STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	C 11/04/2020

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F 000	INITIAL COMMENTS Correction date 11-5-20 The following deficiencies relate to the COVID-19 Focused Infection Control Survey and the investigation of complaints 93058-C, 93064-C, 93493-C, 93503-C, 93504-C, and 93621-C and facility reported incident 93505-I conducted by the Department of Inspection and Appeals on October 6 - November 4, 2020. The survey identified the facility was not in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Complaints 93058-C, 93064-C, 93493-C, 93503-C and 93504-C were substantiated Complaint 93621-C was not substantiated Facility reported incident 93505-I was not substantiated See the Code of Federal Regulations (42CFR) 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	F 580		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 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 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 and family	F 580		

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F 580	Continued From page 2	F 580		

interviews the facility failed to notify the resident representative of significant changes in condition or a need to alter treatment for 2 of 4 residents reviewed. (Resident #3 and #6). The facility reported a census of 25 residents.

Findings include:

According to an admission Minimum Data Set (MDS) with a reference date of 7/22/2020, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 8 indicating mild cognitive impairment. The MDS documented Resident #3 required extensive assistance of two staff for bed mobility and transfers. The MDS listed the following diagnoses: coronary artery disease, septicemia, multiple sclerosis, and depression.

Review of Resident #3's care plan revealed a focus area that indicated he had a positive COVID-19 result on 7/24/2020. The care plan instructed staff to offer and assist with the use of a telephone, tablet or computer to maintain contact with family and friends with an initiation date of 7/20/2020.

Review of Resident #3's Electronic Health Record (EHR) revealed a positive COVID-19 test result with an analyzed and released date of 7/23/2020.

Review of Resident #3's EHR revealed the one phone number for the resident's #2 emergency contact.

Review of Resident #3's clinical record revealed the discharging hospital's facesheet contained a different phone number for the resident's #2 emergency contact.

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F 580	Continued From page 3 On 10/7/2020 at 2:26 PM, an attempt to call the resident's #2 emergency contact was made by the surveyor using the number listed in the EHR. The phone call went to a voice recording which asked the caller to enter a phone number and a pin. There was no option to leave a message for the number listed. A call was made to another contact for Resident #3 to verify the number. The contact provided a different number. The same number had been listed on the discharging hospital's Facesheet for the resident's #2 emergency contact. Review of the facility's Cliniconex Communication Record (the method used by the facility to communicate with family about COVID-19 updates within the facility) revealed the number they used for the updates had been the incorrect phone number. In an interview on 10/6/2020 at 12:59 PM, a family member reported her grandma would call the facility for updates and the facility would tell her that the nurse or doctor could only give information, but no one would call her back. During a family interview on 10/22/2020 at 1:04 PM she was asked if she was able to speak with her family member and she stated they had to take the phone back to him because he was in isolation, other times they had troubles getting the phone back to him. She stated when she would call to get updates from the facility, she wanted to speak to a nurse but she was told they were not allowed to give out information. She stated she told staff she would like to have a nurse call her and they would not call her back. When asked what phone number she provided, she stated her cell phone. She stated the facility did not inform	F 580		

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F 580	Continued From page 4 her Resident #3 had tested positive for COVID-19 and was upset because she does not understand how he got it. She stated he tested negative before he left the hospital and twice during his stay at the facility; with negative results then he got a positive result. She stated another family member had informed her of his positive test result. According to a quarterly MDS dated 9/9/2020, Resident #6 had diagnoses that included aphasia, non-Alzheimer's dementia, depression, bipolar disorder, and COVID-19. The MDS documented a BIMS score of 14 indicating the resident demonstrated no cognitive impairment. The MDS also documented she was independent for bed mobility and transfers. Review of Resident #6's care plan revealed she had cognitive impairment (revision date 7/3/19) and her BIMS score varied at times. The care plan documented the resident had impaired decision making, short term memory impairment and amnesiac disorder. A progress note dated 9/22/2020 at 11:36 AM revealed the Interim Social Worker documented she spoke to the resident regarding her relationship with another male resident. She stated that she does wish to be in a relationship with him. The SW advised that if he wishes to end the relationship that she must honor his preferences. She informed Resident #6 that if they are in a room alone together they must close the door to protect the resident rights of other residents. She also informed her that if she is ever uncomfortable or wishes to end the relationship that she must let staff know. Resident #6 verbalized understanding and gave permission	F 580		

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F 580	Continued From page 5 to the social worker to let her brother know of the relationship. During a family interview on 10/16/2020 at 11:40 AM Resident #6's family member was asked if they were aware of the relationship their family member had in the facility. They stated no, they were not made aware of this. They stated the facility did not contact them about the incident although they are listed as contact to be notified with changes in Resident #6's status. They stated they received updates related to COVID-19, but not about her being found in a room with a male resident. When asked if Resident #6 had a legal guardian, they stated she had a legal guardian that was appointed by the state. During an interview 10/20/2020 at 10:25 AM with Resident #6's guardian/conservator, she stated she has been her guardian/conservator since September of 2019. She stated she should be called regarding any changes with Resident #6. When asked if the facility calls her, she stated she does not get calls about her, so she assumed nothing has happened or they do not notify her. When asked if she had been notified of Resident #6 having a relationship with another resident, she stated they did not notify her of having a relationship with a male resident. During a staff interview on 10/29/2020 at 10:20 the Marketing Director/Interim Social Worker was asked if she contacted Resident #6's family regarding to the relationship she had. She stated she was not able to reach him because nobody answered the phone or returned a call. Review of the facility's Notification of a Change in a Resident's Condition with a last reviewed date	F 580		

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F 580	Continued From page 6 of 11/1/2018 revealed staff are to notify the resident representative of any accident or incident (per Federal and State regulations) and abnormal lab findings.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, and facility policy review the facility failed to investigate the reason for bruise the resident's family members noticed under his right eye during a FaceTime call (Resident #3). The facility reported a census of 25 residents. Findings include: According to an admission Minimum Data Set (MDS) assessment tool dated 7/22/2020,	F 610		

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F 610	Continued From page 7 Resident #3 had diagnoses that included : coronary artery disease, heart failure, multiple sclerosis, and depression. The MDS documented Resident #3 had a Brief Interview of Mental Status (BIMS) score of 8, which meant the resident demonstrated moderate cognitive impairment. The MDS indicated Resident #3 required extensive assistance of two staff for bed mobility, transfers and toilet use. Review of Resident #3's care plan revealed the following focus area: Resident #3 has impaired functional mobility as evidenced by altered gait or balance related to multiple sclerosis with an initiated date of 7/20/2020. The focus area had the following interventions initiated on 7/20/2020: hoyer lift and 2 assist with transfers and non-weight baring status, although Resident #3 would often crawl to transfer (according to the resident's Significant Other - SO). The care plan revealed he used a wheelchair for locomotion which staff propelled, and also identified the resident as at risk for falls (initiated 7/20/20) as evidenced by gait and balance problems. The care plan directed staff to complete skin inspection with all cares, observe for redness, open areas, scratches, cuts, and bruises, and report changes to the nurse (initiated 7/15/20). Review of the Resident #3's Electronic Health Record (EHR) revealed 3 skin assessments had been completed on 7/22/2020, 7/29/2020 and 8/1/2020. The skin assessments did not list bruising to Resident #3's right eye. Review of Resident #3 EHR revealed no documentation in the progress notes related to facial bruising.	F 610		

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F 610	Continued From page 8 Review of the facility's fall log for July 2020 revealed no falls had been documented. Review of the August 2020 log revealed one fall listed on 8/1/20. Review of a fall report dated 8/1/20 at 7:00 PM revealed staff summoned to Resident #3's room to find resident lying next to the bed on the floor on his left side with his left arm under him. No bleeding noted. Review of Resident #3's EHR revealed it lacked any documentation related to facial bruising. During a family interview on 10/6/2020 at 12:59 PM, Resident #3's family stated other family members told her about his falls while in the facility. During this family interview she stated they had a video chat with him on 7/27/2020 and noticed bruising under his right eye. The family member stated Resident #3 had mentioned that he had fallen out of bed 2-3 times. The family asked the facility what they were doing about this and they were told he did not fall. She stated she also saw the bruising at the funeral and it was covered with make-up. She stated this was reported to the facility and they denied knowledge of it. During an interview on 10/8/2020 at 10:11 AM, Resident #3's SO stated one nurse let Resident #3 use her cell phone to "FaceTime" his family. During the FaceTime chat, she noticed the black eye and asked him what happened. She stated it looked sore and purple and Resident #3 told her he fell out of bed and hit his eye on a couch. She stated she did not think he had a couch in his room; it might have been a table. She stated it was unusual for him to move a lot as he could not	F 610		

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F 610	Continued From page 9 move his legs due to the multiple sclerosis. She also reported a nurse told her she had found him on the floor and he had hit his chest. She added the nurse that told her "made it sound like no big deal." She had asked the resident's family members about the bruising to his eye but they stated hadn't they hadn't noticed. She stated another family member took a picture of the bruised eye at the funeral. She gave Staff B's phone number as the nurse that lent him here cell phone to "FaceTime" his loved ones. During an additional family interview on 10/22/2020 at 1:04 PM, the person reported Resident #3 told her he had fallen out of bed 3 times. During a staff interview on 10/9/2020 at 2:28 PM Staff A Certified Medication Aide (CMA) was asked if she remembered Staff #3 having any bruising on his face. Staff A stated she vaguely remembered facial bruising under his eye, but did not know what happened or which eye was affected. During a staff interview on 10/21/2020 at 12:19 PM the current Director of Nursing (DON) reported she was not working at the facility when Resident #3 resided there. During a staff interview on 10/27/2020 at 11:50 AM, Staff C Registered Nurse (RN), stated she did not remember bruising, but if he had bruising it could have been from the way he would throw himself on the ground. She added she was home sick during some of the time he was in the facility and had been notified he had rolled out of bed, but nobody reported any bruising. She also reported she had not witnessed any facial	F 610		

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F 610	Continued From page 10 bruising herself.	F 610		
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 observation, record review and staff interview the facility failed to follow manufacturer instructions when using skin prep while completing wound treatment for 1 of 3 residents reviewed (Resident #7). Staff completed wound treatments and dressing changes for Resident #7 by spraying liquid skin prep and shield then immediately applied the dressing. The manufacturer instructions directed indicated to apply then allow 30 seconds to dry before applying a dressing. The facility reported a census of 25 residents. Findings include: According a significant change Minimum Data Set (MDS) assessment tool dated 9/23/20, Resident #7 had diagnoses that included chronic obstructive pulmonary disease (COPD), insomnia and history of falls.. The MDS documented Resident #7 demonstrated moderate cognitive impairment, had one Stage 2 pressure ulcer, moisture associated skin damage (MASD) and pressure ulcer/injury care, applications of ointments/medications, and application of dressings to feet.	F 658		

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F 658	Continued From page 11 Review of the #7's care plan revealed a focus area with an initiated date of 6/19/2019 indicated she had impaired skin integrity related to excessive weight, skin folds, friction/shearing, immobility, and incontinence. Review of the October 2020 Skin and Wound Treatment Administration Record (TAR) revealed the following order with a start date of 10/1/2020: skin prep to left heel and cover with foam heal dressing. To be changed every other day and as needed (PRN). Review of the sting free alcohol free liquid skin prep and shield label revealed the directions stated to allow 30 seconds to dry before applying dressing or cover. Observation on 10/8/2020 at 3:31 PM revealed Staff G Licensed Practical Nurse (LPN) had completed wound care treatments and dressing changes for Resident #7's pressure wounds. Staff G cleansed the left heal wound, sprayed it with skin prep, immediately applied the dressing, then wrapped the area. Staff G failed to allow the skin prep to dry prior to finishing the dressing treatment. During a staff interview with the DON on 10/30/2020 at 12:30 PM she was asked if staff are to follow the manufacturer's directions to wait 30 seconds to dry before applying a dressing. She stated she would add that information to the TAR for the other resident that utilized skin prep so staff would wait the recommended dry time.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 12 § 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 resident record review, facility policy review, and staff and family interview, the facility failed to act in accordance with professional standards of practice related to assessment and intervention when a resident experienced a significant change in condition and also related to following physician's orders for 2 of 4 residents reviewed (Resident #2 and #3). The facility sent a fax to the physician on 8/3/2020 at 12:30 PM to inform him of Resident #3's change in condition. The physician returned a response on 8/3/2020 at 3:14 PM to send to the emergency room (ER). The facility failed to send the resident to the ER because they did not see the return fax that contained the physician's order in response to the resident's decline. On 8/4/20 at 2:15 a.m., staff identified the resident was not breathing and they could not detect a pulse or a blood pressure. Staff initiated CPR and called 911. The ambulance arrived and transported the resident to the hospital at 2:38 a.m. At 3:15 a.m., the hospital notified the facility that Resident #3 had passed away. Review of the fax the physician had sent back to the facility on 8/3/20 revealed it had been noted by the nurse on 8/17/2020 - 14 days later. These findings constitute an Immediate Jeopardy to resident health and safety. The facility identified a census of 25 residents.	F 684		

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F 684	Continued From page 13 Findings include: 1. According to an admission Minimum data set (MDS) assessment tool dated 7/22/20, Resident #3 had diagnoses that included: coronary artery disease, septicemia, multiple sclerosis, and depression. The MDS revealed the resident had a Brief Interview for Mental Status test score (BIMS) score of 8, which meant the resident demonstrated moderate cognitive impairment. The MDS documented he required extensive assist of two staff for bed mobility and transfers. Review of Resident #3's care plan revealed a focus area that indicated he had a positive COVID-19 result on 7/24/2020. The care plan instructed staff to monitor for elevated temperature, respiratory symptoms such as cough, sore throat, or shortness of breath, and report to the physician if occurs (initiated 7/20/2020). The care plan encouraged staff to observe, document and report mental status changes and report changes to the charge nurse for further evaluation (initiated 7/20/2020). The care plan directed staff to monitor vital signs every shift and as needed (PRN), and monitor/document/report to physician mental status changes. The care plan also directed staff to monitor, document, and report fever, chills, cough, purulent sputum, pleuritic chest pain, tachypnea, an anxious/flushed appearance, hypoxia, confusion, and disorientation to physician PRN (initiated 7/28/20). Review of Resident #3's Electronic Health Record (EHR) revealed a positive COVID-19 test result with an analyzed and released date of 7/23/2020.	F 684		

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F 684	Continued From page 14 Review of Resident #3's Electronic Health Record (EHR) revealed chest x-ray results dated 7/28/2020. The reasons for the X-ray were listed as fever, dehydration, and COVID positive. Findings documented no acute abnormality. Review of Resident #3's EHR revealed a fax to the physician on 8/3/2020 at 12:30 PM with the following reason for physician notification: resident very lethargic, refusing meal, and medications, positive COVID-19 test, remains in isolation, restless with the following vital signs listed: temperature 98.3, blood pressure 110/67, pulse 90, respiration 16, and oxygen saturation 88%. The fax was completed by Staff G Licensed Practical Nurse (LPN). The fax had a sent time stamp that showed the facility sent the fax on 8/3/2020 at 12:44 PM, and a return time stamp that showed the physician returned the fax to the facility (with orders) on 8/3/2020 at 3:14 PM. However, the fax contained a timed and noted date Staff B on 8/17/2020 at 11:44 AM (14 days later). Review of Resident #3's EHR revealed the following progress notes: -8/2/2020 at 3:37 AM: Staff summoned to Resident #3's room to find him on floor where he lay next to his bed on his left side with left arm lying underneath his body. There was no bleeding noted, although staff assumed he did hit his head. The resident was rolled so his arm was out from underneath his body, and staff completed full range of motion (ROM) on his shoulder and he tolerated it well. No injuries noted. Resident was assisted by staff from the floor and into bed, and assessment and vital signs completed with no further injuries noted.	F 684		

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F 684	Continued From page 15 -8/4/2020 at 3:00 AM: At 2:15 AM Resident #3 was observed unresponsive with no pulse, no blood pressure, and not breathing. Resident was warm to the touch, sternal rub completed and the resident was not responsive to tactile or verbal stimuli, so staff initiated CPR and called 911 at 2:17 AM. CPR resumed until ambulance and 911 staff arrived at 2:38 AM to transport the resident to the nearest hospital. - 8/4/2020 at 3:39: at 3:15 am, the hospital called to report that the resident had passed away. Review of Resident #3's Medication Administration Record for 8/2020 revealed he refused all of his morning medications. During a family interview on 10/6/2020 at 12:59 PM stated Resident #3's mother had talked to him the day before he died and reported he had been incoherent, moaning, and groaning. His mother told the facility staff the resident needed to see the doctor but was told no because the doctors were not coming to the facility due to COVID-19. The family member then stated that is when his significant other called his practitioner's office to see what needed to be done. The family member stated the practitioner's office called the facility about the resident's condition. During an interview on 10/8/2020 at 10:11 AM, the resident's SO reported the resident's mom called him the morning before he passed, talked to him, and then called her and to say he did not sound good and could not hold a conversation. Resident #3's SO reported being significant other was upset because he needed to see a doctor. She stated she called the facility and told nurse he needed to see a doctor. The nurse stated the doctor comes in the evenings sometimes but has	F 684		

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not been here since the outbreak. She stated she called his primary care provider (PCP) they used outside of the facility and told them they had a concern with Resident #3 and he needed a doctor. She told the PCP they could not get any help and that was when the PCP's nurse called to get an update and vital signs. The PCP's nurse called the significant other back and stated the facility doctor needed to see him and the facility nurse did not talk of the concerns that were relayed to her by the family.

During a staff interview on 10/8/2020 at 3:38 PM, Staff G was asked if she worked the day before Resident #3 died (8/3/2020). She stated she was not sure because she had just switched to the day shift & needed to check her phone. When asked about the fax she sent on 8/3/2020 she stated that was when anyone would pull paper off the fax machine and put it wherever they wanted. She stated recently staff were told to put a fax in the fax bin or let staff know it is important. She reported starting about a month ago, the Director of Nursing (DON) and Regional Nurse Consultant would keep up on faxes that would come through. She stated staff were educated to not just pull stuff off the printer and put it somewhere else. When asked if she talked to Resident #3's family the day he showed a decline, she stated she remembered talking to his SO. She described the resident as lethargic, just not himself, not eating, not drinking, and he opened eyes but did not acknowledge she was there. She stated when she would try to hand him his water or medication cup he would not take it, and would just looked at her. She stated she told Resident #3's SO she had sent a fax to the physician. She remembered talking with Resident #3's previous doctor and that she had told him he had declined. Staff G

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F 684	Continued From page 17 was asked if staff could have sent Resident #3 out without an order and she stated with his situation she needed an order because at that time it wasn't warranted to send out without an order. She stated if she followed up the next day and his condition at not changed, she would have called. She stated she also would have called if his condition had worsened during her shift. During a follow-up interview on 10/9/2020 at 9:43 AM Staff G was asked if she passed the information on to the oncoming nurse related to her concerns about Resident #3. She stated she let Staff I LPN know during her report and she had written it on the 24 hour report paper. She stated Staff I was new to the facility so when she did her report she went to each resident room to show her who everyone was. When asked if the nursing staff charts their report anywhere she stated on the 24 hour report paper that is on a clip board on the row of the fax machine. Staff G was asked if the facility utilized hot charting she stated they have a hot charting binder which has everything they are to chart on for the day they worked. She stated there is a list of residents and what staff need to chart about each shift. Staff G stated the hot binder chart never used to be updated but now the DON makes sure it is updated every night. Staff G was asked what made her decide to fax the doctor rather than call the doctor, she stated he had a change in condition. She stated about a month ago she had been educated that if there was change in condition to call the doctor, not to fax them. During a staff interview on 10/14/2020 at 12:10 PM Staff E CNA was asked to describe Resident #3, she stated when he first got here he was easy	F 684		

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F 684	Continued From page 18 going and liked to sit in his recliner, but when he had COVID he was not doing too well. She stated the day before he passed away his oxygen was down, he wasn't not talking and wasn't himself because he had declined. She reported she was there breakfast and lunch and he would not eat. She stated he usually drank Mountain Dew but that day he would not drink it and spit it on himself like he had no strength to hold anything in his mouth. He was on oxygen and didn't normally require it. During a staff interview on 10/9/2020 at 1:03 PM Staff L CNA was asked to describe working with Resident #3, she stated she only worked at the facility a couple nights when he was at the facility, liked to sleep in his chair, would reposition him every 2 hours during the night shift. Staff L worked with him on 8/3/2020 on the night shift and he was not talking and on oxygen. He wouldn't drink his Mountain Dew. She stated in report staff stated they were trying to feed him, but he was not eating. She stated they tried to give him fluids throughout the night but he refused. She added he was not normally on oxygen and was normally a quiet guy that would talk for a little bit but had to sit with him. She stated that night he looked like he was not doing very well and they checked on him more frequently than normal. She reported Staff I, LPN worked that night, was and did not work there long. Attempts were made to contact Staff K and Staff I on 10/9/2020 and messages were left requesting a return call. Neither Staff K nor Staff I called back. During a staff interview on 10/13/20202 at 9:32	F 684		

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F 684	Continued From page 19 AM the Medical Director was asked if Resident #3 should have been sent to the hospital and he stated the staff should have send him to the ER according to his order. He stated unless there was refusal from the Power of Attorney (POA) or resident, because of their right to refuse, there should not have been a reason for him not to go the ER. When asked if staff could have sent Resident #3 to the ER without an order he stated they could have sent him out without an order then called later for one, given the information on the fax that was sent to him. During a staff interview on 10/13/2020 at 10:50 AM Staff B RN was asked if she took care of Resident #3, she stated she did not do a lot of care with him. Staff B was asked if a resident had a decline how would she notify the doctor, she stated she would make a telephone call to the physician. She added any change in condition would require a telephone call, it has always been that way. When asked about the fax she noted on 8/17/2020, 14 days after it had been faxed to the facility, she stated she was catching up on notes and had noted the doctor had signed the order. During a staff interview on 10/13/2020 at 10:26 AM the DON was when would staff notify a doctor about a resident via fax versus a phone call? The DON stated any change in condition would require a call to the doctor right away. She stated any time a resident is in distress or needs treatment within an hour would justify a call to the doctor. The DON stated if a resident was experiencing symptoms of a urinary tract infection they routinely would fax the doctor. The reason to call versus fax the doctor is highly variable based on the amount of distress the resident is in. The DON was asked if a resident had a change in	F 684		

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condition such as refusing meds, meals, very lethargic, oxygen saturations below 90%, on oxygen when not normally, with positive COVID test and a fax was sent to the doctor, how long would you wait until you called or followed up? She stated that would require a call right away. She stated to her that person is showing signs that they are declining and sending a fax is not appropriate for that. The DON was asked if she would send a resident to the ER without a doctor's order and she stated that should never happen. If the resident was in active respiratory distress and cannot get hold of doctor, then call 911. The priority becomes the resident's care and safety.

During a family interview on 10/22/2020 at 1:04 PM the family member stated she talked with Resident #3 the day before he passed away. She stated it was not a good conversation. She stated she had a hard time hearing him, talking very low. She stated she asked the facility staff is he saw a doctor and they told her that the doctor did not come because of COVID-19. The nurse told her she would try to get a doctor but not sure he would come out.

During a staff interview on 10/27/2020 at 11:50 am Staff C RN/previous DON said Resident #3 developed COVID-19 and she knew him a little bit, but when he started to decline but she was off work because she had COVID-19. She remembered she had received a call from the nurse that night that he passed and she had told that staff member he was a full code and they needed to do everything they could for him. Staff C was asked if the nurse that took care of him noticed a decline, had faxed the doctor but never heard back, what should she have done? She

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F 684	Continued From page 21 stated the nurse should have made a phone call instead of sending a fax. She stated she had preached that over and over to her nurse. She stated she often had conversations about when to call the doctor, if anything was alarming enough to contact the doctor they should have called. Review of the facility's Policy and Procedure: Physician's Orders with a revision date of 7/1/2017 revealed the licensed nurse is required to record the order in the Electronic Health Record (EHR), the Physician Order Sheet (POS), and on the appropriate Medication Administration Record (MAR)/Treatment Administration Record (TAR). Review of the facility's Notification of a Change in a Resident's Condition policy with a last reviewed date of 11/1/2018 revealed staff are to notify the physician/resident representative when there is a significant change in unstable vital signs, symptoms of any infectious process, change in level of consciousness, and unusual behavior. The facility was notified of the Immediate Jeopardy on 8/13/20. The facility abated the IJ on 8/13/20 by implementing the following actions: a. Medical Director notified he will receive phone calls in place of faxes 24/7 in the event a resident has a change in condition. If the physician is not available, the facility will call his after-hours clinic number. The DON has his cell number and she can reach out to him as well. b. 100% audit completed on all residents to ensure there were no immediate changes in condition.	F 684		

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F 684	Continued From page 22 c. Inservices provided to all licensed staff on proper protocol and procedures for responding to a resident's change in condition including assessment/intervention, physician notification, and documentation of the event. d. Facility will monitor change in condition through clinical meeting 5 times weekly through 4 weeks then monthly to ensure ongoing compliance. Monitored findings will be brought to monthly QAPI for review. e. Regional Nurse Consultant will educate licensed staff on completing head to toe assessments and identifying early changes of conditions. 2. According to a quarterly Minimum Data Set (MDS) with a reference date of 9/9/2020 revealed Resident #2 had a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS indicated she required limited assistance of 1 staff for bed mobility, personal hygiene and extensive assistance of 2 staff. The MDS listed the following diagnoses: heart failure, peripheral vascular disease, diabetes mellitus, stroke, hemiplegia, and depression. Review of Resident #2's care plan revealed a focus area with an initiation date of 10/31/2018: she had potential for impaired skin integrity related to diabetes, excessive weight-skin folds, incontinence, thin fragile skin. On 5/18/2020, coccyx non pressure moisture, see wound log. The focus area revealed the following interventions with an initiation date of 10/31/2018: air mattress to her bed, weekly head to toe	F 684		

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F 684	Continued From page 23 assessments by a licensed nurse, review skin risk factors via pressure injury assessment and clinical observation/assessment, encourage frequent repositioning in bed and chair, apply chair cushion to her wheelchair, keep her clean and dry, use barrier cream, good pericare and observe skin with all cares, report any changes to the nurse. The care plan encouraged staff to check and change Resident #2 with rounds with an initiation date of 5/19/2020 and added a Roho cushion to her wheelchair on 9/16/2020. Review of Resident #2's clinical record revealed a fax to the physician dated 8/15/2020 at 2:15 PM that was sent from Staff B Registered Nurse (RN). The reason for physician notification: resident has moisture area to coccyx which has declined. The facility would like to change treatment from triad cream to Aquacel extra to wound and place bordered dressing twice a day (BID) and as needed (PRN) if saturated until healed. The fax was time stamped as sent on 8/15/2020 at 2:04 PM from the facility. On 8/17/2020 the physician replied ok. The order was not time and noted by the facility. The fax was time stamped as being returned on 8/17/2020 at 3:28 PM from the physician's office. Review of Resident #2' Electronic Health Record (EHR) revealed Resident #2's completed and discontinued orders from 5/20/2020-9/16/2020 revealed the following orders: apply Dermesyn and Aquacel extra to coccyx wound bed, cover with sacrum dressing until healed with a start and end date of 8/23/2020; iodosorb to coccyx wound bed with gauze dressing and apply bordered gauze with a start date of 8/31/2020 and end date of 9/10/2020; clean wound to coccyx with wound cleanser, apply Dermesyn and collagen powder	F 684		

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F 684	Continued From page 24 to the wound and cover with bordered dressing daily and as needed (PRN) if saturated until healed with a start a start date of 9/11/2020 and an end date of 9/16/2020 and medihoney with calcium alginate to coccyx wound daily and PRN soiling, cover with sacral foam dressing with a start date of 9/16/2020 and an end date of 9/21/2020. Review of Resident #2's August 2020 Treatment Administration Record (TAR) revealed the order to change treatment from triad cream to Aquacel extra to wound and place bordered dressing BID and PRN if saturated until healed, was not on the TAR.	F 684		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not	F 790		

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F 790	Continued From page 25 charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review, staff and complainant interviews, and facility policy review the facility failed to provide dental services for 1 of 3 residents reviewed (Resident #2). The dental service used by the facility had no records that pertained to an examination for the resident. The facility reported a census of 25 residents. Findings include: According to a quarterly Minimum Data Set (MDS) dated 9/9/2020, Resident #2 had diagnoses that included: heart failure, peripheral vascular disease, diabetes mellitus, stroke, hemiplegia, and depression. The MDS revealed a Brief Interview of Mental Status (BIMS) score of 5, and required limited assistance of 1 staff for bed mobility and personal hygiene. The MDS identified the resident did not have a broken or	F 790		

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loosing fitting full or partial denture, and showed no mouth or facial pain, discomfort, or difficulty chewing.

Review of Resident #2's care plan revealed a focus area with an initiation date of 10/31/2018: resident has potential for pain related to chronic pain. The care plan encouraged staff explore non-pharmacological pain alleviating interventions. Staff are to identify, record and treat Resident #2's conditions which may increase pain and discomfort. Staff are to observe her during cares for signs of pain such as facial grimacing, hesitancy with movement, furrowed brows, saying ouch. These interventions were initiated on 10/31/2018.

The facility was asked to provide dental records for Resident #2 from 10/2019 to 10/2020. The dental provider had no documentation related to the resident from the dental hygienist.

During an interview on 10/6/2020 at 3:49 PM a hospital staff member stated that when Resident #2 was admitted to the hospital it appeared oral care had not been completed for quite some time. She reported the resident's oral cavity emitted a foul odor, contained dry blood, appeared to have pus present at her gum line, and her remaining teeth were loose.

During a staff interview on 10/21/2020 at 10:45 AM Staff D Certified Nursing Assistant (CNA) was asked when oral care gets completed she stated it depends but she completes oral cares in the mornings. She stated not all residents allow it to be completed. When asked who is responsible for completing oral cares she stated the CNAs. Staff D was asked if residents leave the facility to

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F 790	Continued From page 27 go to the dentist or if one comes to the facility and she answered "both." Staff D was asked to describe how she would provide oral care for someone with only a few teeth, and she said she would brush the remaining teeth and use a swab to clean the rest of the mouth. Staff D reported some mornings Resident #2 would allow oral cares and other mornings she would not. Staff D stated even if she tried to use a swap it was hit and miss. During a staff interview on 10/21/2020 at 10:53 AM Staff E CNA reported CNAs completed oral care in the morning and at bedtime. She stated the dental staff would come to the facility before COVID-19 hit the facility. Staff E was asked how she would complete oral care on a resident with missing teeth she stated she would the swaps that have the small sponge at the end of a stick. She stated she mainly completed Resident #2's baths and never had to brush her teeth, but had heard she always refused to allow staff to do it. During a staff interview on 10/21/2020 at 12:19 PM the Director of Nursing (DON) said CNAs are to complete oral cares in the morning and at night and if the resident resident refuses they should report it to the nurse so the nurses can talk to the resident and provide education about the importance of dental hygiene. She stated the nurses would need to do an assessment to see if they had any sores anywhere and if there were problems nurses should notify the dentist. The DON reported the resident scheduled to see the dentist but passed away prior to the appointment date. During a staff interview on 10/21/2020 at 3:14 PM Staff H LPN was asked how she thought	F 790		

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F 790	Continued From page 28 Resident #2 oral hygiene was, she stated while the Resident #2 was on the COVID unit she had blood in her mouth. She would ask what has happening but no one knew. She stated she was constantly moving and chewing on her lips. She stated Resident #2 had loose teeth and the one front tooth would wiggle and bleed. She thought maybe she was grinding her teeth. During a staff interview on 10/27/2020 at 11:50 AM, Staff C Registered Nurse (RN) and former Director of Nursing stated oral cares should be completed morning, evening and as needed. She stated the CNAs usually completes oral cares but if a nurse is helping a CNA they can also complete the task too. She added it does not all fall on the CNAs. Staff C reported a dental hygienist used to come once every 3 months and the dentist came in when needed, and some resident's went to the office prior to COVID-19. Staff C stated staff would complete oral cares on a resident with missing teeth the same way they would with someone with all of their teeth. She she stated sometimes Resident #2 was fine with oral care and resist at other times. Staff C stated she tried to brush them while on the COVID unit and Resident #2 would gag and was resistant to it. On a good day she thought she was receptive. Staff C stated if Resident #2 was frequently resistant it was not communicated to her. She offered that if they had told her she could have educated Resident #2 or had the nurses attempt to provide oral cares. When asked if she felt like her oral care was being completed, she stated truthfully it was dependent on the day and who was working. She stated during COVID a lot of stuff was not getting done as well as they should have been. Staff C was asked if a resident refused oral care on a routine basis, what she	F 790		

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F 790	Continued From page 29 would expect from staff she stated they should get the nurse involved. When asked what would you expect staff to do if a resident complained of pain in her oral cavity, she stated she would tell staff to stop oral cares and alert a nurse to give pain medication PRN and complete an assessment to figure out the reason for her pain. She said she would encourage staff to not continue with oral care if it was hurting Resident #2. She stated during COVID would residents continue to see the dentist, she stated if they absolutely needed to be taken care. If this was at the time she was COVID positive, she would have made sure she got her needs met, such as compassionate care visit. Staff C stated Resident #2 had poor dentation and should have been a necessity. If she was refusing and/or in pain and had she known she would have set up dental with her. Review of the facility's Dental Services policy with an approved date of 1/24/2019 revealed the facility will provide dental services to residents as needed. The policy indicated all residents will be screen on an annual basis as part of the comprehensive assessment and the charge nurse may request dental screening in the event a resident complains of dental problems.	F 790		
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	F 842		

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F 842	Continued From page 30 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; (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-	F 842		

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F 842	Continued From page 31 (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 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, facility incident investigation and staff interview the facility failed to maintain complete and accurate resident charts for 3 of 8 residents reviewed (Resident #3, #5 and #6). The facility failed to document Resident #3's decline in health status in his Electronic Health Record (EHR). The facility reported Residents #5 and #6 had been found in a resident room, sitting on the bed and Resident #6 had pulled her shirt down as staff entered the room. Resident #5 and #6's EHR lacked a progress note detailing the incident that took place. The facility reported a census of 25 residents. Findings include: 1. According to an admission Minimum Data Set (MDS) with a reference date of 7/22/2020 ,	F 842		

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Resident #3 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. The MDS indicated Resident #3 required extensive assistance of two staff for bed mobility, transfers and toilet use, and had diagnoses that included: coronary artery disease, heart failure, multiple sclerosis, and depression.

Review of Resident #3's care plan revealed a focus area initiated on 7/20/2020: at risk for contracting COVID-19 due to nursing facility/community living and compromised immune system. The resident had a positive COVID-19 test on 7/24/2020 and on 7/28/2020 the facility initiated the following interventions: monitor vital signs every shift and as needed (PRN); monitor, document, and report to the doctor of mental status changes; monitor, document, report to the doctor PRN for the following signs and symptoms of pneumonia: fever, chills, cough, purulent sputum, chest pain, tachypnea, anxious, flushed appearance, hypoxia, confusion, and disorientation.

Review of Resident #3's Electronic Health Record (EHR) revealed a positive COVID-19 test result with an analyzed and released date of 7/23/2020.

Review of Resident #3's Electronic Health Record (EHR) revealed chest x-ray results dated 7/28/2020 that found no acute abnormality. The reasons for the x-ray were listed as fever, dehydration, and COVID positive.

Review of Resident #3's EHR revealed a facsimile (fax) to the physician on 8/3/2020 at 12:30 PM with the following reason for physician notification: resident very lethargic, refusing

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meals, and medications, positive COVID-19 test, remains in isolation, restless with the following vital signs listed: temperature 98.3, blood pressure 110/67, pulse 90, respiration 16, and oxygen saturation 88%. The fax was completed by Staff G Licensed Practical Nurse (LPN).

Review of Resident #3's vital signs documented in his EHR revealed the most recent vital signs documented. The last blood pressure was obtained on 8/1/2020 at 7:30 PM, temperature and pulse was obtained last on 8/2/2020 at 12:50 AM and respirations and oxygen saturation last obtained on 8/2/2020 at 12:51 AM. The resident's EHR lacked documentation of the vitals that were communicated with the physician on the fax that was sent on 8/3/2020.

Review of Resident #3's EHR revealed the following progress notes:

-8/2/2020 at 3:37 AM: staff was called into Resident #3's room to find resident lying on floor next to his bed, on his left side with left arm lying underneath his body. There was no bleeding noted, assumed that he did hit his head. Resident was rolled so his arm was out from underneath his body. Full range of motion (ROM) completed on his shoulder and it was tolerated well. No injuries noted. Resident was assisted by staff from the floor to the bed. Further assessment was done with no further injuries noted. Vital signs were completed and within normal limits.

-8/4/2020 at 3:00 AM: At 2:15 AM Resident #3 observed as unresponsive with no pulse, no blood pressure, and not breathing. Resident was warm to the touch, sternal rub done and the resident was not responsive to tactile or verbal

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stimuli. Due to Resident #3's full code status, staff initated CPR and called 911 at 2:17 AM. CPR resumed until ambulance and 911 staff arrived at 2:38 AM and transported Resident #2 to the nearest hospital.

Resident #3's EHR lacked documentation related to his change in health status on 8/3/2020.

During a staff interview on 10/8/2020 at 3:38 PM Staff G LPN, she stated she remembered talking to Resident #3's significant other the day she sent the fax to the physician. She stated Resident #3 was not himself: lethargic, not eating or drinking, and opened his eyes but did not acknowledge her presence. Staff G said when she would try to hand him his water or medication cup he would not take it and just looked at her. When asked if she documented this anywhere, she stated she should have. When informed there was no progress note found, she said if there was no progress note, then she must not have charted it.

During a follow-up interview on 10/9/2020 at 9:43 AM with Staff G she was asked if the information related to Resident #3's condition change was passed along to the oncoming nurse. Staff G stated she did notify Staff I LPN of the change during their shift report. She stated she then did a walk through with Staff I to show her each resident in the facility. When asked if she documented her report anywhere she stated on the 24 hour report paper on the clip board by the fax machine. She also stated they used hot charting and she had documented on that as well.

The facility was asked to provide the 24 hour report sheets and hot charting sheets for 8/3/2020. On 10/12/2020 at 11:30 AM the

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F 842	Continued From page 35 Regional Nurse Consultant stated the team was unable to find the requested documents. During a staff interview on 10/30/2020 at 12:30 PM the new Director of Nursing (DON) said with a change in condition staff should document it in the progress notes and include the vital signs. When informed the record lacked a progress note or vital signs documented on 8/3/2020 when Resident #3 started to decline, she stated staff should have documented that and if it is not documented it was not done. The DON stated they have systems in place to follow with a change in resident conditions. 2. According to a significant change MDS dated 9/16/20, Resident #5 had a BIMS score of 13 (no cognitive impairment). The MDS indicated he was independent for bed mobility and transfers and listed the following diagnoses: muscle weakness and gastrostomy tube. Review of Resident #5's care plan revealed a focus area initiated on 9/21/20: readiness for enhanced relationship with an inter-facility person of interest as evidenced based verbalized desire for an intimate relationship. Review of #5's EHR revealed the following progress note on 9/22/2020 at 11:23 AM: the Social Worker spoke with resident regarding his relationship with a female resident. He stated that he does wish to be in a relationship with her. She discussed boundaries and if she ever changes her mind or says no then he must honor her preferences, resident verbalized understanding. The Social Worker advised that if they are in a room alone together the door must be shut to protect the resident rights of other residents.	F 842		

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F 842	Continued From page 36 Resident #5 gave permission to this to notify his son about the relationship so he is aware. Informed resident that if he ever wishes to end the relationship that he should notify staff, and he verbalized understanding. Review of Resident #5's EHR revealed it lacked documentation of a detailed progress note on the events of 9/19/2020. 3. According to a quarterly Minimum Data Set dated 9/9/2020, Resident #6 had a BIMS score of 14 (no cognitive impairment). The MDS documented the resident was independent for bed mobility and transfers and had diagnoses that included: aphasia, non-Alzheimer's dementia, depression, and COVID-19. Review of Resident #6's care plan revealed a focus area with an initiated date of 9/21/2020: readiness for enhanced relationship with an inter-facility person of interest as evidenced based verbalized desire for an intimate relationship. Review of Resident #6's EHR revealed the following progress note dated 9/22/2020 at 11:36 AM the Interim Social Worker documented she spoke to the resident regarding her relationship with another male resident. She stated that she does wish to be in a relationship with him. Advised that if he wishes to end the relationship that she must honor his preferences. She informed Resident #6 that if they are in a room alone together that they must close the door to protect the resident rights of other residents. She also informed her that if she is ever uncomfortable or wishes to end the relationship that she must let staff know. Resident #6	F 842		

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F 842	Continued From page 37 verbalized understanding and gave permission to the social worker to let her brother know of the relationship. Review of Resident #6's EHR revealed it lacked documentation of a detailed progress note on what took place on 9/19/2020. Review of the facility's incident audit report revealed an incident date of 9/19/2020 at 4:50 PM. The report indicated Staff A Certified Medication Aide (CMA) notified Staff B Registered Nurse (RN) of Resident #5 in the room of Resident #6 with the door closed. After Staff A knocked on the door to deliver her supper tray, there was no answer, so Staff A opened the door to find Resident #5 sitting on the bed with Resident #6 and she had pulled her shirt down. During a staff interview on 10/30/2020 at 12:30 PM the DON was asked if staff should document in the progress notes for incidences such as the one that took place between Resident #5 and #6 and she answered yes. Review of the facility's Notification of a Change in a Resident's Condition with a last reviewed date of 11/1/2018 directed staff are to document in the interdisciplinary team (IDT) notes: resident change in condition and physician notification.	F 842		
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	F 880		

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F 880	Continued From page 38 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 39 (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 interviews, the facility failed to screen the Department of Inspections and Appeals (DIA) representative prior to entering the facility. The facility also failed to perform proper hand hygiene while completing a treatment and dressing change for 1 of 3 residents reviewed (Resident #7) . The facility reported a census of 25 residents. Findings include: 1. Observation on 9/25/2020 at 2:04 PM revealed Staff C Registered Nurse (RN) approached the DIA representative (Surveyor) at the front entrance wearing a surgical mask and goggles and walked to a room to complete the entrance	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	C 11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

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F 880	Continued From page 40 conference. Observation revealed between the front entrance and the therapy room a resident not wearing a mask to cover their nose and mouth. The entrance conference began with questions about COVID-19 and then Staff C stated oh, I did not screen you, then left the room. At 2:08 PM, Staff C obtained an infrared thermometer and obtained the surveyor's temperature. Staff C failed to properly screen the surveyor before they entered the facility. Review of the facility's Visitor Acknowledge Visitation Guidelines revealed the following visitation procedures: arrive wearing a facemask or one will be provided, check-in with the receptionist, complete the risk evaluation with temperature check, perform hand hygiene with sanitizer. Review of the facility's Risk Evaluation Tool: Identify Employees & Essential Visitors at Risk for COVID-19 with a revision date of 7/2020 revealed the following: -Person Performed Hand Hygiene with Alcohol-Based Sanitizer -New Onset of Shortness of Breath or Cough -Person Present with 2 or More Symptoms: temperature >100.4, sore throat, chills, headache, loss of taste/smell, diarrhea, muscle aches, vomiting, fatigue, nausea, congestion/runny nose. -Temperature Beginning of the Shift -Temperature End of Shift -Person Worked in Facility with +COVID -Person Worked with Individuals with +COVID -Person Instructed to Utilize PPE-N95 Mask Prior to Resident Contact -Person Educated on Social Distancing & Hand	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 41 Hygiene -Have you tested for +COVID? Enter Test Date: -Do you have a pending COVID test? -The signature of the visitor and evaluator is at the bottom of the tool 2. According to a Minimum Data Set (MDS) assessment tool dated 9/23/2020, Resident #7 had diagnoses that included depression, chronic obstructive pulmonary disease (COPD), insomnia, and history of falling. The MDS documented a Brief Interview of Mental Status (BIMS) score of 9, which meant the resident demonstrated moderate cognitive impairment. The MDS revealed she required extensive assist of two staff for bed mobility and was totally depended on 2 staff for transfers. The MDS indicated she was always incontinent of bowel and bladder, had a pressure ulcer/injury, a scar over a bony prominence, or non-removable dressing/device, was at risk for developing pressure ulcers, and had one Stage 2 pressure ulcer at the time of the assessment. The MDS also indicated Resident #7 had moisture associated skin damage (MASD) and listed the following treatments: pressure reducing device for her chair and bed, turning/repositioning program, nutrition or hydration intervention, pressure ulcer care, and applications of ointments/medications and dressings to feet. Review of Resident #7's October 2020 Skin and Wound TAR revealed the following order: skin prep to left heel and cover with foam heel dressing. Change every other day and PRN until healed. Observation on 10/8/2020 at 3:31 PM revealed Staff G Licensed Practical Nurse (LPN) had	F 880		

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F 880	Continued From page 42 completed wound treatments and dressing changes to Resident #7's left heel and buttock wound. As Staff G entered Resident #7's room housekeeping had dropped a wipe on the floor, Staff G picked it up with her right bare hand, threw it away, touched her mask with her right hand. Staff G then handled the supplies for Resident #7's treatments and dressing changes: foam dressing (packaged), coloplast, unpackaged cloth wrap to secure the dressing, skin prep, and allevyn dressing with her right hand. Staff G stated Resident #7 had just had a bath. There was a knock at the door and another staff member handed her a sandwich in a baggie to give to Resident #7's roommate. With her left hand Staff G gave the roommate the bagged sandwich then touch the foam dressing to write the date on it. Staff G then applied gloves and completed the treatment and dressing change to Resident's left heel. Staff G failed to complete proper hand hygiene between tasks and prior to providing Resident #7's treatment and applying her new dressing to her left heel. During a staff interview on 10/30/2020 at 12:30 PM the Director of Nursing (DON) was informed of the dressing change observation with Staff G. The DON stated the scenario gave plenty of opportunities to complete hand hygiene.	F 880		

Plan of Correction
Oakland Manor
Survey: September 25, 2020 – November 4, 2020
Correction Date: 11/05/2020

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

1) Immediate Fix
2) Potential Residents Affected
3) System Changes
4) Monitoring/QAPI
5) DOC

F580 Notification of Changes

1) Immediate fix
   A. R3 expired on 8/4/2020
   B. SSD/Designee updated contact information on R6 in EMR on 11/5/2020
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
   A. 100% audit completed by SSD/Designee to ensure updated contact information for residents is correct in EMR by 11/6/2020. Contact information for all residents will be updated quarterly with the care plan.
   B. DON/Designee In-Serviced Nursing Staff on Notification on Change in Condition including assessment, interventions, notification of change, follow up, and documentation on 11/5/2020.
   C. DON/Designee completed facility audit tool on notification of change 3x/week for 4 weeks beginning 10/16/2020
4) DON/Designee will Monitor through Facility Audit Tool 3X/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 11/5/2020.

F610 Investigate/Prevent/Correct Alleged Violation

1) R3 expired on 08/04/2020.
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
   A. DON/Designee completed an In-Service on injury of unknown origin on 11/5/2020.
   B. DON/Designee completed an in-service on abuse policy and procedures to all staff on 10/8/2020 and 11/5/2020.
   C. DON/Designee completed facility audit tool for incident reporting, change in condition, and bath/skin sheets 3x/week for 4 weeks beginning on 10/16/2020
4) DON/Designee will Monitor through Facility Audit Tool 3X/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 11/5/2020.

F658 Services Provided Meet Professional Standards

1) Immediate Fix
   A. R7 expired on 10/12/2020.
   B. DON/Designee Completed 100% Audit on Dressing Changes on 11/3/2020.
   C. Licensed Nursing Staff educated on dressing changes on 11/5/2020.
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
   A. DON/Designee In-Serviced Licensed Nursing Staff on Dressing Changes including preparation, procedures, documentation, and follow up on 11/5/2020.

B. DON/Designee in-serviced Licensed Nursing Staff on wait time/dry time for skin prep per manufacturer label and on the location of wait/dry time on label on 11/5/2020.

4) DON/Designee will Monitor through Facility Audit Tool 3X/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 11/5/2020.

F684 Quality of Care

1) Immediate fix
   A. R2 expired 9/24/2020
   B. R3 expired 8/4/2020
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
   A. Medical Director notified that he will receive phone calls 24/7 in the event of a Residents' change of condition on 10/6/2020 at monthly QAPI meeting.
   B. DON/Designee completed an in-service with nursing staff on notification of change with Medical Director 24/7 on 10/8/2020 and 11/5/2020. Medical Director's cell phone number and after-hours clinic phone number provided at this time and updated in EMR under the communication tab.
   C. DON/Designee completed education with nursing staff on where to find contact information in EMR and how to get to the contact information for facility management staff and Medical Director on 11/5/2020.
   D. DON/Designee completed an in-service with nursing staff on proper protocol and procedures for responding to a residents' change in condition including assessment/intervention, physician notification and documentation of the event on 10/8/2020 and 11/5/2020.
4) Facility will monitor change in condition through clinical meeting 5x/week for 4 weeks and then monthly to ensure ongoing compliance. Monitored findings will be brought to monthly QAPI for review.
5) Date of Compliance: 11/5/2020.

F790 Dental Services

1) R2 expired on 09/24/2020.
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
   A. Dental Services were provided to all residents who requested dental services on 10/19/2020 for treatments and on 10/20/2020 with the dental hygienist.
   B. DON/Designee Completed in-service with nursing staff on Dental Services on 11/5/2020.
   C. DON/Designee completed in-service with nursing staff on oral hygiene including frequency, appropriate oral hygiene instrument, and notification of change on 11/5/2020.
4) DON/Designee will Monitor through Facility Audit Tool 3X/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 11/5/2020.

F842 Resident Records

1) Immediate fix
   A. R3 expired on 8/4/2020.
   B. R5 Treatment record was reviewed/audited on 9/19/2020.
   C. R6 Treatment record was reviewed/audited on 9/19/2020.
   D. R5 Care plan was updated on 9/21/2020.
   E. R6 Care plan was updated on 9/21/2020.
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
   A. DON/Designee completed in-service with nursing staff on documentation omissions and proper documentation on 10/8/2020 and 11/5/2020.
   B. DON/Designee Completed In-Service with nursing staff on incident reporting, notification of change, and proper documentation on 11/5/2020.
4) DON/Designee will Monitor through Facility Audit Tool/Clinical Meeting tool 5x/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 11/5/20.

F880 Infection Prevention & Control

1) Immediate fix
    A. R7 expired on 10/11/2020.
    B. DON/Designee completed in-service with nursing staff on entrance screening, PPE usage, gloving, Infection Control & Hand Hygiene on 11/5/2020.
2) All Residents have the potential to be affected by this deficient practice.
3) System Changes
    A. DON/Designee completed an in-service with facility staff on COVID-19 Policy and Transmission Based Precautions on 10/8/2020 and 11/5/2020.
    B. DON/Designee completed Facility Audit Tool for Infection Control and hand hygiene 5x/week for 4 weeks beginning 10/16/2020.
    C. DON/Designee Completed In-Service with Nursing Staff on Infection Control and Hand Hygiene on 11/5/2020.
    D. NHA/DON/Designee completed an in-service with facility staff on entrance/exit screening for staff and visitors on 10/8/2020, 10/30/2020, and 11/5/2020.
4) DON/Designee will Monitor through Facility Audit Tool 3x/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 11/5/2020.

Immediate Plan of Correction for Immediate Jeopardy tag F684

1) Medical director notified that he will receive phone calls 24/7 in place of faxing in the event of a residents' change of condition. If the physician is not available, the facility will call his after-hours clinic number and the DON has his cell phone number and she can reach out to him as well. These numbers are located in the communications tab in PCC for future reference.
2) E-interact in PCC will be completed on residents with change of condition including physician notification and in-servicing license staff on notification of changes policy A.9.
3) 100% audit completed on resident to ensure there are no immediate changes of condition.
4) Inservice provided to licensed staff on proper protocol and procedures for responding to a residents' change in condition including assessment/intervention, physician notification and documentation of the event.
5) Facility will monitor change in condition through clinical meeting 5x/wk x 4 weeks then monthly to ensure ongoing compliance.
6) Monitored findings will be brought to monthly QAPI for review.
7) RNC will educate on completing head to toe assessments and identifying early changes of conditions.

Directed Plan of Correction for F880 Infection Prevention & Control

1. The Administrator/Director of Nursing (DON) and/or Infection Preventionist will conduct in-services for all staff employed by the facility. The in-services will consist of training on implementation of COVID 19 infection control policies and procedures. The Centers for Disease Control and Prevention (CDC) has infection control training modules available to nursing homes. In-service training materials will include:
    - PPE lessons: https://www.youtube.com/watch?v=YYTATw9yav4&feature=youtu.be
    - Sparkling Surfaces: https://www.youtube.com/watch?v=t7OH8ORr5Ig&feature=youtu.be
    - Clean Hands: https://www.youtube.com/watch?v=xmYMUly7qiE&feature=youtu.be
    - Keep COVID OUT: https://www.youtube.com/watch?v=7srwrF9MGdw&feature=youtu.be
2. The Administrator/DON/Infection Preventionist/Designee will conduct in-services for all staff employed by the facility. The in-services will consist of training on the implementation of hand hygiene and proper personal protective equipment (PPE) use including gowns, gloves, and facemasks. Staff will be trained to perform hand hygiene (even if gloves are used in the following situations: before and after contact with resident; after contact with blood, body fluids, or visibly contaminated surfaces; after contact with objects and surfaces in the resident's environment; after removing personal protective equipment (e.g., gloves, gown, facemask); and before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, and/or dressing care, etc..). To be completed by 10/12/2020.

3. The facility will Include documentation of the training completed with a timeline of completion.
4. The Administrator/DON/Infection Preventionist/Designee will complete and document visual rounds of staff for compliance with infection control policy and procedures (including hand hygiene, PPE usage, and lift cleaning). These rounds will be conducted weekly for four weeks and monthly thereafter. Any staff found through the monitoring process to have failed to follow facility policy and procedure will receive 1:1 instruction from the DON/Infection Preventionist/Designee as appropriate. DON/Designee will monitor through facility audit tool 5X/Week for 4 Weeks and then Monthly to ensure ongoing compliance. Monitored findings will be brought to monthly QAPI meeting for review.
5. The facility will conduct a root cause analysis (RCA) which will be done with assistance from Gina Anderson @ ganderson@telligen.com. Gina Anderson was emailed on 10/11/20 and did inform the facility on 10/12/20 of the education that will occurred on 10/13/2020. The department heads will attend the training and it will be done with the assistance from the Infection Preventionist/Designee, Quality Assurance and Performance Improvement committee and governing body. The RCA will be incorporated in the intervention plan.
   Date of completion: 10/13/20.
6. The Administrator/Designee shall ensure all current employees are educated on the systems, policies and procedures required to be developed and implemented by this directed plan of correction.
   Date of compliance: 11/5/20.