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	175347	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 08/21/19.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/21/2019

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facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 15 residents, with three reviewed for Medicare Liability Notices. Based on record review and interview, the facility failed to provide the resident (or their representative) the Advance Beneficiary Notice for skilled services for Resident (R) 17, R23, and R26.

Findings included:

- Medicare Advance Beneficiary Notice (ABN) informs the beneficiary that Medicare may not pay for future skilled therapy services, and provided a cost estimate of continued services. The form included options for the beneficiary to (1) receive specified therapy listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for

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payment, but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for services. (3) I do not want the listed therapy services.

The facility documented R17 was provided with Center of Medicare Service (CMS) 10055 form when the resident skilled services would end 07/10/19. The document lacked estimated cost to the resident and signature of responsible party. A verbal confirmation was documented, but no signature present. CMS 10123 form had not been provided to the resident or resident representative.

The facility documented R23 was provided with CMS 10055 form when the resident skilled services would end 05/14/19. The document lacked estimated cost to the resident and a signature of the responsible party. A verbal confirmation was documented, but no signature present. CMS 10123 form had not been provided to the resident or resident representative.

The facility documented R26 was provided with CMS 10055 form when the resident skilled services would end 06/07/19. The document lacked estimated cost to the resident and signature of responsible party. A verbal confirmation was documented, but no signature present. CMS 10123 form had not been provided to the resident or resident representative.

On 08/14/19 at 03:30 PM, Administrative Nurse D verified she was not aware of the CMS 10123 form and had not provided it to the resident or their representative. Administrative Nurse D stated she had hoped to catch the residents representatives to sign the CMS 10055 form

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F 582	Continued From page 3 when they came to the facility for a visit, she also verified she did not know it was possible to mail out the information for the ABN signatures. The facility's undated "Beneficiary Notice Requirements" policy, documented liability notices are issued to notify Medicare beneficiaries of their financial liability for services when skilled coverage criteria are not met. Forms issued are Skilled Nursing Advanced Beneficiary Notice of Non-coverage (form 10055) and Advance Beneficiary Notice of Non-coverage (form 10123). The facility failed to provide the resident (or their representative) the ABN form when discharged from skilled services for R17, R23 and R26, placing the resident's at risk to make uninformed decisions for their skilled services.	F 582		
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. 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	F 604		

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F 604	Continued From page 4	F 604		

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:
The facility had a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 25 was free of physical restraints.

Findings included:

- R25's "Physician Order Sheet", dated 07/10/19, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, weakness, pain, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), restlessness and agitation.

The quarterly "Minimum Data Set" (MDS), dated 07/15/19, recorded the resident had severe

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cognitive impairment, altered level of consciousness, and required extensive assistance of one to two staff for Activities of Daily Living (ADLs). The MDS further documented the resident's balance not steady, only able to stabilize with staff assistance, no limitation in functional range of motion, used a walker and wheelchair for mobility, and daily use of floor mat alarm and wander alarms.

The fall Care Area Assessment (CAA), dated 01/22/19, documented the resident had a history of falls.

The restraint CAA did not trigger.

The "Physician Order Sheet", dated 07/10/19, recorded personal alarm used to monitor the resident's movement for safety due to fall risk and poor memory, and used a walker and wheelchair. The orders directed staff to use a Geri chair (an upholstered recliner on wheels that can be pushed around like a wheelchair, usually with a removable tray) to prevent the resident from falling forward.

On 08/14/19 at 02:41 PM, observation revealed the resident sat in her recliner with a personal alarm attached to the recliner and resident, and floor mat alarm. Observation revealed the foot rest elevated, the resident's legs hanging from both sides of the foot rest, nearly touching the floor, as she tried to get out of the chair.

On 08/14/19 at 02:50 PM, Certified Nurse Aide (CNA) N, stated staff put the foot rest up in hopes the resident would "kick back and relax", and the foot rest kept the resident from getting out of the chair.

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F 604	Continued From page 6 On 08/14/19 at 03:03 PM, Administrative Nurse D, stated the resident was capable of getting out of the recliner at times, and the recliner was used to keep the resident from attempting get up. The facility's "Use of Restraints" policy, dated December 2007, documented restraints shall only be used to treat the resident's medical symptoms and never for discipline, staff convenience, or for the prevention of falls. The facility failed to ensure R25 was free of physical restraints, placing the resident at risk for injuries or falls.	F 604		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to initiate a comprehensive assessment after a significant change in status	F 637		

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for Resident (R) 25.

Findings included:

- R25's "Physician Order Sheet", dated 07/10/19, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, weakness, pain, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), restlessness and agitation.

The admission "Minimum Data Set" (MDS), dated 01/16/19, recorded the resident had moderately impaired cognition, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), physical and verbal symptoms directed toward others, rejection of cares and wandered to potentially dangerous places. The MDS further documented the resident required supervision to limited assistance of one staff for Activities of Daily Living (ADLs), occasionally incontinent of bladder, frequently incontinent of bowel with no toileting program, and no pain.

The quarterly MDS, dated 07/15/19, recorded the resident has severe cognitive impairment, altered level of consciousness, required extensive assistance of one to staff for ADLs, frequently incontinent of bladder, occasionally incontinent of bowel with no toileting program, and staff assessed pain by the resident's facial expressions.

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The ADL Care Area Assessment (CAA), dated 01/22/19, recorded the resident had memory deficit skills.

The urinary incontinence CAA, dated 01/22/19, recorded recent history of incontinence.

The behavioral symptoms CAA, dated 01/22/19, documented the resident wandered, resistive to cares, threatened and yelled at staff.

The care plan, dated 07/23/19, documented the resident had limited physical mobility, used a Geri chair (an upholstered recliner on wheels that can be pushed around like a wheelchair, usually with a removable tray), resisted cares, threatening aggressive behavior, and became more restless and agitated around 02:30 PM. The care plan directed staff to monitor the resident's behaviors, encourage physical activity, mobility, allow the resident to wake independently, and eat a late breakfast.

The "Physician Orders" dated 07/10/19, documented the resident required staff assistance with ambulation, a fall risk, used a walker or wheelchair for mobility, and used a Geri chair to prevent the resident from falling forward.

On 08/14/19 at 02:50 PM, observation revealed Certified Nurse Aides (CNA) N and O, used a gait belt and walker to assist the resident to stand and transfer to a commode. CNAs N and O provided proper peri-care and transferred the resident to her Geri chair.

On 08/15/19 at 01:29 PM, Licensed Nurse (LN) I stated the resident had a decline in her ADLs and

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F 637	Continued From page 9 overall condition since her admission. On 08/15/19 at 01:18 PM, Administrative Nurse E, verified the resident had declined in several ADLs when she compared the admission MDS to the quarterly July MDS, and a significant change in status MDS should have been initiated. The Resident Assessment Instrument Manual Version 3.0, dated October 2017, defines a significant change as a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, is not self limiting (for decline only), impacts more than one area of the residents health status, and requires interdisciplinary review and or revision of the care plan. The facility failed to conduct a significant change MDS for R25, placing the resident at risk for receiving inappropriate care.	F 637		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		

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F 655	Continued From page 10 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to develop a baseline oxygen care plan for Resident (R) 127. Findings included:	F 655		

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- R127's "Physician's Order Sheet", dated 07/31/19, documented diagnoses of congestive heart failure (a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), foot drop (inability or difficulty in moving the ankle and toes upward), weakness, hypertension (high blood pressure), and dyspnea (difficulty breathing).

The admission care plan, dated 08/08/19, documented the resident received oxygen, via nasal cannula (oxygen tubing, with two prongs inserted into the nose, to deliver oxygen), at two liters, humidified. The care plan documented the resident had limited physical mobility related to weakness, foot drop, and unsteady gait.

The admission Care Area Assessments (CAAs) were not completed.

The "Physician's Orders", dated 08/07/19, documented the resident received oxygen at two liters per nasal cannula, via concentrator (a device that concentrates oxygen from air) or tank to keep oxygen saturation (the specific balance of oxygen in the blood) greater than 90 percent (%).

On 08/12/19 at 04:30 PM, during initial tour, observation revealed the resident's oxygen concentrator placed in the resident's bathroom, with approximately 25 to 30 feet of tubing from the concentrator to the resident's recliner. Observation revealed the oxygen tubing was loosely coiled on the floor outside the resident's bathroom.

On 08/14/19 at 10:57 AM, observation revealed

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F 655	Continued From page 12 the resident ambulated to the bathroom, without assistance or oxygen tubing. Observation revealed the resident shuffled his feet and stepped over the loosely coiled tubing. On 08/13/19 at 10:07 AM, the resident's family member stated the oxygen machine made too much noise in the hospital, and interfered with the family's communication with the resident, who was hard of hearing, The resident's family member stated close monitoring of the tubing was critical, the resident's feet had gotten tangled in the tubing, but the resident had not fallen. The family member confirmed facility staff had not educated the resident or family regarding the hazards to the resident. On 08/15/19 at 02:44 PM, Administrative Nurse D confirmed an oxygen care plan had not been developed to reflect the resident's concentrator placement preference, the tubing placement hazard, or fall risk related to the concentrator and/or tubing. The facility's "Care Plans, Comprehensive Person-Centered" policy, dated December 2016, documented the facility would develop and implement a comprehensive, person-centered care plan that would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The facility failed to develop and implement a person-centered care plan for R127, placing the resident at risk for hazards related to the oxygen concentrator and tubing.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to develop Resident (R) 1's care plan to include nutritional interventions following a significant weight loss.

Findings included:

- R1's "Physician's Order Sheet" dated 08/07/19, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, major depressive disorder (major mood disorder), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), gastro esophageal reflux (backflow of stomach contents to the esophagus), and restlessness and agitation.

The quarterly "Minimum Data Set" (MDS), dated 07/29/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of one, indicating severely impaired cognition. The MDS documented the resident required extensive assistance of one staff for toilet use, supervision of one staff for bed mobility, dressing, eating, personal hygiene, supervision with walking in the corridor, and independent with walking in room, transfers, and locomotion on and off the unit. The MDS documented weight loss, not on a prescribed weight loss regimen.

The nutrition Care Area Assessment (CAA),

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dated 05/06/19, documented the resident weighed 197 pounds (#), ate independently, broken and missing right front upper teeth, and instructed staff to monitor the resident for any weight loss or nutritional needs.

The admission care plan, dated 05/13/19, lacked a nutritional care assessment or staff direction.

The 2019 "Vitals and Weights" documented the following weights:
04/25/19 197.0# (admission)
05/21/19 196.0# (-0.5%)
06/17/19 200.6# (+2.4%)
07/23/19 183.6# (-8.20)
08/12/19 184.0# (+0.22)

The 04/29/19 at 01:24 PM, Nutrition/Dietary admission note documented the resident's current weight 197#. The dietary note documented the resident's daily protein requirement of 75 grams (gm), and instructed staff to encourage protein intake, review weights, monitor laboratory results, and meal intake percentage.

The 07/06/19 at 09:00 AM, nurse's note documented the resident refused breakfast and stated she wanted grape juice in her room, grape juice was given and resident drank it.

On 08/14/19 at 12:25 PM, observation revealed resident ate approximately 40% of her meal. Observation revealed no staff offered additional portions to the resident or an alternative meal.

On 08/15/19 at 08:20 AM, observation revealed the resident consumed 100% of her hot cereal, and no staff offered additional portions of cereal.

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Surveyor asked the resident if she would like additional portion, and resident stated, "yes, but only half". Surveyor informed the kitchen staff and additional food was delivered to the resident. Observation revealed resident consumed 100% of her breakfast.

On 08/15/19 at 12:16 PM, Dietary Staff (DS) BB, stated the residents' weights were obtained by the Certified Nurse Aides (CNAs) and given to Activity Staff (AS) Z, who recorded the weights in the facility's electronic health record program. DS BB stated the weekly weights were reviewed during the weekly Clients At Risk (CAR) meeting. DS BB confirmed Consultant (C) HH had not been notified of R1's weight loss until 08/15/19, when she was in the facility for her monthly review of all residents' weights and dietary concerns. DS BB confirmed the resident had exceeded the 5% weight loss in July 2019, and no attempt had been made to notify C HH.

On 08/15/19 at 01:18 PM, C HH stated she had not been notified of the resident's weight loss. C HH confirmed the weight loss and stated DS BB should have notified her prior to her monthly visit to review resident weights and dietary concerns. C HH stated the resident had past issues with edema, but stated she should have been notified of the triggered weight loss to decide on a course of action. C HH confirmed the care plan had not been updated and a central staff member should be responsible for the monitoring and revision of the care plans.

On 08/15/19 at 04:23 PM, Administrative Nurse D confirmed R1's weight loss and lack of action to stabilize the resident's weight loss. Administrative Nurse D confirmed the resident's care plan

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F 656	Continued From page 17 revision with interventions, were not put in place when the resident's nutritional status had changed. The facility's "Care Plans, Comprehensive Person-Centered" policy, dated December 2016, documented assessments of residents are on-going and care plans are revised as information about the residents and the residents' conditions change. The facility failed to develop and implement a person-centered nutrition care plan for R1, placing the resident at risk for inadequate nutrition and decline in status.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		

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F 657	Continued From page 18 (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: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to review and revise care plans for Resident (R) 9 for accidents, and R15 for restorative services. Findings included: - R9's "Physician Order Sheet", dated 08/07/19, recorded diagnoses of muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, restlessness and agitation, and diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with other diabetic neurological (disorder of nerves) complications. The quarterly "Minimum Data Set" (MDS), dated 06/13/19, recorded the resident had severe cognitive impairment, and required extensive assistance of one to two staff for bed mobility, dressing, toileting, and personal hygiene. The MDS documented the resident's balance not steady, only able to stabilize with staff assistance for sitting to standing positions, no functional range of motion impairment, no alarms, and used a wheelchair for mobility.	F 657		

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The fall Care Area Assessment (CAA), dated 12/25/18, recorded the resident had a potential problem for falls related to weakness, immobility, and cognition.

The care plan, dated 06/18/19, recorded the resident at risk for falls related to muscle weakness and directed staff to educate the resident and family about safety reminders and what to do if a fall occurred. The care plan directed staff to review the resident for significant changes in cognition and decision making capacity, and review the medical record for medications or complications that could predispose the resident to falls or increase fall risk.

The "Physician Order", dated 06/06/19, directed occupational therapy to evaluate and treat the resident for self care, endurance, and safety with Activities of Daily Living (ADLs).

The 08/02/19 at 11:51 PM, progress note recorded staff found the resident on the floor next to his bed.

The 08/08/19 at 10:50 PM, progress note recorded staff found the resident on the floor in his room, and lifted him back into the bed with a mechanical lift (a device used to comfortably move dependent residents from place to place with minimal strain placed on the caregiver).

On 08/13/19 at 09:08 AM, observation revealed Licensed Nurse (LN) H transferred the resident from his wheelchair to a recliner with a sit to stand lift.

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On 08/14/19 at 08:21 AM, Administrative Nurse D stated the investigation and care plan review had not been completed for R9's falls.

The facility's "Assessing Falls and Their Causes" policy, dated October 2010, recorded guidelines for assessing a resident after a fall to identify cause of the fall. The policy directed staff to review the resident's care plan for any special needs of the resident.

The facility failed to review and revise the care plan for R9 after two falls, placing the resident at risk for further falls.

- R15's "Physician's Order Sheet", dated 08/07/19, documented diagnoses of cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the blood vessels supplying oxygen to the brain), pain in unspecified joint, abnormalities of mobility, chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and secondary osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right wrist.

The quarterly "Minimum Data Set" (MDS), dated 06/19/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS documented the resident required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use, personal hygiene, limited assistance of one staff for walking in room and corridor, and independent with supervision for

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eating. The MDS documented the resident had functional impairment of upper and lower extremities on the right side, and used a walker and wheelchair for mobility.

The care plan, dated 07/23/19, documented the resident preferred total assistance with dressing and grooming, and directed staff to provide Passive Range of Motion (PROM) with the resident's right arm and hand, and apply a hot moist pack to the resident's right arm. The care plan lacked specific direction to staff for the restorative program.

The "Activity of Daily Living (ADL)" Care Area Assessment (CAA), dated 09/25/19, documented the resident had pain on his right side which made it harder for him to do his ADLs independently. The CAA documented the resident had a difficult time dressing himself, and a decline in mood which made the resident request assistance with ADLs.

The "Restorative Task" history, dated 11/15/18, documented Restorative PROM, apply hot moist pack to the resident's right arm and hand, and PROM to arm and hand. The "Restorative Task" history documented the facility failed to provide restorative services 17 of 69 times between 04/17/19 and 08/15/19.

On 08/13/19 at 10:17 AM, observation revealed Certified Nurse Aide (CNA) M entered the resident's room and applied a hot moist pack to the resident's right shoulder. Continued observation revealed at 10:26 AM, CNA M entered the room, removed the hot moist pack, and began PROM to the resident's right arm and shoulder. Observation revealed no calculated

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repetitions for any PROM exercise. Continued observation revealed at 10:42 AM, CNA M exited the resident's room.

On 08/14/19 at 02:12 PM, Consultant (C) GG stated, on discharge from skilled therapy CNA M would be notified of recommendations for restorative therapy to maintain the resident's level of function. C GG stated CNA M was responsible for the restorative program maintenance, follow program recommendations, chart refusals, and contact C GG with updates and concerns.

On 08/15/19 at 09:19 AM, CNA M stated several of the residents who were scheduled for restorative services had missed days of service due to CNA M's preparation for knee surgery. CNA M stated she had to work the floor as a CNA due to limited staffing, and no replacement had been trained. CNA M confirmed Administrative Nurse D monitored the restorative program, entered information into the facility's electronic health record program, reevaluated residents who had declined in status or had a change in condition, and notified therapy with concerns. CNA M confirmed the as needed (PRN) instruction was misleading. CNA M stated she had not entered scheduled dates for restorative services due to irregularity in her schedule.

On 08/15/19 at 09:19 AM, Administrative Nurse D confirmed the lack of specific direction to staff on PROM in the resident's care plan and restorative program.

The facility's "Care Plans, Comprehensive Person-Centered" policy, dated December 2016, documented the facility would develop a person-centered care plan. The facility would

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F 657	Continued From page 23 complete ongoing assessments and revise care plans as information about the resident and the resident's conditions change The facility failed to revise R15's restorative care plan, placing the resident at risk for a decreased in level of function and a decline in status.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to provide a consistent restorative program for Resident (R) 15. Findings included:	F 688		

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F 688	Continued From page 24 - R15's "Physician's Order Sheet", dated 08/07/19, documented diagnoses of cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the blood vessels supplying oxygen to the brain), pain in unspecified joint, abnormalities of mobility, chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and secondary osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right wrist. The quarterly "Minimum Data Set' (MDS), dated 06/19/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS documented the resident required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use, personal hygiene, limited assistance of one staff for walking in room and corridor, and supervision with eating. The MDS documented the resident had functional impairment of upper and lower extremities on the right side, and used a walker and wheelchair for mobility. The care plan, dated 07/23/19, instructed staff to provide Passive Range of Motion (PROM) with the resident's right arm. The care plan documented the resident preferred total assistance with dressing and grooming. The care plan directed staff to apply a hot moist pack and perform PROM to the resident's right arm and hand The Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 09/25/19, documented	F 688		

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the resident had pain on the right side which made it harder for him to do his ADL's independently. The CAA documented the resident had a difficult time dressing himself, and a decline in mood which made the resident request assistance with ADLs.

The "Restorative Task" history, dated 11/15/18, documented Restorative (PROM), apply hot moist pack and perform PROM to the resident's right arm and hand. The "Restorative Task" history documented the facility failed to provide restorative therapy 17 of 69 times from 04/17/19 to 08/15/19.

On 08/13/19 at 10:17 AM, observation revealed Certified Nurse Aide (CNA) M entered the resident's room and applied a hot moist pack to the resident's right shoulder. Continued observation at 10:26 AM, revealed CNA M entered the room, removed the hot moist pack, and began PROM to the resident's right arm and shoulder. Observation revealed no calculated repetitions to any PROM exercise. Continued observation at 10:42 AM, revealed CNA M exited the resident's room.

On 08/14/19 at 02:12 PM, Consultant (C) GG stated, on discharge from skilled therapy CNA M would be notified of recommendations for restorative therapy, to maintain the resident's level of function. C GG stated CNA M was responsible for the restorative program maintenance, follow program recommendations, chart refusals, and contact C GG with updates and concerns.

On 08/15/19 at 09:19 AM, CNA M stated several of the residents who were scheduled for

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F 688	Continued From page 26 restorative services had missed days of service due to CNA M's preparation for knee surgery. CNA M stated she had to work the floor as a CNA due to limited staffing, and no replacement had been trained. CNA M confirmed Administrative Nurse D monitored the restorative program, entered information into the facility's electronic health record program, reevaluated residents who had declined in status or had a change in condition, and notified therapy with concerns. CNA M confirmed the as needed (PRN) instruction was misleading. CNA M stated she had not entered scheduled dates for restorative services due irregularity in her schedule. On 08/15/19 at 09:19 AM, Administrative Nurse D confirmed the lack of specific direction to staff on PROM in the resident's care plan and restorative program. The facility's "Restorative Nursing Services" policy, dated July 2017, documented residents would receive restorative nursing care as needed to help promote optimal safety and independence. The policy documented restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. The facility failed to develop and implement a person-centered restorative program for R15, placing the resident at risk for a decrease in level of function and decline in status.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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§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:
The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as possible for two of 15 sampled residents, Resident (R) 9 and R127.

Findings included:

- R9's "Physician Order Sheet", dated 08/07/19, recorded diagnoses of muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, restlessness and agitation, and diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with other diabetic neurological (disorder of nerves) complications.

The quarterly "Minimum Data Set" (MDS), dated 06/13/19, recorded the resident had severe cognitive impairment, and required extensive assistance of one to two staff for bed mobility, dressing, toileting, and personal hygiene. The MDS documented the resident's balance not steady, only able to stabilize with staff assistance for sitting to standing positions, no impairment in functional range of motion, no alarms, and used a wheelchair for mobility.

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The fall Care Area Assessment (CAA), dated 12/25/18, recorded the resident a risk for falls related to weakness, immobility, and cognition.

The care plan, dated 06/18/19, recorded the resident was at risk for falls related to muscle weakness. The care plan directed staff to educate resident and family about safety reminders and what to do if a fall occurred, review for significant changes in cognition and decision making capacity, and review the medical record for medications or complications that could predispose the resident to falls or increase fall risk.

The "Physician Order", dated 06/06/19, directed occupational therapy to evaluate and treat the resident for self care, endurance, and safety with Activities of Daily Living (ADLs).

The 08/02/19 at 11:51 PM, progress note recorded staff found the resident on the floor next to his bed.

The 08/08/19 at 10:50 PM, progress note recorded staff found the resident on the floor in his room, and lifted him back into the bed with a mechanical lift (a device used to comfortably move dependent residents from place to place with minimal strain placed on the caregiver).

On 08/13/19 at 09:08 AM, observation revealed Licensed Nurse (LN) H transferred the resident from his wheelchair to a recliner with a sit to stand lift (mechanical device used to assist residents from a sitting to standing position).

On 08/14/19 at 08:21 AM, Administrative Nurse D

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stated the investigation and care plan review had not been completed for R9's falls.

The facility's "Assessing Falls and Their Causes" policy, dated October 2010, recorded guidelines for assessing a resident after a fall, to identify cause of the fall. The policy directed staff to review the resident's care plan for any special needs of the resident.

The facility failed to provide adequate supervision, staff assistance, and implement new interventions to prevent falls for R9, placing the resident at risk for further falls and injury.

- R127's "Physician's Order Sheet", dated 07/31/19, documented diagnoses of congestive heart failure (a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), foot drop (inability or difficulty in moving the ankle and toes upward), weakness, hypertension (high blood pressure), and dyspnea (difficulty breathing).

The admission care plan, dated 08/08/19, documented the resident received oxygen, via nasal cannula (oxygen tubing, with two prongs inserted into the nose, to deliver oxygen), at two liters, humidified. The care plan documented the resident had limited physical mobility related to weakness, foot drop, and unsteady gait.

The admission Care Area Assessments (CAA) were not completed.

The "Physician's Orders", dated 08/07/19,

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documented the resident received oxygen at two liters per nasal cannula, via concentrator (a device that concentrates oxygen from air) or tank to keep oxygen saturation (the specific balance of oxygen in the blood) greater than 90 percent (%).

On 08/12/19 at 04:30 PM, during initial tour, observation revealed the resident's oxygen concentrator placed in the resident's bathroom, with approximately 25 to 30 feet of tubing, from the concentrator to the resident's recliner. Observation revealed the oxygen tubing was loosely coiled on the floor outside the resident's bathroom.

On 08/14/19 at 10:57 AM, observation revealed the resident ambulated to the bathroom, without assistance or oxygen tubing. Observation revealed the resident shuffled his feet and stepped over the loosely coiled tubing.

On 08/13/19 at 10:07 AM, the resident's family member stated the oxygen machine made too much noise in the hospital, and interfered with the family's communication with the resident, who was hard of hearing, The resident's family member stated close monitoring of the tubing was critical, the resident's feet had gotten tangled in the tubing, but the resident had not fallen. The family member confirmed facility staff had not educated the resident or family regarding the hazards to the resident.

On 08/15/19 at 02:44 PM, Administrative Nurse D confirmed the lack of recognition of potential accident hazards related to the resident's concentrator placement preference, the tubing placement hazard, or fall risk related to the concentrator and/or tubing.

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F 689	Continued From page 31 The facility's "Assessing Falls and Their Causes" policy, dated October 2010, documented the facility would identify causes of falls, recognize environmental risk factors, and promptly address environmental issues. The facility failed to identify and address environmental risk factors for R127, placing the resident at risk for falls.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on	F 692		

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observation, interview, and record review, the facility failed to maintain adequate nutrition for one of two sampled residents, Resident (R) 1, with a significant weight loss.

Findings included:

- R1's "Physician's Order Sheet" dated 08/07/19, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, major depressive disorder (major mood disorder), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), gastro esophageal reflux (backflow of stomach contents to the esophagus), and restlessness and agitation.

The quarterly "Minimum Data Set" (MDS), dated 07/29/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of one, indicating severely impaired cognition. The MDS documented the resident required extensive assistance of one staff for toilet use, supervision of one staff for bed mobility, dressing, eating, personal hygiene,supervision with walking in the corridor, and independent with walking in room, transfers, and locomotion on and off the unit. The MDS documented weight loss, not on a prescribed weight loss regimen.

The nutrition Care Area Assessment (CAA), dated 05/06/19, documented the resident weighed 197 pounds (#), ate independently, broken and missing right front upper teeth, and instructed staff to monitor the resident for any weight loss or nutritional needs.

The admission care plan, dated 05/13/19, lacked

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a nutritional care assessment or staff direction.

The 2019 "Vitals and Weights" documented the following weights:
04/25/19 197.0# (admission)
05/21/19 196.0# (-0.5%)
06/17/19 200.6# (+2.4%)
07/23/19 183.6# (-8.20)
08/12/19 184.0# (+0.22)

The 04/29/19 at 01:24 PM, dietary admission note documented the resident's current weight 197#, and a daily protein requirement of 75 grams (gm). The dietary note instructed staff to encourage protein intake, review the resident's weights, monitor laboratory results, and percentage eaten at meal time

The 07/06/19 at 09:00 AM, nurse's note documented the resident refused breakfast and stated she wanted grape juice in her room, grape juice was given and resident drank it.

On 08/14/19 at 12:25 PM, observation revealed resident ate approximately 40% of meal. Observation revealed no staff offered additional portions to the resident or an alternative meal.

On 08/15/19 at 08:20 AM, observation revealed the resident consumed 100% of her hot cereal, and no staff offered additional portions of cereal. Surveyor asked the resident if she would like additional portion, and resident stated, "yes, but only half". Surveyor informed the kitchen staff and additional food was delivered to the resident. Observation revealed resident consumed 100% of her breakfast.

On 08/15/19 at 08:22 AM, Licensed Nurse (LN) I

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stated residents who were a weight concern, were monitored in the dining room, assisted by staff, or encouraged to eat. LN I stated snacks were not passed routinely, but residents could request a snack or get one from the kitchenette, which had been stocked with sandwiches, fruit, and yogurt.

On 08/15/19 at 12:16 PM, Dietary Staff (DS) BB, stated the residents' weights were obtained by the Certified Nurse Aides (CNA) and given to Activity Staff (AS) Z, who recorded the weights in the facility's electronic health record program. DS BB stated the weekly weights were reviewed during the weekly Clients At Risk (CAR) meeting. DS BB confirmed Consultant (C) HH had not been notified of R1's weight loss until 08/15/19, when she was in the facility for her monthly review of all residents' weights and dietary concerns. DS BB confirmed the resident had exceeded the 5% weight loss in July 2019, and no attempt had been made to notify C HH.

On 08/15/19 at 01:18 PM, C HH stated she had not been notified of the resident's weight loss. C HH confirmed the weight loss and DS BB should have notified her prior to her monthly visit to review resident weights and dietary concerns. RD HH stated she was available by phone any time, but did not have remote access to the facility's electronic health record program, to directly monitor new dietary concerns. C HH stated the resident had past issues with edema, but stated she should have been notified of the triggered weight loss to decide on a course of action.

On 08/15/19 at 04:23 PM, Administrative Nurse D confirmed the weight loss and lack of action to

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F 692	Continued From page 35 stabilize the resident's weight loss. The facility's "Nutritional (impaired)/Unplanned Weight Loss - Clinical Protocol" policy, dated September 2012, documented the nursing staff would monitor and document the weight and dietary intake of residents. The policy documented the staff and physician would identify pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes. The staff would implement appropriate general or cause-specific interventions with careful consideration of resident choice and nutritional needs. The facility failed to provide adequate nutrition for R1, who had a significant weight loss, placing the resident at risk for malnutrition and decline in status.	F 692		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on record review and interview, the facility failed to ensure five of eight nurse aides employed at the facility, for at least a year, completed the minimum 12 hours of in-service per year, and lacked a system for appropriately tracking nurse aide education.	F 730		

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F 730	Continued From page 36 Findings included: - Review of the facility's nurse aide training records revealed five of eight Certified Nurse Aides (CNA), who were employed at the facility for at least a year, lacked completion of the minimum 12 hours of required in-service. Review of the facility's CNA "Training Reports" lacked adequate tracking of the employee in-service hours in a timely and effective manner. On 08/13/19 at 03:04 PM, Administrative Nurse D stated she had not developed a system to effectively monitor the CNA in-service hours and confirmed the lack of the recommended 12 hours of training. The facility's "In-Service Training Program, Nurse Aide" policy, dated December 2016, documented all nurse aide personnel would participate in regularly scheduled in-service training classes. The policy documented annual in-services would include continuing competence of nurse aides, and no less than 12 hours per employment year. The facility failed to ensure every nurse aide, employed at the facility at least on year, completed the minimum 12 hours of in-service per year, and lacked an effective tracking system, placing the residents at risk for inadequate care and services	F 730		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the	F 741		

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appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
[as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].

§483.40(a)(2) Implementing non-pharmacological interventions.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 15 residents. Based on interview and record review, the facility failed to ensure staff had training/competencies related to dementia and behavior care for five of eight staff reviewed for training/competencies.

Findings Included:

- Review of the facility's "Nurse Aide Training Records" documented the following:

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F 741	Continued From page 38 Certified Nurse Aide (CNA) LL lacked evidence of dementia/behavior care training CNA MM lacked evidence of dementia/behavior care training CNA PP lacked evidence of dementia/behavior care training CNA QQ lacked evidence of dementia/behavior care training CNA RR lacked evidence of dementia/behavior care training The facility's "In-Service Training Program, Nurse Aide" policy, dated December 2016, documented all nurse aide personnel would participate in regularly scheduled in-service training classes. The policy documented in-service training would include training in dementia management. The facility failed to ensure five of eight staff reviewed for training/competencies related to dementia and behavior care had the required in-service education, placing the residents at risk for inappropriate care.	F 741		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents, with three reviewed for a pureed diet. Based on interview, observation, and record review, the facility failed to prepare appropriate pureed foods, in a form	F 805		

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designed to meet individual needs, for Resident (R) 2, R5, and R25.

Findings included:

- On 08/13/19 at 10:59 AM, observation revealed Dietary Staff (DS) CC removed three (1/2 cup) servings of buttered noodles from the steam table and placed two portions in a one cup processor container. DS CC processed the noodles with beef broth, without following a recipe, and set aside in a bowl. DS CC then added a third serving to the processor container, pushed the lid container down with ungloved fingers, processed the noodles, and added them to the bowl containing the other two servings. DS CC then mixed, covered, and placed the pureed noodles in the steam table. Observation revealed the pureed noodles were lumpy and stiff. DS CC added beef broth from a two-cup measuring container, without measuring, added the remainder of the three pureed servings into the one cup processor container, processed, and placed them in the steam table. Observation during pureed meal preparation revealed DS CC touched the inside of the processor cover with her ungloved hands multiple times.

On 08/13/19 at 02:10 PM, Dietary Staff (DS) BB stated DS CC should have used gloves or the larger processor to prepare the pureed foods. The smaller processor did not have the capacity for three pureed portions, which effected the consistency.

The "Buttered Noodles" recipe, dated July 2017, documented food would be placed in the processor, processed until smooth adding two tablespoons (tbsp) of stock per portion.

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F 805	Continued From page 40 Upon request, the facility did not provide a pureed food preparation policy. The facility failed to prepare appropriate pureed foods for R2, R5, and R25, placing the residents at risk for choking.	F 805		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on interview, observation, and record review, the facilty failed to prepare, store, and serve food in a safe and sanitary manner for the 27 residents who received food prepared in the facility kitchen.	F 812		

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Findings included:

- On 08/12/19 at 09:11 AM, during initial tour, observation revealed one refrigerator in the Activity room, lacked a thermometer and contained ice cream, apple juice, and yogurt.

On 08/12/19 at 09:45 AM, observation revealed Licensed Nurse (LN) H obtained a slice of bread from a container with bare hands, placed the bread in the toaster, then administered medications to Resident (R) 22. Continued observation at 09:50 AM, revealed Certified Nurse Aide (CNA) SS retrieved the toast with bare hands and placed it on a plate, left the area, returned with gloves, buttered and spread jelly on the toast, and served it to the resident.

On 08/12/19 at 09:58 AM, during initial tour, observation revealed a refrigerator in the common entrance area contained four berry magic cups (nutritional supplement), dated 07/19. The refrigerator contained one sandwich, without date or name, two resident orange juice boxes, dated 06/19, one opened prune juice box, with expiration date of 06/19, one opened apple juice box with expiration date of 07/01/19, and two small vanilla pudding containers with expiration date of 06/17/19.

On 08/12/19 at 09:58 AM, LN H verified the above items were not dated or had expired, and removed and discarded the items from the refrigerator.

On 08/12/19 at 10:07 AM, LN H stated she washed her hands prior to touching the toast, so it was acceptable.

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F 812	Continued From page 42 On 08/12/19 at 10:10 AM, CNA SS stated she touched the toast with her bare hands because she was out of gloves, but usually wore gloves On 08/13/19 at 09:48 AM, Dietary Staff (DS) BB stated the common area refrigerator cleaning was a joint effort with nursing staff. DS BB stated nursing staff were placed items in the refrigerators and were jointly responsible for the items. DS BB confirmed gloves should be worn when food was handled. The "Food Receiving and Storage" policy, dated July 2014, documented food would be received and stored in a manner that complied with safe food handling practices. The policy documented all foods stored in the refrigerator or freezer would be covered, labeled, dated, and partially eaten food would not be kept in the refrigerator. The policy documented refrigerators would have working thermometers and monitored for temperatures according to state-specific guidelines. The facility failed to prepare, store, and serve food in a sanitary manner, placing the residents at risk for foodborne illness.	F 812		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are	F 825		

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F 825	Continued From page 43	F 825		

required in the resident's comprehensive plan of care, the facility must-

§483.65(a)(1) Provide the required services; or

§483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

This REQUIREMENT is not met as evidenced by:

The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to provide physician ordered physical therapy for Resident (R) 127.

Findings included:

- R127's "Physician's Order Sheet", dated 07/31/19, documented diagnoses of congestive heart failure (a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), foot drop (inability or difficulty in moving the ankle and toes upward), weakness, hypertension (high blood pressure), and dyspnea (difficulty breathing).

The admission care plan, dated 08/08/19, documented the resident had limited physical mobility related to weakness, foot drop, and unsteady gait. The care plan instructed staff to provide activities that encouraged physical activity and mobility, Physical Therapy (PT),

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F 825	Continued From page 44 Occupational Therapy (OT), and Speech Therapy (ST) as ordered. The care plan documented the resident used a four-wheeled walker, ambulated with stand-by assistance of one staff to the dining room, and rested if needed. The admission Care Area Assessments (CAA) were not completed. The "Physician's Orders", dated 08/05/19, documented the resident discharged to the facility with skilled PT, OT, and ST therapies. On 08/14/19 at 10:57 AM, observation revealed the resident ambulated to the bathroom, without assistance or oxygen tubing. Observation revealed the resident shuffled feet and stepped over the loosely coiled tubing. On 08/12/19 at 02:30 PM, Consultant (C) GG stated the resident had not been evaluated for PT. On 08/15/19 at 04:10 PM, Administrative Nurse D stated she thought the resident had been evaluated for Physical Therapy services, but was unable to provide documentation. The facility's "Specialized Rehabilitative Services" policy, dated December 2009, documented therapeutic services are provided only upon the written order of the resident's attending physician. The facility failed to provide PT for R127, placing the resident at risk for decline in status.	F 825		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865		

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F 865	Continued From page 45 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 resident. The sample included 15 residents. Based on observation, record review, and interview, the facility's Quality Assessment and Assurance program failed to provide good faith efforts to identify multiple issues of concern. Findings included: - Based on observation, record review and interview, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) and Advanced Beneficiary Notice of Non-coverage (ABN) to Resident (R) 17, R23, and R26. Refer to F582. Based on observation, record review, and interview, the facility failed to provide R25 a restraint free environment. Refer to F604.	F 865		

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F 865	Continued From page 46 Based on observation, record review, and interview, the facility failed to complete a significant change in status assessment for R25. Refer to F637. Based on observation, record review, and interview, the facility failed to complete a baseline care plan for R127. Refer to F655. Based on observation, record review, and interview, the facility failed to provide a comprehensive care plan to include nutrition for R1. Refer to F656. Based on observation, record review, and interview, the facility failed review and revise care plans for R9 and R15. Refer to F657. Based on observation, record review, and interview, the facility failed to provide range of motion (ROM) for R15. Refer to F688. Based on observation, record review, and interview, the facility failed to provide an environment free of accident hazards for R9 and R127. Refer to F689. Based on observation, record review, and interview, the facility failed to provide nutrition status maintenance for R1. Refer to F692. Based on observation, record review, and interview, the facility failed to provided nurse aide performance reviews and 12 hours a year in-services. Refer to F730. Based on observation, record review, and interview, the facility failed to provide sufficient	F 865		

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F 865	Continued From page 47 competent staff for behavioral health. Refer to F741. Based on observation, record review, and interview, the facility failed to provide an infection prevention and control program. Refer to F880. Based on observation, record review, and interview, the facility failed to provide an appropriate diet for R2, R5, and R25. Refer to F805. Based on observation, record review, and interview, the facility failed to provide, store, prepare, and serve food under sanitary conditions. Refer to F812. Based on observation, record review, and interview, the facility failed to provide rehabilitation services for R127. Refer to F825. Based on observation, record review, and interview, the facility failed provide quality assurance and performance improvements. Refer to F867. Based on observation, record review, and interview, the facility failed to conduct quarterly quality assurance meetings with required attendance. Refer to F868. Based on observation, record review, and interview, the facility failed to provide an antibiotic stewardship program. Refer to F881. On 08/15/19 at 03:53 PM, Activity Staff Z stated she took over the quality assessment and assurance program two days ago, and did not have a structured program in place.	F 865		

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F 865	Continued From page 48 The facility failed to have evidence of ongoing and sustained program during transition in leadership and staff, to identify, develop, and implement appropriate plans of action through an effective quality assurance program that identified and addressed the above issues involving multiple conditions of the resident's home.	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility's Quality Assessment and Assurance (QAA) program failed to assess data obtained at meetings and implement interventions to address multiple issues of concerns for the 27 residents, who resided in the facility. Findings included: - Based on observation, record review and interview, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) and Advanced Beneficiary Notice of Non-coverage (ABN) to Resident (R) 17, R23, and R26. Refer to F582. Based on observation, record review, and	F 867		

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F 867	Continued From page 49	F 867		

interview, the facility failed to provide R25 a restraint free environment. Refer to F604.

Based on observation, record review, and interview, the facility failed to complete a significant change in status assessment for R25. Refer to F637.

Based on observation, record review, and interview, the facility failed to complete a baseline care plan for R127. Refer to F655.

Based on observation, record review, and interview, the facility failed to provide a comprehensive care plan to include nutrition for R1. Refer to F656.

Based on observation, record review, and interview, the facility failed review and revise care plans for R9 and R15. Refer to F657.

Based on observation, record review, and interview, the facility failed to provide range of motion (ROM) for R15. Refer to F688.

Based on observation, record review, and interview, the facility failed to provide an environment free of accident hazards for R9 and R127. Refer to F689.

Based on observation, record review, and interview, the facility failed to provide nutrition status maintenance for R1. Refer to F692.

Based on observation, record review, and interview, the facility failed to provided nurse aide performance reviews and 12 hours a year in-services. Refer to F730.

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F 867	Continued From page 50	F 867		

Based on observation, record review, and interview, the facility failed to provide sufficient competent staff for behavioral health. Refer to F741.

Based on observation, record review, and interview, the facility failed to provide an infection prevention and control program. Refer to F880.

Based on observation, record review, and interview, the facility failed to provide an appropriate diet for R2, R5, and R25. Refer to F805.

Based on observation, record review, and interview, the facility failed to provide, store, prepare, and serve food under sanitary conditions. Refer to F812.

Based on observation, record review, and interview, the facility failed to provide rehabilitation services for R127. Refer to F825.

Based on observation, record review, and interview, the facility failed provide quality assurance and performance improvements. Refer to F867.

Based on observation, record review, and interview, the facility failed to conduct quarterly quality assurance meetings with required attendance. Refer to F868.

Based on observation, record review, and interview, the facility failed to provide an antibiotic stewardship program. Refer to F881.

On 08/15/19 at 03:53 PM, Activity Staff Z stated she took over the quality assessment and

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F 867	Continued From page 51 assurance program two days ago, and did not have a structured program in place. The facility failed to develop a systematic analysis or actions to measure success and implement appropriate plans of actions to correct or identify quality deficiencies.	F 867		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to maintain a Quality Assessment and Assurance Committee (QAA) that met quarterly and had the required membership attendance. Findings included:	F 868		

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F 868	Continued From page 52 - The facility provided the QAA committee attendance roster for 11/29/18, 04/02/19, and 08/05/19. The documentation recorded the administrator and director of nursing had not participated in the 11/29/18 meeting. On 08/05/19 at 03:53 PM, Activity Staff (AS) Z stated she took over the quality assessment and assurance program two days ago, and did not have a structured program in place. The facility's "QAPI Plan" dated, 04/02/19, documented the meetings will be held monthly and or quarterly. The facility failed to maintain a QAA committee that met quarterly and had required membership in attendance.	F 868		
F 880 SS=F	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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F 880	Continued From page 53	F 880		

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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F 880	Continued From page 54 §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: The facility had a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility lacked documentation of an infection control system and oversight for the 27 residents who resided in the facility. Findings included: - On 08/14/19 at 01:00 PM, Administrative Nurse D and Licensed Nurse (LN) G verified there was not a structured program for infection control. LN G stated she had recently been designated infection control preventist. On 08/15/19 at 11:24 AM, Laundry Staff (LS) U, reported staff used Quatricide (disinfect product) in laundry with clostridium difficile (C-Diff) (an inflammation of bacteria in the colon, which is passed from person to person, that causes severe damage to the colon and can even be fatal). Manufacturer guidelines for Quatricide revealed it did not eliminate the C-Diff infectious material from laundry. LS U verified she had checked with the company that provided Quatricide, and verified the product did not eliminate C-Diff infections.	F 880		

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F 880	Continued From page 55 The facility failed to provide an infection prevention and control program, and an environment to prevent the development and transmission of disease for the 27 residents who resided in the facility, placing the residents at risk for infection.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 15 residents. Based on record review and interview, the facility failed to develop and implement an antibiotic stewardship program specific to the facility. Findings included: - Review of the "Infection Control Program" lacked documentation regarding an antibiotic stewardship program which included antibiotic use protocols and a system to monitor and evaluate antibiotic use. On 8/14/19 at 01:00 PM, Administrative Nurse D and Licensed Nurse (LN) G, stated they monitored the use of antibiotics, but had no criteria for the appropriate use, or a systematic	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(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 881	Continued From page 56 follow up after completed course of antibiotics. LN G stated she tracked the use of antibiotic and verified the correct antibiotic used from culture results, if applicable. Both Administrative Nurse D and LN G verified there had been no formal meeting regarding infections and the use of antibiotics. The facility failed to develop an antibiotic stewardship program specific to the facility, that included antibiotic use protocols, placing the residents at risk for unnecessary medications.	F 881		