STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255300	A. BUILDING _____ B. WING _____	C 10/03/2019

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 9/30/19 through 10/3/19. The SA also conducted a complaint survey for MS #16027, MS #16115, and MS #15907. Upon investigation, the SA could not substantiate any alleged abuse regarding MS #16027 and MS #15907, but did substantiate the facility failed to prevent a resident from falling, related to use of a mechanical lift and cited regulatory deficiencies at F656 and F689, related to MS #16115. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited other regulatory deficiencies F645, F646, F656, F689, F690, F727, and F 880. At the time of the survey, the census was 85 and the facility held a license for 88 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		11/1/19

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

Electronically Signed | 10/24/2019

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 656	Continued From page 1 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: MS #16115 Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the care plan for two (2) of 23 resident care plans reviewed, Resident #9 for the use of a full body lift, and Resident #3 for catheter care. Findings include: Review of the facility's "Care Plans" policy, not	F 656	1. Immediate Action taken for the Residents found to have been affected include: The Care Plan of the Residents affected were reviewed by the Minimum Data Set Coordinator on 10/04/2019 and found to be accurate. The Certified Nursing Assistant involved in this incident was terminated on 07/20/2019. Resident #3 was assessed by the Director of Nursing Services with no adverse outcomes being identified on 10/04/2019.	

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F 656	Continued From page 2 dated, revealed: Each resident will have a plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care. The Certified Nursing Assistant (CNA) Daily Care Guide is part of the comprehensive care plan and used as the tool to make staff aware of the resident's daily care needs. Assigned disciplines will be identified to carry out the interventions. Review of Resident #9's comprehensive care plan, dated 3/19/19, revealed that a total lift with two (2) person assist and medium sling were required for transfers, related to her risk for falls and history of falling, Review of a "Resident Incident Report", dated 7/20/19 at 6:00 AM, revealed Resident #9 was found lying on her right side on the floor in her room. The incident report documented that CNA #2 stated she was using the sit-to-stand lift and Resident #9 didn't stand up, so she lowered her to the floor. The incident report was documented by Licensed Practical Nurse (LPN) #4. Review of the summary and conclusion to the investigation provided by the facility, dated 7/26/19, revealed the facility determined CNA #2 did transfer Resident #9 with the incorrect lift, resulting in a fall for Resident #9. Review of the "Departmental Notes", dated 7/20/19 at 7:17 AM, documented by LPN #4, revealed a CNA stated she was getting Resident #9 up with the sit to stand lift and the resident didn't stand up, so she assisted her to the floor, lying on her right side. Resident #9 then complained of pain in her right shoulder, according to the nurses notes. LPN #4 note	F 656	2. Identification of other Residents having the potential to be affected was accomplished by: The facility has determined all Residents requiring a lift and requiring catheter care have the potential of being affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The MDS Coordinator began a 100% Audit on 10/21/2019 on all Care Plans to insure Residents requiring a lift and Residents requiring catheter care are properly assessed for the correct lift and proper catheter care. This information was corrected by 10/23/2019 and placed on the Resident's Care Plan. An In-service, beginning on 10/21/2019, will be performed by the CNA Coordinator with all CNAs concerning Following Activities of Daily Living Care according to the Care Plan by 11/01/2019. This information is provided to the CNAs daily through the Electronic Medical Record System by Kiosks placed throughout the facility. Also the Staff Development Nurse or Registered Nurse Supervisor will perform an ADL In-Service with all new hires during their orientation, instructing them to follow the Resident Care Plan. 4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: The MDS Coordinator will perform an audit on all Care Plans to ensure Residents requiring a lift and requiring catheter care are properly	

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F 656	Continued From page 3 documented she notified the physician with new orders for a stat X-ray of the right arm and Tylenol 650 milligram (mg) was given for pain. Review of the X-ray report, dated 7/20/19, revealed no fracture, however there was a dislocation of the right shoulder. Resident records revealed Resident #9 returned with orders for a sling, which she refused to wear. An attempt to call CNA #2 at 10/01/19 at 02:59 PM, resulted in no answer, with a message left to return the call. During an interview on 10/01/19 at 3:46 PM, LPN #4 stated CNA #2 called for help after Resident #9 had been placed on the floor. LPN #4 said the stand-up lift was used for Resident #9, and was still in the room. LPN #4 stated she helped assist Resident #9 back to the bed, by using the lift pad. She said Resident #9 complained of pain in her shoulder and she notified the physician, who ordered an x-ray of the arm. During an interview on 10/03/19 at 11:05 AM, Registered Nurse (RN) #1 stated Resident #9's care plan matched the Resident Assessment and the need for a total lift. RN #1 said the expectation was to follow the care plan according to the evaluation of the resident assessment, which for Resident #9 included using the full body lift and using two (2) people at all times during the lift. Resident #3 A review of Resident #3's care plan, initiated 4/6/18, revealed the resident had an indwelling catheter, related to a diagnosis of Benign Prostatic Hyperplasia (BPH) and was at Risk for	F 656	assessed for the correct lift for two months beginning on 10/21/2019 through December 2019. This Audit will be brought monthly to the Quality Assurance Performance Improvement Committee for two months for recommendations or corrections that may be needed through December 2019.	

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F 656	Continued From page 4	F 656		

Infection. An intervention included catheter care every shift.

An observation on 10/01/19 at 05:11 PM, revealed CNA #3 performed catheter care on Resident #3. CNA #3 washed her hands, gloved and touched her uniform as if she was wiping her hands. CNA #3 obtained a cloth and wiped the head of the penis moving the cloth from place to place around the head of the penis. CNA #3 using the same cloth, and without turning the cloth, wiped up and down the shaft of the penis. CNA #3 removed her gloves, and re-gloved without washing her hands. CNA #3 dried the groin area and the penis with the same area of towel.

During an interview on 10/02/19 at 03:04 PM, CNA #3 revealed that she should have wiped the head of the penis once, discarded the cloth, and gotten a clean cloth to wipe the penis again. CNA #3 stated that she remembered wiping the head of the penis more than once with the same cloth. CNA # 3 stated she should have not wiped the shaft of the penis with the same cloth that she used to wipe the head of the penis, and she should have dried each area separately, instead of wiping the whole area with the same towel. CNA #3 stated that she should have washed her hands after removing her gloves and before gloving again.

During an interview on 10/01/19 at 1:50 PM, LPN #5 stated the she expected the care plan to be followed and updated by the staff when needed.

During an interview on 10/03/19 at 12:55 PM, the Director of Nursing stated Resident #3's care plan was not followed for the correct procedure to provide catheter care.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #MS #16115 Based on staff interview, record review, and facility policy review, the facility failed to provide adequate supervision and assistance, related to the use of mechanical lifts, to prevent falls with minor injury for one (1) of four (4) residents reviewed for accidents, Resident #9. Findings include: Review of the facility's "Modified Lifting Policy", revised 5/29/15, revealed the staff would follow the documented lifting protocol deemed appropriate for each resident. The policy also revealed the information related to the lift would be documented in the smart charting and a sticker system, which was located on each lift. Review of a "Resident Incident Report", dated 7/20/19, and the facility investigative report, dated 7/26/19, revealed Resident #9 was found lying on her right side on the floor in her room. The incident report documented that Certified Nurse Aide (CNA) #2 used the wrong lift to transfer the resident; she used the sit-to-stand lift and the	F 689	1. Immediate Actions taken for the residents found to have been affected include: The Certified Nursing Assistant involved in this deficient practice was terminated on 7/20/2019. The Licensed Practical Nurse Charge Nurse on duty performed an In-service on Proper Body Mechanics, Proper Use of a Mechanical Lift and the Dot Identifier System for using the correct lift on 7/20/2019 the morning of the incident. The Staff Development Nurse performed an In-Service on Facility Policy on 7/20/2019 requiring two people assisting when using any lift while transferring a Resident. This In-service also includes the use of the Dot Identifier System for identifying the correct mechanical lift and using the Kiosk System, placed throughout the facility, to find the lift requirements for residents. This In-Service was performed on 7/20/2019. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the	11/1/19

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F 689	Continued From page 6 resident had been assessed for the total lift. The CNA reported Resident #9 didn't stand up, while using the lift, so she lowered her to the floor. Resident #9 was transferred to the hospital, where X-rays revealed a dislocation of the right shoulder. Treatment included a shoulder immobilizer. Review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/26/19, revealed the resident needed extensive assist of two (2) persons to transfer. The care plan, initiated 3/19/19, revealed Resident #9 required the use of the total lift with two (2) person assistance. Review of the "Departmental Notes", dated 7/20/19 at 7:17 AM, documented by LPN (Licensed Practical Nurse) #4, revealed a CNA reported she was transferring Resident #9 with the sit-to-stand lift and the resident was unable to stand up, so she assisted her to the floor, lying on her right side. Resident #9 complained of pain in her right shoulder, the physician was notified and a new order received for a stat X-ray to the right arm. Tylenol 650 milligram (mg) administered for pain. Interview on 10/01/19 at 09:46 AM, with the Administrator revealed the facility policy was to use two (2) people for all lifts, and to transfer residents according to the resident assessment. The Administrator stated CNA #2 was terminated after the investigation on 7/21/19, for failure to follow the facility policy. An attempt to call CNA #2 at 10/01/19 at 02:59 PM, was unsuccessful, with a message left to return the call. Review of CNA #2's personnel file	F 689	potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Services will be In-Serviced by the Director of Nursing Services, Staff Development Nurse or Registered Nurse Supervisor on the policy for Accidents and Supervision beginning 10/21/2019 to be completed by 11/01/2019. All Resident Falls/Accidents will be reviewed daily by the Interdisciplinary Team during the Morning Stand Up Meeting to ensure appropriate implementation of safety interventions including updating the Plan of Care. 4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: The Interdisciplinary Team and the Director of Nursing Services, Facility Administrator or RN Supervisor will review each incident report upon occurrence beginning 10/04/2019 to ensure appropriate interventions are implemented and an updated Plan of Care is complete. The Director of Nursing Services or RN Supervisor will complete weekly chart audits for two months through December 2019 and will review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of falls/accidents and that Care Plans have been updated to reflect these interventions. Audited records will be reviewed by the High Risk Committee weekly beginning 11/01/2019 and the Quality Assurance Performance	

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F 689	Continued From page 7 revealed she was terminated on 7/21/19, for wrong or improper lift with a resident causing an injury. During an interview on 10/01/19 at 3:46 PM, LPN #4 said she first became aware of the incident after CNA #2 called for help and Resident #9 was already on the floor. LPN #4 said the stand-up-lift was still in the resident's room. LPN #4 stated Resident #9 complained of pain in her shoulder, so she notified the Physician, received orders for an X-ray, and gave the resident Tylenol. Review of the Departmental Notes dated 7/20/19 at 11:25 AM revealed Resident #9 was transferred to the hospital for evaluation. Review of the "Radiology Report", dated 7/20/19, revealed the humerus of Resident #9's right shoulder was anteriorly and inferiorly dislocated, with respect to the glenoid. There was no fracture. Conclusion: Anterior shoulder dislocation. Review of the Emergency Department form, dated 7/20/19, revealed the reason for visit was shoulder pain-swelling, shoulder dislocation/fall. The final Diagnosis: shoulder dislocation, unspecified subluxation of right shoulder joint. Review of Nurse's Notes, dated 7/20/19 at 11:25 AM, revealed Resident #9 returned to the facility at 8:00 AM with a should immobilizer in place, however the care plan addressed the resident's refusal of the care. An observation on 10/02/19 at 10:55 AM, revealed Resident #9 was transferred with a full body lift and two (2) staff, without difficulty or	F 689	Improvement Committee will review monthly and will make recommendations and changes as needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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F 689	Continued From page 8 distress. There was no noted injury to Resident #9. Interview on 10/02/19 at 03:18 PM, with the Director of Nursing (DON), revealed she was not working at this facility when the incident happened with Resident #9. The DON said the check off with the lifts, for CNA #2, could not be located. There was a documented "New Hire Orientation Video Checklist", dated 10/31/18, signed by CNA #2, for a 25 minute video completion for Vander and Vera lifts. Review of facility "Face Sheet" revealed Resident #9 was admitted on 4/14/15, with a diagnosis of Dementia, Unspecified.	F 689		