MDS assessment dated 5/28/20, Resident #5 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, dressing, and toilet use. The resident's diagnoses included Alzheimer's disease.

An ADL report 7/22-8/4/20 documented the resident required extensive assistance with toilet use and transfers, and did not ambulate.

The Kardex (interventions from the current care plan) dated 8/4/20 identified the resident independent with toilet use, independent with a walker in her room and throughout the facility, and independent with transfers.

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F 657	Continued From page 10 During an observation on 8/4/20 at 9:48 a.m. Staff L, CNA and Staff N assisted the resident with transfer and toilet use. Staff L stated they assisted the resident with cares. During an interview on 8/5/20 at 1 p.m. the DON stated the resident's care plan did not reflect her current needs.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for an incident with a change in condition for 1 of 6 residents reviewed (Resident #1). The facility reported a census of 37 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated 4/16/20, Resident #1 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed	F 684		

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mobility and transfer. The resident's diagnoses included malignant neoplasm of the prostate.

The Care Plan revised 1/7/16 identified the resident with the potential for alteration in comfort.
The interventions included instructing the resident to inform the nurse of any pain/discomfort and ask for pain treatment before pain became too severe, informing the nurse if pain relief not achieved, and observing for verbal and non verbal signs and symptoms of pain being experienced by the resident.

The Progress Notes dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in the wheelchair (w/c). When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt, and application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg PO given, with staff to monitor.

In a Witness Statement dated 6/5/20 Staff D stated she pushed the resident out of the dining room after lunch and the left side of the w/c foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it.

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During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away and the area appeared swollen.

The clinical record lacked a complete assessment of the resident's left foot/ankle including palpation, range of motion, and an assessment of the severity of the resident's ankle pain.

The June 2020 Medication Administration Record (MAR) showed the resident received scheduled Tylenol at 8 p.m. on 6/5/20. The resident received a PRN dose of Tylenol at 1:30 a.m. 6/6/20 for left ankle and left leg pain with no assessment of the severity of the pain. The MAR indicated the PRN was effective, however the Progress Notes dated 6/6/20 at 2:32 a.m. documented only slight improvement.

The Progress Notes dated 6/6/20 at 6:45 a.m. documented awaiting Hospice to return a phone call regarding the resident's left ankle, swollen and painful to touch. The prior nurse stated the resident's left side of foot hit while moving the resident via the w/c through a doorway with no noticeable injury after the occurrence.

A fax to the physician 6/6/20 asked for a clarification of the Norco (Hydrocodone/narcotic analgesic) order (dose, amount, frequency) and if okay to change the Tylenol order to PRN every 6 hours. Hospice reported a voice order received. The physician responded Norco 5/325 1 tab every

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6 hours PRN pain, and okay for an ace wrap to left ankle PRN swelling.

The Pain Assessment in Advanced Dementia Scale (PAINAD) included instructions for observing the patient for five minutes before scoring his or her behaviors and score the behaviors according to the chart. Definitions of each item provided. The patient could be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication). The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain;
4-6=moderate pain;
7-10=severe pain.

The June MAR showed the resident received scheduled Tylenol at 7 a.m. 6/6/20. He received Hydrocodone at 11:30 a.m., 5:28 p.m., and 11:35 p.m. with pain at 7 (severe pain) with each administration. The MAR indicated the pain medication was effective, however the Progress Notes dated 6/6/20 at 12:55 p.m. documented follow up pain at 5, and at 9:21 p.m. follow up pain at 6, (indicating pain not relieved or reduced significantly).

The MAR showed the resident received scheduled Tylenol at 7 a.m. and PRN Hydrocodone at 7:09 a.m. on 6/7/20 with pain at a 7. The Progress Notes dated 6/7/20 at 7:09 documented the resident had frequent episodes of crying out, left ankle painful to touch, and resident saying "Oh god please take me I just want to die, I don't want to do this anymore". The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity.

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The facility failed to notify the physician of the resident's severe pain and crying out.

The Progress Notes dated 6/7/20 at 12:53 p.m. documented the resident had frequent episodes of crying out, left ankle painful to touch, saying "Oh god, please take me, I just want to die, I don't want to do this anymore". The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity. Call received from hospice checking on the resident after beginning Lortab (Hydrocodone). Hospice stated that it may be a better idea to schedule Lortab 2 tabs 2 times a day (BID) and then 1-2 tabs every 4 hours PRN to stay ahead of the pain. Hospice stated voice order received. Call paced to verify voice order.

The Progress Notes dated 6/7/20 at 1:08 p.m. documented voice order received to discontinue (D/C) current BID Tylenol 650 mg and change to Norco 5/325 2 tabs BID and 1-2 tabs every 4 hours PRN. OK to continue with PRN Tylenol as well.

The MAR documented the resident received Hydrocodone at 1:25 p.m. for pain of 7. The Progress Notes dated 6/7/20 documented the resident received Hydrocodone for continuing to call out, would try to alleviate pain with 1 tab (despite the fact they received orders for 1 to 2 tabs, 1 tab did not relieve the pain earlier, and hospice indicating the need to stay ahead of the pain). The Progress Notes at 9:22 p.m. documented the PRN was ineffective, pain at an 8 (more severe pain than previously indicated). The MAR 6/7/20 at 7 p.m. showed the resident received the scheduled dose of Hydrocodone with PAINAD of 8. The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident started

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Hydrocodone 2 tabs at bedtime (HS), and he rested comfortably.

The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident continued with current pain management orders, starting Hydrocodone/Tylenol 5/325 mg 2 tabs orally at HS without signs and symptoms of adverse reaction. The left foot remained swollen even with the ACE wrap in place. The resident had light purple bruising to bilateral sides of the left foot. Applied pressure reducing boot per the resident's request.

The Progress Notes dated 6/8/20 at 12:13 p.m. documented the resident had purple bruising to the left inner ankle and bottom of the heel. The resident yelled out when the left foot touched or moved.

The Progress Notes dated 6/9/20 at 11:16 a.m. documented the resident seen in the a.m. by the physician's assistant (PA-C) via telehealth video visit to assess the left ankle injury. The resident hard of hearing and not able to answer questions. The resident laid in bed during the visit and yelled out when moving or touching the ankle. Per the PA-C, continue with pain management, and if the family wished an X-ray could be ordered. The Power of Attorney (POA)/family member called and updated. Hospice staff nurse at facility for 14 day Registered Nurse (RN) visit and would collaborate with the family and let the facility know how they wished to proceed.

A late entry in the Progress Notes dated 6/9/20 at 11:00 a.m. documented the resident's POA called back and stated he would like to proceed with an x-ray regardless of the Hospice

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recommendations, and x-ray scheduled for 1 p.m. at the clinic.

The Progress Notes dated 6/9/20 at 2:30 p.m. documented receipt of results from the resident's x-ray. He had a nondisplaced fracture to the left medial malleolar tip. Received a new order for stirrup ankle brace and would continue with comfort cares and pain medication to control his pain.

A Physician Order sheet dated 6/9/20 at 2 p.m. documented the resident had an avulsion fracture of the left distal medial malleolar tip, non-displaced. New orders received for a universal stirrup ankle brace for 3 weeks.

The Progress Notes dated 6/10/20 at 8:44 a.m. documented the resident had the brace on his left foot and propelled in his w/c, The resident took scheduled Lortab and then slept with a pillow under his leg and it seemed to help until he moved around and he told the nurse he just hit a spot then he had tears in his eyes with pain. The resident received PRN pain med and TLC and he got calmer.

A fax dated 6/11/20 asked the physician if the resident should wear the airform ankle brace continuously. The physician responded to wear continuously for 4 weeks.

During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing stated they did not have an incident report for the incident and no physician and family notification until a later date,

During an interview on 8/5/20 at 11:57 a.m. Staff M, Licensed Practical Nurse (LPN) stated she

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F 684	Continued From page 17 probably did not do an incident report (for the 6/5/20 incident) because there was nothing objective except the resident's pain. Staff M stated if not documented, she did not notify anyone (of the incident). An Incident/Accident Management policy reviewed 11/19 documented incident/accident identification and reporting were the responsibility of all employees of the facility. The procedure included evaluating for injury and if injury suspected or present, providing first aide and/or outside medical intervention, verifying notification of the physician and responsible party, and any impact on the resident.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to provide adequate supervision, implement interventions per the care plan, and investigate incidents to identify risks to prevent accidents for 3 of 4 resident's reviewed (Resident #1, #4, and #5) and failed to prevent hazards in the environment by locking two fire doors which posed a hazard and impeded exit from the facility for all residents in the event of a fire or an emergency. The facility reported a census of 37	F 689		

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residents.
Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 4/16/20, Resident #1 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility and transfer. The resident's diagnoses included malignant neoplasm of the prostate.

The current Care Plan identified the resident with a self care deficit related to (r/t) altered balance, cerebrovascular disease, tachycardia and history of neoplasm of the prostate revised 1/7/16. The interventions included providing supervision to set up help with locomotion in the wheel chair (w/c), the resident able to propel himself (revised 10/6/18).

The Progress Notes dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in the w/c. When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt, with application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg PO given, staff to monitor.

In a Witness Statement dated 6/5/20 Staff D stated she pushed the resident out of the dining room after lunch and the left side of the w/c foot pedal caught on the door and pulled the

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resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it.

During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away and the area appeared swollen. She did not know if she turned too sharp or what happened.

The Progress Notes dated 6/6/20 at 6:45 a.m. documented awaiting Hospice to return a phone call regarding the resident's left ankle, swollen and painful to touch. The prior nurse stated the resident's left side of foot hit while moving the resident via w/c through a doorway with no noticeable injury after the occurrence.

A fax to the physician 6/6/20 asked for a clarification of the Norco (Hydrocodone/narcotic analgesic) order (dose, amount, frequency) and if okay to change the Tylenol order to PRN every 6 hours. Hospice reported a voice order received. The physician responded Norco 5/325 1 tab every 6 hours PRN pain, and okay for an ace wrap to the left ankle PRN swelling.

The Pain Assessment in Advanced Dementia Scale (PAINAD) included instructions for observing the patient for five minutes before scoring his or her behaviors and score the behaviors according to the chart. Definitions of each item provided. The patient could be

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observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication). The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain.

The June MAR showed the resident received scheduled Tylenol at 7 a.m. 6/6/20. He received Hydrocodone at 11:30 a.m., 5:28 p.m., and 11:35 p.m. with pain at 7 (severe pain) with each administration. The MAR indicated the pain medication was effective, however the Progress Notes dated 6/6/20 at 12:55 p.m. documented follow up pain at 5, and at 9:21 p.m. follow up pain at 6.

The MAR showed the resident received scheduled Tylenol at 7 a.m. and PRN Hydrocodone at 7:09 a.m. on 6/7/20 with pain at a 7. The Progress Notes dated 6/7/20 at 7:09 a.m. documented the resident had frequent episodes of crying out, left ankle painful to touch saying "Oh god please take me I just want to die, I don't want to do this anymore". The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity.

The Progress Notes dated 6/7/20 at 12:53 p.m. documented the resident had frequent episodes of crying out, left ankle painful to touch, saying oh god, please take me, I just want to die, I don't want to do this anymore. The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity. Call received from hospice checking on the resident after beginning Lortab (Hydrocodone). Hospice stated that it may be a better idea to schedule Lortab 2 tabs 2 times

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a day (BID) and then 1-2 tabs every 4 hours PRN to stay ahead of the pain. hospice stated voice order received. Call paced to verify voice order.

The Progress Notes dated 6/7/20 at 1:08 p.m. documented voice order received to discontinue (D/C) current BID Tylenol 650 mg and change to Norco 5/325 2 tabs BID and 1-2 tabs every 4 hours PRN. Okay to continue with PRN Tylenol as well.

The MAR documented the resident received Hydrocodone at 1:25 p.m. for pain of 7. The Progress Notes dated 6/7/20 documented the resident received Hydrocodone for continuing to call out, would try to alleviate pain with 1 tab. The Progress Notes at 9:22 p.m. documented the PRN was ineffective, pain at an 8 (more severe pain than previously indicated).
The MAR 6/7/20 at 7 p.m. showed the resident received the scheduled dose of Hydrocodone with PAINAD of 8. The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident started Hydrocodone 2 tabs at bedtime (HS), and he rested comfortably.

The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident continued with current pain management orders, starting Hydrocodone/Tylenol 5/325 mg 2 tabs orally at HS without signs and symptoms of adverse reaction. The left foot remained swollen even with the ACE wrap in place. The resident had light purple bruising to bilateral sides of the left foot. Applied pressure reducing boot per the resident's request.

The Progress Notes dated 6/8/20 at 12:13 p.m. documented the resident had purple bruising to

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the left inner ankle and bottom of the heel. The resident yelled out when the left foot touched or moved.

The Progress Notes dated 6/9/20 at 11:16 a.m. documented the resident seen in the a.m. by the physician's assistant (PA-C) via telehealth video visit to assess the left ankle injury. The resident hard of hearing and not able to answer questions. The resident laid in bed during the visit and yelled out when moving or touching the ankle. Per the PA-C, continue with pain management, and if the family wished an X-ray could be ordered. The Power of Attorney (POA)/family member called and updated. Hospice staff nurse at facility for 14 day Registered Nurse (RN) visit and would collaborate with the family and let the facility know how they wished to proceed.

A late entry in the Progress Notes dated 6/9/20 at 11:00 a.m. documented the resident's POA called back and stated he would like to proceed with an x-ray regardless of the Hospice recommendations, and x-ray scheduled for 1 p.m. at the clinic.

The Progress Notes dated 6/9/20 at 2:30 p.m. documented receipt of results from the resident's x-ray. He had a nondisplaced fracture to the left medial malleolar tip. Received a new order for stirrup ankle brace and would continue with comfort cares and pain medication to control his pain.

A Physician Order sheet dated 6/9/20 at 2 p.m. documented the resident had an avulsion fracture of the left distal medial malleolar tip, non-displaced. New orders received for a universal stirrup ankle brace for 3 weeks.

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The Progress Notes dated 6/10/20 at 8:44 a.m. documented the resident had the brace on his left foot and propelled in his w/c, The resident took scheduled Lortab and then slept with a pillow under his leg and it seemed to help until he moved around and he told the nurse he just hit a spot then he had tears in his eyes with pain. The resident received PRN pain med and TLC and he got calmer.

A fax dated 6/11/20 asked the physician if the resident should wear the airform ankle brace continuously. The physician responded to wear continuously for 4 weeks.

During an interview on 8/3/20 at 12 p.m. Staff A, CNA stated the resident usually wheeled himself in and out of the dining room. She said if not busy they would push him out of the dining room and go lay him down.

During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated they did not have an incident report for the incident or physician and family notification until a later date, At 4 p.m. the DON stated Staff D probably pushed the resident out of the dining room so another resident could go in and eat, and probably in a hurry. The DON confirmed the resident could wheel himself out of the dining room. She expected the physician and the family would be notified as soon as possible after an incident occurred.

A facility Teachable Moment report dated 6/15/20 documented Staff D re-educated on w/c transport of residents including potential safety hazards of negotiating the w/c in room and hallway focusing

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on doorways, corners and decreasing velocity throughout. Patient specific training for left hemiparesis to ensure left lower extremity and upper extremity properly positioned on pedals and arm rest.

2) According to the MDS assessment dated 2/11/20, Resident #4 scored 13 on the BIMS indicating no cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, dressing, and toilet use. The resident's diagnoses included seizure disorder.

The Care Plan revised 12/3/19 identified the resident a very high risk for falls related to seizures and involuntary movements. The interventions included see restraint plan of care, the resident needed safety seat belt on when in w/c due to seizures and movements. All staff to monitor and check the resident every 1-2 hours and as needed, in wheel chair and bed due to seizures and safety needs.

The Care Plan revised 12/03/19 identified the resident needed and used a seat belt when in the wheelchair as physical restraints related to safety and protection from falls and injuries with seizures and movements revised 12/3/19. The resident needed the seat belt restraint applied when in the wheelchair and released every 30 minutes or repositioned every hour to bed. Document restraint use and release as per facility protocol. The resident needed assistance and supervision when not restrained due to seizure activity and involuntary movements and high fall risk.

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The Care Plan revised 12/3/19 identified the resident with progressive ADL self care performance and interventions included the resident needed the sit to stand lift or stand and pivot with 2 staff extensive assist for transfers.

1. The Progress Notes dated 4/12/20 at 5:11 p.m. documented the writer was urgently called to the dining room after the resident fell out of wheelchair. Upon arrival, the resident sat on the floor surrounded by copious amounts of blood with a large amount draining from 2 deep lacerations on the L forehead and L eyelid. Unable to measure due to the exudates. No change in mental status. The facility called the ambulance at 5 p.m. to transport the resident to the emergency department (ED).

An Emergency Room Visit Note dated 4/12/20 at 6:26 p.m. documented the resident had a 1.5 cm long laceration to her left upper eyelid and a 2.3 cm long laceration to the left side of the forehead with the deepest portion of the laceration in the center of the wound, where fascia noted.

In an undated Witness Report at 5 p.m. Staff B, CNA wrote he situated the resident at the dining room table then headed away. After about 40 seconds he heard a noise and found the resident on the floor with blood on the floor. The resident had not been seat belted in her chair.

During an interview on 8/3/20 at 10:20 a.m. the Director of Nursing (DON) stated they did not let Staff B, agency staff, return after the incident (4/12/20). He admitted he did not buckle the resident in and knew she should be. At 12:45 p.m. the DON stated Staff B had worked at the facility on 4/5/20, 4/10/20, and 4/11/20. She said

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Staff B was very remorseful, but aware the seat belt needed to be in place.

During an interview on 8/3/20 at 10:58 a.m. Staff D, Certified Medication Aide (CMA) stated the resident always wore the seatbelt when in the wheel chair.

During an interview on 8/3/20 at 1:35 p.m. Staff H, Cook stated she saw Staff B wheel the resident to the dining room. She looked slouchy in the chair. She walked into the kitchen and when she looked through the window she saw the resident on the floor. She alerted staff to the fall.

During an interview on 8/3/20 at 1:57 p.m. Staff F, CNA (worked 4/12/20) stated she thought Staff B got the resident up by himself. She didn't know if Staff B had worked with the resident before. She did not know how he would know how to care for the resident, or if he had access to the care plan. Staff B admitted he did not buckle the seat belt but said he didn't know she had a belt. She had not witnessed staff not applying the seat belt. She said an agency staff would normally be pared up with a facility staff, because facility staff were aware of the resident's needs.

During an interview on 8/3/20 at 2:30 p.m. Staff I, CNA (worked 4/12/20) stated she did not assist Staff B get the resident up to the wheel chair. She said Staff B felt horrible about the fall. He said he did not buckle the seat belt, he forgot. She said usually agency staff would double up with regular staff . If agency staff had a question, they would need to ask a nurse. She said she and Staff F were busy and Staff B started getting residents up himself. She did not think the resident could unfasten the seatbelt herself.

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During an interview on 8/3/20 at 2:48 p.m. Staff E, (worked 4/12/20) Licensed Practical Nurse (LPN) stated she did not assist Staff B getting the resident up in the wheel chair. She did not see him push the resident into the dining room, she came after the fall. Staff B said he didn't even know she had a seatbelt to put on her. She said agency staff worked with a consistent staff member to learn the care of each resident. Staff B was sincerely upset about the incident. Staff E stated she had nothing but good things to say about Staff B.

2. A fax dated 11/23/19 notified the physician the resident fell off the toilet at 7 a.m. and hit her head on the floor causing a laceration to the left side of her head with a large pool of blood.

The Care Plan identified the resident had progressive ADL Self Care Performance Deficit revised 12/3/19. The interventions included the resident required extensive assistance of 2 staff with transfers on and off the commode, and with adjusting clothing and cleansing and changing padding when using the commode. One staff to remain with the resident when on the commode due to movements and seizures revised 12/03/19. The Care Plan identified the resident at very high risk for falls and the interventions included assist of 2 when using the toilet r/t increased involuntary movements/tremors.

An Incident Report dated 6/22/20 at 9:40 a.m. documented the resident used the toilet with staff by her side. Staff did not have wet wipes for cleaning the resident so she left the resident and went around the corner to look quickly. When she returned the resident was on the floor. The

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resident reported hitting her head, and laid on her left side with no clear injuries.

During an interview on 8/3/20 at 10:20 a.m. the DON stated the CNA did not follow the care plan.

During an interview on 8/3/20 at 10:58 a.m. Staff D, CMA (with the resident at the time of the fall) stated the resident needed 2 to transfer to the toilet, and 1 person to stay with her, with eyes on her at all times. If needed something another person could get it.

During an interview on 8/3/20 at 11:54 a.m. Staff A, CNA stated never leave the resident alone on the toilet.

During an interview on 8/3/20 at 1:57 p.m. Staff F, CNA stated no one with assist 1 or 2 should be left unattended on the toilet.

During an interview on 8/3/20 at 2:30 p.m. Staff I, CNA stated when on the toilet could not leave the resident at all.

The facility policy Transfer Techniques dated 1/13 identified the purpose to safely transfer a resident while minimizing the risk of injury to the resident and caregiver. The procedure included obtaining assistance as needed, and reviewing and revising the resident transferring plan as indicated.

3) According to the MDS assessment dated 2/27/20, Resident #5 scored 3 on the BIMS indicating severe cognitive impairment. The resident demonstrated independence in bed mobility, transfers, ambulation, dressing, and toilet use. The resident's diagnoses included

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Alzheimer's disease.

The Care Plan revised 1/27/16 identified the resident with the potential risk for falls r/t history of falls, dementia with behavioral disturbances, The resident needed a safe environment with: floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, personal items within reach, etc.

The Progress Notes dated 3/24/20 at 5:07 a.m. documented a CNA stated she walked by the resident's room and observed the resident crawling out of the bathroom. The CNA alerted the nurse and staff entered the room to observe the resident moving herself from the floor and sitting in a chair. The resident's top and bottom lip were bloody with increased swelling towards the left side. The resident unable to give description (of the incident). Increased confusion noted during the night, with the resident awake and wandering from room to dining room all night, believing it was meal time and staff unable to redirect. Fax sent to the physician with update

The Progress Notes dated 3/24/20 at 4:15 p.m. documented the resident up to the bathroom with assistance, noting a moderate amount of blood in her urine. The family notified and ambulance called. Resident evaluated in the ER.

A Pre-hospital Care Report documented the ambulance dispatched for an elderly female who suffered a fall and urinating blood. Staff reported the resident had not been herself lately, gait impairment, increasingly confused, and suffered multiple falls that day. The resident had a laceration to her finger and multiple contusions to her face. Staff reported after the last fall (around

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3:30 p.m.) the resident was unconscious when found.

Emergency Room Visit Notes dated 3/23/20 at 5:09 p.m. documented the resident presented to the ER after 2 falls. The resident had a laceration to the right 3rd digit down to the tendon. The laceration was closed with 2 sutures.

The Progress Notes lacked any documentation the resident had another fall, and lacked documentation of the resident's status between the 2 falls.

An Incident report dated 3/24/20 at 3:45 p.m. documented the resident found on the floor near her bathroom, and was initially unresponsive, but aroused to stimuli. She had a laceration to her right middle finger and a small abrasion on the left side of her forehead. Resident assisted to ambulate to a chair near the nurse's station for constant monitoring, and seated at the nurse's station. They cleaned and steri stripped the wound pending further treatment. The report documented the resident had confusion all day and had not slept much the night before.

The clinical record lacked documentation the facility provide increased supervision in regard to the early a.m. fall with increased confusion and lack of sleep.

The Progress Notes dated 3/24/20 at 7:00 p.m. documented the resident returned to the facility with stitches to her right middle finger.

The Progress Notes dated 3/25/20 at 1:26 a.m. documented the resident rested in bed since returning from hospital ED visit with 2 stitches

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present to the right middle finger laceration. The area looked clean and open to air. The resident continued with redness and increased swelling to the left side of the top and bottom lip, and redness to the left side of her chin.

During an interview on 8/5/20 at 1 p.m. the DON stated`there were no new interventions put in place after either fall on 3/24/20.

The Progress Notes dated 4/22/20 at 7:43 a.m. documented staff heard the resident calling out for help from her room. Staff entered and observed the resident face down on the floor unable to tell staff details of the incident. The resident screamed out in pain and grabbed her left hip when assessing her left lower extremity. Call placed to on call provider and order received to send the resident to the ED for further evaluation of left hip pain and left sided low back pain. The resident left the facility at 7:43 a.m. on a stretcher via ambulance.

The Progress Notes dated 4/22/20 at 10:34 a.m. documented receipt of a call from the ED and the resident fractured her left hip. The family wished to proceed with surgical intervention, and the resident would be transferred for surgery.

The facility did not have an incident report or investigation of the fall to determine root cause and possible interventions to prevent falls.

During an interview on 8/4/20 at 2:08 p.m. the DON stated they did not do an investigation after the 4/22/20 fall with fracture to determine the cause.

An Incident/Accident Management policy

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reviewed 11/19 documented an investigation would be completed within 5 days of the occurrence.

Upon entrance to the facility on 7/29/20 at 9:30 AM the surveyor entered through the front door. Signage was present at the entrance that directed, no visitors. A phone number was provided to call to enter the facility due to Covid-19 restrictions. The Administrator was observed to lock the dead bolt lock with a key from the inside after the surveyor entered. At that time the Administrator stated the door had been locked to prevent visitors from entering. The Administrator further confirmed the door would not open when locked and required the key to unlock. Surveyor attempted to open the door when locked and the door failed to open. The key is located either in a box to the left of the front door, or in the lock. The door is located at the front of the facility which is the main entrance/exit. The Administrator stated that a staff person is located in an office adjacent to the entrance during business hours only. The door is identified as a fire exit by signage and lighting.

An Environmental tour of all exits was completed on 7/29/20 at 2:10 PM with the Director of Nursing (DON). An additional exit door, located between the kitchen and storage hall adjacent to the dining room was found to be locked and restricted exit from the facility. The exit was noted to be a double set of doors, facing the South East that was marked off with yellow tape. The door was identified as an emergency fire exit by signage with instructions for delayed egress. Emergency exit lighting present. The door was locked by an internal door handle lock. The

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F 689	Continued From page 33 surveyor was unable to open the door when locked even when keyed pad access code was entered. Door handle lock was turned to unlock which allowed the surveyor to open the door. The DON confirmed the door is locked at all times. Additionally, confirmed the front door was locked with a dead bolt lock at all times. In an interview on 7/29/20 at 3:30 PM the Administrator confirmed the doors have been locked to restrict visitor access since March 15, 2020. The Administrator stated there have been no fire or other emergency that required exit from the facility since that time. The Administrator provided a plan for having doors unlocked.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		

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demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview the facility failed to provide incontinent care in a manner to prevent infection for 2 of 3 residents reviewed (Resident #1 and #4). The facility reported a census of 37 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 6/12/20, Resident #1 had highly impaired hearing with no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for toilet use. The resident's diagnoses included a fracture and malignant neoplasm of the prostate.

The current Care Plan revised 5/5/19 identified the resident had occasional bladder and bowel incontinence. The interventions included the resident used a pull up disposable brief. Change with a.m. and bedtime (HS) cares and as needed (PRN).

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During an observation on 7/30/20 at 12:30 p.m. Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) and Staff G, CNA transferred the resident to bed with the total mechanical lift. Staff D performed perineal care of the groins, front, then the resident rolled to his right with bowel movement noted. Staff D wiped several times using a different cloth each wipe. The last wipe had bowel movement on it and Staff D placed a new incontinent pad without wiping clean and did not clean the scrotal area.

The facility Perineal Care policy for a male revised 04/13 identified the purpose to promote cleanliness and prevent infection. The procedure included after cleaning the front to position to expose and clean the bottom of the scrotum and the anal area.

2) According to the MDS assessment dated 5/12/20, Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with toilet use. The resident's diagnoses included seizure disorder.

The Care Plan revised 12/3/19 identified the resident had functional bladder incontinence. The interventions included checking every 2-3 hours and as required for incontinence. Wash, rinse and dry the perineum.

During an observation on 7/30/20 at 10:52 a.m. Staff L, CNA and Staff G, CNA provided incontinent care with Staff K, Licensed Practical Nurse (LPN) observing. Staff L performed front incontinent care and then the resident turned to

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F 690	Continued From page 36 her right. The resident had bowel incontinence. Staff L wiped multiple times turning the disposable wipe, then wiped the genital area using the same soiled wipe. During an interview on 8/4/20 at 4 p.m. the Director of Nursing (DON) stated she would expect staff to change gloves with hand hygiene, use a new wipe to clean the genital area after cleaning bowel incontinence from a resident, and clean thoroughly after incontinence. The facility Perineal Care policy for a female revised 04/13 identified the purpose to promote cleanliness and prevent infection. The procedure included washing the genital area avoiding the anal area. After cleaning in the front, cleansing the anal area starting at the posterior vaginal opening and wiping front to back, then removing gloves and washing hands.	F 690		
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, record review and staff and resident interviews, the facility failed to prepare and provide palatable food to the residents. The facility reported a census of 37	F 804		

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residents.

Findings Include:

1.The Minimum Data Set (MDS) assessment tool, dated 4/23/20, documented Resident #2 with a Brief Interview for Mental Status Score (BIMS) of 15, which documents intact cognition.

In an interview on 7/29/20 at 2:20 PM Resident #2 stated most of the time the food is cold. Clarified all meals are cold, and she can't eat it. Stated she is the first in the dining room, but the last to eat. Able to eat independently.

2.The MDS assessment tool, dated 5/14/20, documented Resident #6 with a BIMS of 15, which documents intact cognition.

In an interview on 7/30/20 at 10:30 AM Resident #6 stated the food is often cold, the other day the green beans were cold and couldn't eat them. Able to eat independently.

Observation of the lunch meal on 7/29/20, from 11:17 AM to 1:07 PM, revealed Staff O, Cook, assigned to serve the meal. Food temperatures prior to initiation of meal service were as follows: Baked Fish 161 degrees and Cooked Carrots 174 degrees. Further observation revealed at 1:05 PM revealed Resident # 4 served baked fish. At 1:07 end temperatures revealed the following food temperatures: Baked Fish 115 degrees and Cooked Carrots 120 degrees. AT 1:08 PM Resident #4 stated her meal was OK. Evaluation of a test tray began at 1:10 PM. The baked fish was cold and inedible. The cooked carrots were also cool, lacked flavor, and unplatable. Staff O reported, baked fish was the alternative and 5

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F 804	Continued From page 38 residents were served. In an interview on 7/29/20 at 1:20 PM Staff O, Cook stated she hasn't previously noted that the food wasn't staying hot. Stated all steam table controllers were on. Staff O stated the facility takes and documents beginning food temperatures but only takes ending food temperatures if food appears cold. Stated had made maintenance aware and will be evaluating. In an interview on 8/4/20 at 12:30 PM the Administrator reported maintenance had evaluated the steam table and it was working properly. The Administrator stated the table may not have been turned on properly, and reported the facility would now be monitoring end temperatures.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		

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F 842	Continued From page 39 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to complete incident reports for 2 of 3 residents reviewed (Resident #1 and #5). The facility reported a census of 37 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 6/12/20, Resident #1 had no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for toilet use. The resident's diagnoses included a fracture and malignant neoplasm of the prostate.

The Progress Notes dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in the wheelchair (w/c). When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt and application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg PO given, with

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staff to monitor.

A Witness Statement dated 6/5/20 Staff D stated she pushed the resident out of the dining room after lunch and the left side wheel chair (w/c) foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it.

During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away. She did not know if she turned too sharp or what happened.

A Physician Order sheet dated 6/9/20 at 2 p.m. documented the resident had an avulsion fracture of the left distal medial malleolar tip, non-displaced. New orders received for a universal stirrup ankle brace for 3 weeks.

During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated they did not have an incident report for the incident. At 4 p.m. the DON stated she expected an incident report completed for each incident and confirmed they did not complete one for the incident.

During an interview on 8/5/20 at 11:57 a.m. Staff M, Licensed Practical Nurse (LPN) stated she probably did not do an incident report (for the 6/5/20 incident) because there was nothing objective except the resident's pain. She said

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she did not know it qualified as an incident. She thought incidents included falls, skin issues and med errors.

2) According to the MDS assessment dated 2/27/20, Resident #5 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident demonstrated independence in bed mobility, transfers, ambulation, dressing, and toilet use. The resident's diagnoses included Alzheimer's disease.

The Progress Notes dated 4/22/20 at 7:43 a.m. documented staff heard the resident calling out for help from her room. Staff entered and observed the resident face down on the floor unable to tell staff details of the incident. The resident screamed out in pain and grabbed her left hip when assessing her left lower extremity. Call placed to on call provider and order received to send the resident to the Emergency Department (ED) for further evaluation of left hip pain and
left sided low back pain. The resident left the facility at 7:43 a.m. on stretcher via ambulance.

The Progress Notes dated 4/22/20 at 10:34 a.m. documented receipt of a call from the ED, the resident fractured her left hip. The family wished to proceed with surgical intervention and the resident would be transferred to for surgery.

The facility had no incident report for the resident's fall with a fracture.

During an interview on 8/4/20 Staff K, LPN stated she worked the day the resident fell and fractured her hip. She transferred the resident to the

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F 842	Continued From page 43 hospital. She did not complete an incident report. An Incident/Accident Management policy reviewed 11/19 documented incident/accident identification and reporting were the responsibility of all employees of the facility. The employee who witnesses or discovered the incident/accident would notify the supervisor to complete an incident/accident report. An Incident/Accident report would be completed no later than 24 hours after the occurrence. An investigation would be completed within 5 days of the occurrence. The procedure included evaluating for injury and if injury suspected or present, first aide and/or outside medical intervention provided. Verify notification of the physician and responsible party and any impact on the resident.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following	F 849		

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requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board

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care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written

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agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.

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F 849	Continued From page 47 (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure hospice provided the resident's plan of care and notes for 1 resident reviewed (Resident #1). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 6/12/20, Resident #1 had highly impaired hearing with no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for toilet use. The resident's diagnoses included a fracture and malignant neoplasm of the prostate The MDS indicated the resident received hospice	F 849		

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F 849	Continued From page 48 care. The Progress Notes dated 6/3/20 at 12:31 p.m. documented the resident admitted to hospice on 6/2/20 for left side hemiparesis and weight loss. The clinical record lacked any hospice notes or plan of care. During an interview on 8/4/20 at 9:15 a.m. Staff K, Licensed Practical Nurse (LPN) stated she did not think they had any of the hospice information at the facility, she would contact them. At 11 a.m. Staff K provided hospice information faxed to the facility on 8/4/20 at 10:43 a.m. During an interview on 8/5/20 at 12:40 p.m. the Director of Nursing stated they had nothing from hospice until 8/4/20.	F 849		
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	F 880		

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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§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 record review, observation, and staff interview the facility failed to implement a comprehensive infection control program to mitigate the risk of the spread of infection during a COVID-19 outbreak by failing to immediately isolate a resident with Covid-19 (Resident #3) signs and symptoms and failed to clean and disinfect environmental surfaces in the dining room between residents during meal service. The facility reported a census of 37 residents.
Findings include:

1. The Minimum Data Set (MDS) assessment dated 7/18/20, documented diagnoses for Resident #3 included Diabetes, hip fracture, hypertension, and anxiety disorder. The MDS documented the resident scored 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified intact cognition. Resident #3 required limited assistance for bed transfer, and locomotion on the unit.

Observation on 7/30/20 at 9:55 AM revealed door to Resident #3's room door open. No signage on door or exterior of room. No isolation cart present outside of room. Resident invited surveyor into room, however stated not having a good day as had been told she needed to go into

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isolation because had a temperature of 99.2 degrees. Resident not wearing a mask. Surveyor excused self and did not proceed into room.

In an interview on 7/30/20 at 10:00 AM the Administrator and Director of Nursing (DON) confirmed Resident #3 would be moving, but hadn't yet. Further stated the resident had been informed to not come out of her room. Additionally confirmed there was no signage outside of room that would indicate that staff should not enter the room. The resident does have a private room.

On 7/30 20 at 10:52 AM Resident #3 moved to a room in the designated Covid isolation hall. Isolation cart outside of door to room, and isolation precautions directed through a sign on the door.

A nursing Progress Note dated 7/30/20 at 1:15 AM documented Resident #3 complained of a sore throat, had a productive cough with thick green mucous, and a temperature of 99.2 with temporal artery, oxygen saturation was 84% on room air and 90% with oxygen at 2 litres with a mask. PRN (as needed) Tylenol given at this time. In a Progress Note on that same date at 8:50 AM, Staff K, Licensed Practical Nurse (PRN) documented the resident was asked to remain in her room due to symptoms by the night nurse. The resident informed Staff K that she would not stay in room today and exited the room in her wheelchair. Staff K documented she made several attempts to stop the resident with education but all attempts were unsuccessful. It is further documented the DON approached the resident, education provided, resident refused to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52	F 880		

wear a mask, and finally agreed to return to room.

In an interview on 8/4/20 at 12:45 PM the DON stated she would have expected the night nurse to immediately place the resident in isolation precautions when experienced signs and symptoms of Covid 19. The DON provided a screening tool utilized for screening staff and stated would use the same criteria for screening residents. The screening tool directed if experienced any two or the following symptoms: sore throat, headache, fever of 99 degrees, chills, muscle pain, diarrhea, repeated shaking with chills, or a new loss of taste or smell would need to contact supervisor. The DON confirmed Resident #3 experienced two or more symptoms, so would have expected to be placed in isolation precautions.

In an interview on 8/4/20 at 1:00 PM, Staff K, LPN Infection Control Nurse stated she had received report from the night nurse who had informed Resident #3 complained of a sore throat, low grade temp. Staff K informed resident to not leave room and to keep the door shut. Stated she would have expected the night nurse to place Resident #3 in isolation right away.

2. During lunch observation on 7/29/20 at 12 Noon, Staff J, Dietary Aide wiped down table between residents in the dining room and allowed the table to dry.

On 7/29/20 at 12:15 PM Staff J, Dietary Aide utilized a rag from a green bucket in the kitchen window to wipe down the table. The dietary aide identified the green bucket as filled with water and Dawn brand dish soap. A chemical strip identified no chemicals in the bucket of soapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	C 08/11/2020

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F 880	Continued From page 53 water. In an interview on 8/3/20 at 3:30 PM the Facility Coordinator stated dining room and nursing staff are to use a mixture of Dawn, bleach and water to clean tables between resident with communal dining. She confirmed staff had not been instructed on a ratio of bleach, Dawn and water. The Facility Coordinator further stated this was unacceptable so effective immediately the facility will be using a pre-prepared bleach wipe to cleanse the tables between residents.	F 880		