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	255115	A. BUILDING _____ B. WING _____	06/25/2018

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 6/18/18 through 6/25/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F637, F641, F656, F657, F659 F690, F692, and F880. At the time of the survey, the census was 167 and the facility held a license for 180 beds.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to complete a comprehensive assessment for a significant change for one (1) of 33 Minimum Data Sets (MDSs) reviewed, Resident #155. Findings include:	F 637	A Minimum Data Set (MDS) for a significant change in condition for Resident #155 was opened by Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator on 6/22/18. Resident #155 had a hip fracture and a decrease in activities of daily living following a hospital return.	7/27/18

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

Electronically Signed | 07/27/2018

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 637	Continued From page 1 Review of the document typed on the facility's letterhead, dated and signed by the Director of Nursing Services (DNS), dated 06/25/18, revealed the Significant Change in Status Assessment (SCSA) may be warranted for a decline in two or more areas included, " Any decline in an ADL (Activity of Daily Living), physical functioning, area (at least 1/one) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individuals functioning." An interview, on 06/19/18 at 4:17 PM, with Registered Nurse (RN) #3, revealed Resident #155 had a recent hip fracture related to a fall. Record review at this time with RN #3 revealed a Physician's Order, to remove the staples from the right hip on 6/4/18. On 06/20/18 at 12:04 PM, an interview with resident's Responsible Party (RP)/Son in law, stated the facility did notify him when resident fell, and received a right hip fracture. He stated he attends the resident Care Plan conference, and was aware of the medications and treatments for the resident. There were other family members present in the room for her birthday party today, and no concerns were voiced related to the resident's care or staff treatment. The RP reported his Mother-in-Law returned to the facility after hospitalization from her hip fracture. Resident #155 was observed sitting in a wheelchair, neatly dressed, and with no concerns reported. On 06/22/18 at 10:25 AM, an interview with Registered Nurse (RN) #3 revealed, she stated	F 637	All residents who return to the facility with a significant change in condition following a hospitalization have the potential to be affected. The MDS coordinator reviewed all hospital returns from 6/25/18-7/26/18 to ensure that all significant changes in condition were identified. There were no problems noted. On 6/26/18, the Director of Nursing Services (DNS) in-serviced all MDS nurses on identifying all significant changes in condition for those residents who return to the facility following a hospitalization. Beginning 7/30/18, the floor nurses will report changes in residents' condition to the Interdisciplinary Team (IDT). The IDT will report changes to the MDS Coordinator and the MDS Coordinator will open a significant change assessment, if warranted by Resident Assessment Instrument (RAI) guidelines. The MDS Coordinator will continue to review all hospital returns from 07/27/18 for 2 months for a significant change. The MDS coordinator will report to QAAC monthly for two (2) months any problems with significant changes. The QAAC will make recommendations for further reviews, if needed.	

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F 637	Continued From page 2 that when the resident returned to the facility after her hip fracture she was not able to transfer herself and she was unable to walk at this time, and there was a decline in her ADL function. On 06/25/18 at 9:45 AM, an interview with, RN #2/MDS Nurse revealed she stated Resident #155 should have had a Significant Change MDS after the hip fracture because there was no identified concerns. Review of the Accident and Incident reports revealed new interventions with falls, on 2/7/18 and 5/14/18. and more than two areas of change for ADLs. She stated, "The 14 days just got away from me so we are doing one now". On 06/25/18 at 10:50 AM, an interview with the DNS revealed she stated chart checks/audits are done monthly by a consultant, and we also look at them during our Care Plan meetings too. The DSN stated she was responsible for the supervision of the MDS department nurses.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility statement review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for one (1) of 33 resident records reviewed; Resident #42. Findings include:	F 641	A Minimum Data Set (MDS) modification for coding a "no" in Section N for Resident #42 was re-submitted by Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator on 6/26/18. Resident #42 was on routine antipsychotic medications.	7/27/18

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F 641	Continued From page 3 Review of the Resident Assessment Instrument (RAI) 3.0 Manual, revised 10/17, revealed in Chapter Three (3) "Overview To The Item-By-Item Guide to the MDS 3.0, the goal is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes." Review of the facility's statement, signed and dated, on 6/25/18, by the Director of Nursing (DON), revealed each MDS nurse is responsible for the accuracy of the completion of the MDS they are assigned. If/when an inaccuracy is identified, a modification is done per the RAI manual. A review of the Significant Change MDS assessment, with an Assessment Reference Date (ARD) of 5/30/18, revealed Resident #42 was coded under Section N410 (Medications Received) to have received seven (7) days of antipsychotics, 7 days of antianxiety meds, 7 days of antidepressants; and five (5) days of hypnotics during the 7-day look back period. Review of Section N450A (Antipsychotic Medication Review) was coded "No" to the question of did the resident receive antipsychotics since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. Review of the Quarterly MDS assessment, with an ARD of 04/04/18, revealed under Section N410, Resident #42 received 7 days of antipsychotics, 7 days of antianxiety meds, 7 days of antidepressants, and three (3) days of hypnotics. Section N450A was coded "Yes" to indicate the resident received antipsychotics on a	F 641	All residents on antipsychotic medications have the potential to be affected. On 6/26/18 the MDS Coordinator in-serviced all MDS nurses on ensuring that Section N is coded correctly if a resident is receiving antipsychotic medications. The MDS coordinator reviewed all submitted MDSs for correct coding in Section N beginning 6/25/18 through 7/26/18. No problems were noted. The MDS Coordinator and/or assigned MDS nurse will do two random audits on each floor (three floors), each week starting 7/27/18 for two months, reviewing Section N for the correct coding. The MDS Coordinator will report any coding inaccuracies to the QAAC monthly for two months. The QAAC will make recommendations for further review as needed.	

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F 641	Continued From page 4 routine basis. An interview, on 06/25/18 at 11:25 AM, with Registered Nurse (RN)/MDS Nurse #2, revealed upon review of the most recent Significant Change MDS assessment in comparison to the prior Quarterly Assessment, she stated Section N450 was coded "wrong" on the Significant Change MDS assessment. RN #2 revealed Section N450A should have been coded "yes" because Resident #42 is on routine antipsychotic medications. RN #2 stated they use the Resident Assessment (RAI) Manual as a guide. RN #2 further revealed that when a data entry needs to be corrected, the do a "mod" referring to modification assessment. Section N was completed by Registered Nurse (RN) #5 for the both MDS assessments. RN #5 was unavailable to be interviewed. Review of the Face Sheet revealed Resident #42 was admitted by the facility, on 11/22/13, with diagnoses which included Parkinson's Disease, Anxiety Disorder, Unspecified Psychosis, and Major Depressive Disorder. Review of the Significant Change MDS assessment, with Assessment Reference Date (ARD) of 05/30/18, revealed Resident #42 scored three (3) on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment.	F 641		
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	F 656		7/27/18

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F 656	Continued From page 5 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 6 Based on staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan related to gastric tube feeding for Resident #35, urinary catheter care for Resident #519, and bowel and bladder incontinence for Resident #64. This concern was identified for three (3) of 33 care plans reviewed. Findings include: A review of the facility's "Comprehensive Person Centered Care Plans" policy, with a history date of 3/18, revealed each resident will have a person centered plan of care to identify problems, needs, strengths, and goals that will identify how the interdisciplinary team will provide care. Further review of the policy revealed assigned disciplines will be identified to carry out the interventions. Review of the facility's policy titled, Tube Feeding, not dated, revealed the Standard 14: Nurse Aide Scope of Practice included the Nurse Aide will not perform the instillation of any fluids through any tubing. The nurse aide will perform only the tasks in the course standards and Resident Care Procedures manual, unless trained appropriately by licensed staff of the facility with policies and procedures and system for ongoing monitoring to assure compliance with the task, i.e., (see supplements for examples). Resident #519 Review of the Care Plan, dated 06/14/18, revealed a Problem/Need for a Foley catheter secondary to a history of urinary retention. The Approaches included: Secure catheter to thigh to prevent pulling. Keep collection bag below the bladder level. Foley catheter to gravity drainage,	F 656	Resident #519, Resident #35, Resident #64 care plans were reviewed on 06/26/2018 by the Director of Nursing and no changes were made. All residents with an indwelling urinary catheter, residents that require nutrition via PEG, and residents that require incontinent care have the potential to be affected. 6/27/18 through 7/26/18 the Director of Nursing/ Assistant Director of Nursing/ Staff Development nurse in-serviced all staff on turning feeding pumps on/off by licensed personnel only. All nursing staff was in-serviced on proper urinary catheter care, proper incontinent care and following comprehensive care plan. All Certified Nursing Assistants (CNA) had competency check offs completed starting 6/27/18 through 7/26/18 on incontinent care and catheter care. The Director of Nursing/Assistant Director of Nursing/Staff Development Nurse will perform random observation audits on two CNAs on each floor, each day, each shift, Monday through Friday, for proper catheter care and incontinent care, ensuring proper handling of catheter bag and placement of catheter strap. At least one observation per shift will be a tube feeder to ensure that only licensed personnel are turning the feeding pump on and off. These observations will begin 6/27/18 and continue for two months. The Director of Nursing/Assistant Director of Nursing/Staff Development Nurse will	

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F 656	Continued From page 7 catheter strap and privacy bag in place. Provide Foley catheter care with soap and water or incontinent wipes. Secure catheter to thigh to prevent pulling. Keep collection bag below bladder level. Foley catheter to gravity drainage, catheter strap and privacy bag in place. The Goal stated the resident would have no complications related to the use of an indwelling Foley catheter thru 09/2018. On 6/18/19 at 4:30 PM, an observation revealed Resident #519 was lying in his bed with his catheter drainage bag on the floor. Resident #519 was asking about something on his bottom. The Surveyor asked resident's primary nurse, Licensed Practical Nurse (LPN) #1, if she could assist him. LPN #1 pulled his covers back, and discovered the resident does not have a brief on, nor does he have a securing device to his indwelling urinary catheter. LPN #1 stated, "Oh it's on the floor (referring to resident's urinary drainage bag), I'll get it." LPN #1 stated he should have a strap (referring to the catheter securing device), and told the resident, "I'm going to get you a strap." On 6/21/18 at 9:30 AM, an observation revealed did not have a securing device to his catheter. The resident's catheter securing device was noted to be on his bedside table. An observation at this time revealed Resident #519's catheter care provided by Certified Nursing Assistant (CNA) #5 with the assistance of CNA #6. During the catheter care, CNA #5 used a clean wipe and did a downward stroke of the Resident #519's penis twice using the same wipe. CNA #5 did this technique three (3) times around the resident's penis using 3 separate wipes to wipe twice without rotating the wipe, while cleaning the	F 656	report any non-licensed staff who turn feeding pumps on/off; improper incontinent/catheter; and proper placement of urinary catheter bag and leg strap to the QAAC monthly for two months. The QAAC will make recommendations for further observations if needed.	

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F 656	Continued From page 8 resident's penis. CNA #5 then wiped around the head of the resident's penis using one wipe to wipe the area twice. After cleaning the resident's catheter tubing, CNA #5 used the towel that had been placed on the resident to cover him to dry the catheter tubing. CNA #5 then begin assisting the resident to put his pants on, and while threading the catheter drainage bag through the resident's right pant leg as CNA #5 held the resident's catheter drainage bag in her left hand above the resident's bladder, while assisting the resident to put his pants on. CNA #5 assisted the resident to turn onto his left side, while the catheter drainage bag remained on the opposite side of the bed. CNA #5 then assisted the resident to put his shirt on, and assisted the resident to turn onto left side while the catheter drainage bag remained on the opposite side of the bed. During the care, Resident #519 stated something did not feel right down there, while pointing towards his penis area. On 6/23/18 at 3:15 PM, an interview with Registered Nurse (RN) #2/Minimum Data Set (MDS) Nurse revealed she would expect the staff to follow the care plans. A review of the facility's Face Sheet revealed Resident # 519 was admitted on 6/14/18 with a diagnosis of Urinary Retention. Review of Resident #519's Admission MDS, with an Assessment Reference Date (ARD) of 6/21/18, revealed he was coded for the presence of an indwelling catheter. The Basic Interview for Mental Status (BIMS) assessment was not done. Resident #35	F 656		

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F 656	Continued From page 9 Review of Resident #35's Care Plan, dated 04/12/17, revealed the Problem/Need for nutrition via PEG (Percutaneous Endoscopic Gastrostomy) tube, and the roles assigned to the Approaches were N for Nurses, RD for Registered Dietician and D for Dietary. An observation, on 06/22/18 at 2:16 PM, revealed Certified Nursing Assistant (CNA) #1 and CNA #2 provided Resident #35's incontinent care. CNA #2 turned off the feeding pump prior to beginning the incontinent care. CNA #2 provided the incontinent care without any concerns, and turned the feeding pump back on after completing Resident #35's incontinent care. An interview, on 06/22/18 at 2:35 PM, with CNA #2 confirmed she turned the feeding pump off prior to providing the incontinent care, and turned the pump on after care was done. CNA #2 confirmed the nurse should have turned the feeding pump on and off before and after the care. An interview, on 6/25/2018 at 10:29 AM, with the Director of Nursing (DON) confirmed the facility failed to follow professional standards due to the CNA turning the feeding pump on and off during Resident #35's incontinent care. An interview, on 6/25/2018 at 2:00 PM with Registered Nurse (RN) #2/Minimum Data Set (MDS) Nurse revealed the CNAs are expected to follow the Nurse Aide scope of Practice. Review of the Face Sheet revealed the resident was admitted by the facility, on 04/12/17. The Current Diagnoses included Dysphagia,	F 656		

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F 656	Continued From page 10	F 656		

Oropharyngeal Phase and Encephalopathy. The Additional Diagnoses included Gastrostomy Status, Aphasia, and Hypertension.

Review of the Annual MDS, with an Assessment Reference Date (ARD) of 03/22/18, revealed Resident #35's Cognitive Skills for Daily Decision Making was coded a 2, which indicated moderate cognitive impairment-decision making poor; cues and supervision required. Further review of the MDS revealed Resident #35 was checked for a feeding tube.

Resident #64

Review of the Care Plan, dated 11/20/16, revealed a Problem/Need related to (r/t) incontinent of bowel due to decreased mobility and weakness. Has a Suprapubic catheter r/t retention of urine. The Goal revealed episodes of urinary tract infections will be readily identified by staff, and interventions set in place thru 7/20/18. Approached included incontinent care every two (2) hours and as needed.

An observation, on 06/21/18 at 10:00 AM, revealed Resident #64's catheter drainage bag was lying on the floor without a privacy bag. Further observation at this time revealed CNA #1 provided Resident #64's bed bath and Suprapubic catheter care. CNA #1 washed Resident #64's face with a wet towel. CNA #1 applied Dove soap to the towel and washed Resident #64's upper body and under her arms. CNA #1 washed Resident #64's vaginal area with the same soapy towel in a circular motion. CNA #1 failed to wipe Resident #64's perineal area from front to back. CNA #1 placed the soapy towel in the soiled brief, and folded it between

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F 656	Continued From page 11 Resident #64's legs. CNA #1 took a dry towel, and wiped the soap off the resident's body, but did not wipe the soap from in between of Resident #64's vaginal area. CNA #1 left the room to get a brief, and returned to the room with a clean brief, but did not wash her hands. CNA #1 placed clean gloves on, and turned Resident #64 over to clean a small amount of bowel movement from the anal/buttocks area. CNA #1 placed the clean brief on Resident #64, and a clean shirt wearing the same gloves. An interview, on 06/21/18 at 2:29 PM, with CNA #1 confirmed she failed to change towels prior to cleaning Resident #64's vaginal area. CNA #1 also confirmed she failed to wipe from front to back. CNA #1 said the soap should have been rinsed off Resident #64's vaginal area to prevent possible infection. An interview, on 06/25/18 at 10:29 AM, with the Director of Nursing (DON) confirmed the facility failed to prevent the possible spread of infection by leaving soap on Resident #64's vaginal area. The DON also stated the CNA did not follow the facilities incontinent care policy because she did not wipe from front to back. An interview, on 06/25/18 at 10:42 AM, revealed Registered Nurse (RN) #1 confirmed CNA #1 failed to follow the facility's policy by not wiping from front to back, and leaving soap in Resident #64 vaginal area. CNA #1 also failed to change gloves, and wash hands after cleaning Resident #64's bowel movement, and before applying a clean shirt and clean brief. An interview, on 06/25/18 at 2:38 PM, with the Assistant Director of Nursing (ADON) confirmed	F 656		

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F 656	Continued From page 12 CNA #1 failed to follow the infection control policy by allowing the catheter bag to hang on the floor. The ADON said CNA #1 failed to follow the facility policy by not washing the soap off Resident #64 vaginal area, and not washing her hands after leaving the room. The ADON also said CNA #1 failed to follow the policy by not washing her hands, and changing gloves after soiling the glove with bowel movement. An interview, on 6/25/2018 at 2:00 PM, with Registered Nurse (RN) #2/MDS Nurse revealed the CNAs are expected to follow the facilities incontinent care policy when providing incontinent care. Review of the Face Sheet revealed Resident #64 was admitted by the facility on 11/07/12, and readmitted on 11/20/16. The Current Diagnoses included Unspecified Dementia and Chronic Respiratory Failure. Additional Diagnoses include Chronic Kidney Disease. Review of the Quarterly MDS, with an ARD of 04/18/18, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Resident #64 was also checked for an indwelling catheter.	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--	F 657		7/27/18

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F 657	Continued From page 13 (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) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to revise the comprehensive care plan related to a significant weight loss with need for increased staff assistance for one (1) of 33 care plans reviewed; Resident #107 Findings include: Review of the facility's policy titled, "Comprehensive Person Centered Care Plans", dated 03/18, revealed the Comprehensive Person Centered Care Plan contains services provided, preferences, ability, goals for admission and desired outcomes, and care level guides. The facility's policy stated the Interdisciplinary Team (IDT), along with the resident and/or	F 657	Resident #107's weight loss Comprehensive Care Plan was reviewed and revised by the Dietary Manager on 6/22/18, to include a significant weight loss. All residents with significant weight loss and/or with the potential for changes in the ability to feed themselves have the potential to be affected. Director of Nursing/ Assistant Director of Nursing/ Staff Development Nurse and Nurse Supervisors in-serviced nursing staff from 6/26/18 through 7/26/18 on providing additional assistance for a resident who refuses meals and no longer	

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F 657	Continued From page 14 Resident Representative will identify resident problems, needs, strengths, life history, preferences, and goals. The facility's policy also stated the Comprehensive Person Centered Care Plan can be reviewed and/or revised at quarterly intervals in conjunction with the completion of Minimum Data Sets (MDS) quarterly, significant change, and annual assessments. The facility's policy also stated the IDT note (s) are to reflect a review of the care plan goals and approaches. Review of Resident #107's Care Plan, revealed a Problem/Need for being at risk for weight loss related to a diagnosis of Depression and Gastroesophageal Reflux Disease. The problem onset date was 08/27/2015. The Approaches included Hours of Sleep (HS) snack, encourage fluids with meals, weights per facility protocol, regular diet per doctor's order, and Registered Dietician (RD) when needed. Review of Resident #107's Departmental Notes revealed the following Registered Dietician (RD) notes: (1) 4/12/18, Resident has had significant weight loss in 30 and 90 days. Current weight is 156.4 pounds (#), which is a 5.44 % (percent) decrease from previous weight of 165.4# (3/5/18), and 7.13% decrease from 168.5# (1/2/18). Will add resident to weekly weight list to monitor closely. (2) 5/4/18, Resident has had significant weight loss in 90 and 180 days. Current weight is 151# which is a 10.86% decrease from previous weight of 169.4# (2/7/18) and 11.7% decrease from 171# (11/22/17). Will continue to monitor. (3) 6/12/18, Resident has had significant weight loss in 90 and 180 days. Current weight is 153.4# (6/10/18), which is 7.26% decrease from previous weight of 165.4#	F 657	has the ability to feed themselves. Nursing staff will communicate with Unit Manager to update pocket care guide and care plan as needed if a resident is unable to feed themselves and/or requires additional assistance in feeding. On 6/26/18 the Director of Nursing in-serviced the Registered Dietitian (RD) and the Dietary Managers on revising/updating the Nutrition Comprehensive Care Plan when a significant weight loss is identified. The Dietary Manager reviewed all Nutrition Comprehensive Care Plans for residents with significant weight loss beginning 6/25/18 through 7/26/18. No problems were identified. Beginning 6/26/18, the Director of Nursing Services (DNS), Assistant Director Nursing Services, Unit Managers and/or Supervisors will make random meal observations on morning and evening shifts to ensure residents with difficulty feeding have needed assistance with meals. These observations will be daily, Monday through Friday, for two months. The Interdisciplinary Team (IDT) will continue to review all nutrition care plans in weekly care plan meetings to ensure care plans are updated for significant weight loss and appropriate assistance with meals beginning 7/26/18 for two months. The Director of Nursing/Assistant Director of Nursing/Staff Development Nurse will report any nutritional care plans related to significant weight loss monthly for two (2) months to the QAAC. The QAAC will make	

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F 657	Continued From page 15 (3/5/18) and 10.81% decrease from 172# (12/4/18). Continue diet and supplement as tolerated. Will continue to monitor. During an interview, on 06/22/2018 at 12:00 PM, with Registered Nurse (RN) #2/MDS Coordinator, it was confirmed the care plan for Resident #107 did not reflect an actual weight loss with any new interventions. RN#2 confirmed the potential for weight loss had been an identified problem since admission on 08/27/2015. RN #2 also confirmed that no changes have been made to the resident's Care Plan regarding an actual weight loss. RN #2 stated the resident had only needed supervision, and set up for meals from her last quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/15/2018, but now the resident needs someone to actually help her with eating. RN #2 confirmed the current care plan does not include the resident's actual weight loss or nutritional needs for staff assistance related to eating as an approach or an intervention. A review of the Face Sheet revealed Resident #107 was admitted by the facility, on 08/27/2015. The Current Diagnoses included Dementia Without Behavioral Disturbances, and Type Two Diabetes Mellitus With Chronic Kidney Disease. Additional Diagnoses included Anxiety Disorder, Major Depressive Disorder, Anorexia, and Gastric Esophageal Reflux Disease (GERD). Review of Resident #107's 14 Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/12/18, revealed a Basic Interview for Mental Status (BIMS) score was 6, which indicated severe cognitive impairment. Further review of the MDS revealed Resident #107 was	F 657	recommendations for further observations if needed.	

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F 657	Continued From page 16 checked for weight loss, and not on a physician prescribed weight loss regimen.	F 657		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure licensed nursing staff turned Resident #35's feeding pump off and on before and after completion of incontinent care. This concern was identified for one of seven (1 of 7) incontinent and/or catheter care observations. Findings include: Review of the facility's policy titled, Tube Feeding, no date, revealed the Standard 14: Nurse Aide Scope of Practice included the Nurse Aide will not perform the instillation of any fluids through any tubing. The nurse aide will perform only the tasks in the course standards and Resident Care Procedures manual, unless trained appropriately by licensed staff of the facility with policies and procedures and system for ongoing monitoring to assure compliance with the task, i.e., (see supplements for examples). Review of the (Name of State) Nursing Practice Law, with an effective date of July 1, 2010,	F 659	Unit manager/Registered Nurse assessed Resident #35 on 06/22/2018 and no complications were noted related to the by the CNA #2. CNA #2 was counseled by the Executive Director and the Director of Nursing Services on 6/22/18 that only licensed personnel can turn the feeding pump off/on. All residents who receive nutrition via PEG tube have the potential to be affected. Director of Nursing/ Assistant Director of Nursing/ Staff Development Nurse in-serviced all staff on only licensed personnel can turn the feeding pump off/on. In-services completed 6/27/18 through 7/26/18. Observation rounds by Director of Nursing Services, Assistant Director of Nursing and Staff Development Nurse of residents with peg tubes during incontinent care/catheter care began 06/27/2018 thru 07/27/2018 to	7/27/18

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F 659	Continued From page 17 revealed on pages three (3) and four (4) of 26: 73-15-5 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of nursing, and execution of the medical regimen, including the administrating of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Review of the Administrative Code (Name of State) Board of Nursing, Title 30: Professions and	F 659	ensure only licensed personnel were turning feeding pumps off/on. The Director of Nursing Services/ Assistant Director of Nursing/ Staff Development Nurse will make observation rounds beginning 7/27/18 once a week for two months to ensure only licensed personnel are turning pumps off/on. The Director of Nursing/Assistant Director of Nursing will report any non-licensed staff who turn feeding pumps on/off to the QAAC monthly for two months. The QAAC will make recommendations for further observations if needed.	

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F 659	Continued From page 18 Occupations Parts 2801-2900, dated March 16, 2012, pages 13 and 14, revealed: Rule 1.2 Unprofessional Conduct Defined. Unprofessional conduct shall include but not be limited to the following: J. Permitting, aiding, or abetting an unlicensed person to perform activities requiring a license. L. Inappropriately delegating tasks to individuals licensed or unlicensed when the person lacks educational preparedness, experience, credentials, competence, or physical, or emotional ability to complete the task. Review of Resident #35's Care Plan, dated 04/12/17, revealed the Problem/Need for nutrition via PEG (Percutaneous Endoscopic Gastrostomy) tube, and the roles assigned to the Approaches were N for Nurses, RD for Registered Dietician and D for Dietary. An observation, on 06/22/18 at 2:16 PM, revealed Certified Nursing Assistant (CNA) #1 and CNA #2 provided Resident #35's incontinent care. CNA #2 turned off the feeding pump prior to beginning the incontinent care. CNA #2 provided the incontinent care without any concerns, and turned the feeding pump back on after completing Resident #35's incontinent care. An interview, on 06/22/18 at 2:35 PM, with CNA #2 confirmed she turned the feeding pump off prior to providing the incontinent care, and turned the pump on after care was done. CNA #2 confirmed the nurse should have turned the feeding pump on and off before and after the care. An interview, on 6/25/2018 at 10:29 AM, with the Director of Nursing (DON) confirmed the facility failed to follow professional standards due to the	F 659		

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F 659	Continued From page 19 CNA turning the feeding pump on and off during Resident #35's incontinent care. An interview, on 6/25/2018 at 2:00 PM with Registered Nurse (RN) #2/Minimum Data Set (MDS) Nurse revealed the CNAs are expected to follow the Nurse Aide scope of Practice. Review of the Face Sheet revealed the resident was admitted by the facility, on 04/12/17. The Current Diagnoses included Dysphagia, Oropharyngeal Phase and Encephalopathy. The Additional Diagnoses included Gastrostomy Status, Aphasia, and Hypertension. Review of the Annual MDS, with an Assessment Reference Date (ARD) of 03/22/18, revealed Resident #35's Cognitive Skills for Daily Decision Making was coded a 2, which indicated moderate cognitive impairment-decision making poor; cues and supervision required. Further review of the MDS revealed Resident #35 was checked for a feeding tube.	F 659		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		7/27/18

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F 690	Continued From page 20 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent the possibility of a Urinary Tract Infection (UTI) for one (1) of four (4) incontinent care observations; Resident #64, and one (1) of three (3) urinary catheter care observations; Resident #519. Findings include: A review of the facility's policy titled, "Catheter Care" dated 11/10, revealed, cleanse around the area where catheter enters the urethral meatus with a wipe in a downward motion about 4 (four) inches. Avoid pulling on the catheter during	F 690	Resident #519's urinary catheter drainage bag was removed off of the floor by CNA #5. The drainage bag was appropriately placed on the left side of the bed below the bladder and the leg strap was secured following the observation of catheter care on 6/21/18. On 06/21/2018 the Unit Manager/Registered Nurse assessed Resident #519 and no complications were noted related to the indwelling urinary catheter care following observation on 6/21/18. CNAs #5 and #6 were counseled by the Executive Director and Director of Nursing Services on 06/21/2018 on proper catheter care,	

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F 690	Continued From page 21 cleaning. Secure catheter with catheter strap. A review of the facility's policy titled, "Incontinent Care", dated 1/15, revealed; when washing perineal area, wash the entire area moving from front to back. Resident #519 On 6/18/19 at 4:30 PM, an observation revealed resident lying in his bed with his catheter drainage bag on the floor. Resident #519 was awake and inquiring about having something on his bottom. The Surveyor asked resident's primary nurse, Licensed Practical Nurse (LPN) #1, if she could assist him. LPN #1 pulled his covers back, and revealed the resident did not have a brief on, or a securing device to his indwelling urinary catheter. LPN #1 stated, "Oh it's on the floor (referring to resident's drainage bag), I'll get it." LPN #1 stated, he should have a strap (referring to the catheter securing device), and told the resident, "I'm going to get you a strap." On 6/21/18 at 9:30 AM, an observation revealed Resident #519 did not have a securing device to his catheter. The resident's catheter securing device was noted to be on his bedside table. Further observation revealed catheter care was performed by Certified Nursing Assistant (CNA) #5 with the assistance of CNA #6. During the catheter care, CNA #5 used a clean wipe, and wiped down the penis twice using the same wipe, and did this technique three (3) times while wiping the resident's penis. CNA #5 then wiped around the head of the penis using one wipe to wipe the area twice. CNA #5 then began assisting Resident #519 to put his pants on, and while threading the catheter drainage bag through the	F 690	securing leg strap and placing drainage bag on the appropriate side of the bed, taking care to keep the bag below the level of the bladder. On 06/21/2018 the Unit Manager/Registered Nurse assessed Resident #64 and no complications were noted from the incontinent care observed 6/21/18. CNA #1 was counseled by the Executive Director and the Director of Nursing Services on 6/25/18 for following procedures on incontinent care. All residents who receive urinary catheter care or incontinent care have the potential to be affected. The Director of Nursing/ Assistant Director of Nursing/ Staff Development Nurse in-serviced all CNAs and nurses on 6/27/18 through 7/26/18 on urinary catheter care and incontinent care including washing of hands, placement of urinary drainage bag, and proper use of gloves. The Director of Nursing/ Assistant Director of Nursing/ Staff Development Nurse performed clinical check-offs with all CNAs beginning 6/27/18 through 7/26/18. The Director of Nursing/ Assistant Director of Nursing/ Staff Development Nurse will perform random observations of two CNAs on each floor (three floors), each day, each shift Monday through Friday, to ensure they are following catheter care policy and incontinent care policy. These observations began 6/27/18 and will continue for two months. The Director of Nursing/Assistant Director of	

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F 690	Continued From page 22 resident's right pant leg, CNA #5 held the resident's catheter drainage bag in her left hand above the resident's bladder. CNA #5 assisted the resident to turn onto his left side, while the catheter drainage bag remained on the opposite side of the bed. CNA #5 then assisted Resident #519 to put his shirt on, and to turn onto his left side while the catheter drainage bag remained on the opposite side of the bed. On 6/21/18 at 2:00 PM, an interview with CNA #5 revealed, "I double wiped it (referring to when she was cleaning the resident's penis), and should have wiped it one time." CNA #5 also stated the strap was on the bedside table. CNA #5 stated, she held the drainage bag in her left hand while using her right hand to assist the resident, and held it above the bed, and stated, the urine will go back into the resident and could cause an infection or something. CNA #5 stated they get training and in-services "a lot". CNA #5 also stated the urinary drainage bag was behind Resident #519 when she turned him, and should have been in front of him. On 6/21/18 at 2:12 PM, an interview with CNA #6 revealed when CNA #5 was wiping Resident #519, CNA #5 used the same wipe to wipe the resident's penis twice. CNA #6 also stated, when CNA #5 was cleaning the resident's penis, she had seen a mistake and that was when CNA #5 wiped the penis head, she did that same thing (wiped the area twice with the same wipe). CNA #6 stated CNA #5 should have used one wipe to wipe each time, or she could have turned the wipe. CNA #6 also stated the resident's securing device was on the bedside stand, and the catheter drainage bag was on the opposite side of the bed when CNA #5 assisted the resident to	F 690	Nursing/Staff Development Nurse will report to QAAC monthly for two (2) months any problems with CNAs following facility protocol for incontinent/catheter care; placement of urinary drainage bag; and washing hands and changing gloves per facility protocol. The QAAC will make recommendations for further observations if needed.	

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F 690	Continued From page 23	F 690		

turn onto his left side. CNA #6 stated with the catheter tube being on the opposite side of the bed, it (the catheter tubing) could have been pulling. CNA #6 stated CNA #5 also held the drainage bag above the resident's bed which could cause an infection.

On 6/22/18 at 9:30 AM, an interview with Registered Nurse (RN) #1 revealed CNA #5 should have wiped using one wipe around the penis during incontinent or catheter care. RN #1 also stated the catheter should be down the resident's leg with a leg strap, and the catheter drainage bag should be up off of the floor. RN #1 also stated she would expect the catheter drainage bag to be below the resident's bladder.

On 6/22/18 at 11:08 AM, an interview with LPN #1 revealed the problem with the urinary drainage bag being on the floor is it could cause an infection. LPN #1 also stated the resident needs a catheter strap to keep the catheter from pulling.

On 6/22/18 at 2:35 PM, an interview with RN #1 revealed the resident's catheter drainage bag should be up off the floor.

On 6/23/18 at 9:35 AM, an interview with the Director of Nurses (DON) revealed CNA #5 should have used one wipe on one side, and instead of telling them (referring to the CNAs) to rotate the wipe, she stated she tells them to use a new wipe. The DON also stated she expects the drainage bag to be below the bladder of the resident, and on the same side the resident is turned.

On 6/25/18 at 2:10 PM, an interview with RN #5 revealed the catheter drainage bag should not be

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F 690	Continued From page 24 on the floor, but should be hanging on the bed because it's an infection control issue. She also stated it could cause pulling and/or possible dislodgement of the catheter if the drainage bag is on the opposite side of the bed from the position that the resident is turned and facing. RN #5 also stated CNA #5 should not have held the drainage bag above the resident's bladder because it may backflow. On 6/25/18 at 2:15 PM, an interview with the Assistant Director of Nurses (ADON), revealed it is an infection control issue for the drainage bag to be on the floor, and should have been on the side of the resident's bed. The ADON also stated the resident needs a securing device to prevent tension, and the catheter from being dislodged. She stated the drainage bag is not supposed to be above the bladder because it can backflow, which could cause an infection. The ADON stated the CNA could have possibly cross contaminated when she used one wipe to wipe the penis twice. The ADON stated "again having the drainage bag on the opposite side from the position the resident is turned causes tension to the catheter. Review of Resident #519's June 2018 Physician Orders revealed an order, dated 6/14/18, for a Foley to gravity drainage. A review of the facility's Face Sheet revealed Resident # 519 was admitted on 6/14/18 with a diagnosis of Urinary Retention. Review of Resident #519's Admission MDS, with an Assessment Reference Date (ARD) of 6/21/18, revealed he was coded for the presence of an indwelling catheter. The Basic Interview for Mental Status (BIMS) assessment was not done.	F 690		

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F 690	Continued From page 25 Resident #64 During an observation, on 06/21/18 at 10:00 AM, Certified Nursing Assistant (CNA)#1 washed Resident #64's face with a wet towel. CNA #1 applied Dove soap to the towel, and washed Resident #64's upper body and under her arms. CNA #1 washed the resident's vaginal area in a circular motion with the same soapy towel. CNA #1 failed to wipe from the perineal area from front to back. CNA #1 placed the soapy towel in the brief, and folded it between Resident #64 legs. CNA #1 took a dry towel and wiped the soap off the resident's upper body, but did not wipe the vaginal area therefore leaving soap in the vaginal area. CNA #1 left the room to get a clean brief, returned to the room, applied a clean pair gloves, and continued with the incontinent care. CNA #1 failed to wash her hands on her return to the room, prior to applying the new gloves, and continuing the incontinent care. CNA #1 turned Resident #64 over, and cleaned a small amount of bowel movement from the resident's anal and buttocks area, placed a clean brief on the resident,, and put a clean shirt on the resident wearing the same gloves. Review of Resident #64's Lab Reports revealed a catheterized Urine Culture and Sensitivity (C&S), dated 3/09/2018, indicated a UTI due to 100,000 CFU/ml (Colony Forming Units per milliliters) of the bacteria Proteus Mirabilis. Review of the facility's Bed Bath Competency and Skills Checklist, dated 4/16/2018, revealed CNA #1 was checked off to wash the perineum from front to back, and rinse the soap off the resident	F 690		

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F 690	Continued From page 26 after placing soap on the body. An interview with CNA #1, on 06/21/2018 at 2:29 PM, revealed she failed to change towels prior to cleaning Resident #64's vaginal area, and failed to wipe from front to back. CNA #1 stated she should have rinsed the soap off Resident #64's vaginal area to prevent possible infection. During an interview, on 06/25/18 at 10:29 AM, the Director of Nursing (DON) confirmed the CNA failed to prevent the possible spread of infection by leaving soap in Resident #64's vaginal area, and did not wash her hands, or change gloves after cleaning the bowel movement. The DON also stated the CNA should have wiped from front to back. An interview, on 06/25/18 at 10:42 AM, revealed Registered Nurse (RN) #1/Staff Development Nurse confirmed CNA #1 failed to follow the facility's incontinent care policy and procedure guide by not wiping from front to back, leaving soap in Resident #64 vaginal area, and allowing the catheter drainage bag to lay on the floor. CNA #1 also failed to change gloves and wash her hands after cleaning the bowel movement, and before applying Resident #64's clean shirt and clean brief. An interview, on 06/25/18 at 2:38 PM, with the Assistant Director of Nursing (ADON) confirmed CNA #1 failed to follow the infection control policy by allowing the catheter bag to hang on the floor. The ADON also stated CNA #1 failed to follow the facility's policy by not washing the soap off Resident #64 vaginal area, or washing her hands after leaving the room. The ADON said CNA #1	F 690		

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F 690	Continued From page 27 failed to follow the policy by not washing her hands, and changing gloves after soiling the glove with bowel movement. Review of the Face Sheet revealed Resident #64 was admitted by the facility on 11/07/12, and readmitted on 11/20/16. The Current Diagnoses included Unspecified Dementia and Chronic Respiratory Failure. Additional Diagnoses include Chronic Kidney Disease. Review of the Quarterly MDS, with an ARD of 04/18/18, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Resident #64 was also checked for an indwelling catheter.	F 690		
F 692 SS=E	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	F 692		7/27/18

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F 692	Continued From page 28 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility statement review, the facility failed to prevent Resident #107's further weight loss after a significant weight loss was identified related to failure to provide one person physical assistance during meals for three (3) of four (4) meal observations. Findings include: Review of a statement documented on the facility's letterhead, signed and dated on 6/25/18, by the Director of Nursing Services (DNS), revealed, "When a CNA (Certified Nursing Assistant)/nurse notices a change in a resident's ability to feed themselves the staff member will try to assist the resident if the resident will allow them. If the resident refuses assistance, the staff member will attempt at a later time. CNA will ensure the nurse is notified. The facility did not provide a policy related to staff physical assistance feeding residents identified as needing assistance with feeding themselves. Review of Resident #107's Five (5) Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/05/2018, revealed Resident #107 required one person physical assistance for eating. The MDS also revealed a significant weight loss. The prior Quarterly MDS assessment, with an ARD date of 04/15/2018, indicated the resident only needed set-up and supervision for eating. Review of Resident #107's 14 Day MDS, with an ARD date of 05/12/2018,	F 692	On 6/25/18 Resident #107 was reassessed by the RN Unit Manager for an increased need for assistance with feeding. No changes in assistance were made. Staff will continue to provide setup with meals and assistance as needed. Occupational Therapy (OT) evaluated Resident #107 on 06/21/2018. OT recommended to continue with meal setup and assistance as needed. Resident #107 at times refuses staff assistance due to behaviors/tremors. Resident #107 can feed herself and she feeds herself frequently without any problems. The physician decreased her Seroquel on 6/21/18 in an effort to decrease episodes of behaviors/tremors. All residents who feed themselves have the potential to be affected. On 6/26/18 through 7/26/18, the Director of Nursing, Assistant Director of Nursing/ Staff Development Nurse in-serviced all CNAs and Nurses on feeding residents when residents are having difficulty feeding themselves. In-service included for Nurses and CNAs to report a change/difficulty with feeding immediately to the Nursing Supervisor. Beginning 6/26/18, the Director Nursing, Assistant Director of Nursing and Unit Managers and/or Supervisors will make random meal observations on morning	

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F 692	Continued From page 29 revealed the resident needed the physical assistance of one (1) staff member for eating. The MDS was also coded for a significant weight loss. Review of the facility's Daily Care Guide, dated 06/19/2018, revealed Resident #107's assistance for eating was supervision only. The facility's document also revealed Resident #107 was at risk for weight loss. During an observation of the lunch meal service in the dining area on the second floor of the facility, on 06/18/2018 at 11:30 AM, several residents were observed being assisted with meals by the staff. Resident #107 was seated at a table in the dining area, and her hands had tremors, and she was spilling her tea and food in an attempt to feed herself. There was six (6) staff members present in the dining area; however, no staff offered to assist Resident #107 during the entire course of her meal. An observation of the lunch meal service in the dining area on the second floor of the facility, on 06/19/2018 at 12:10 PM, revealed during the entire meal Resident #107 was not assisted to eat by staff. Resident #107 had hand tremors, and was unable to complete her meal. Resident #107 also spilled her tea and her food on her protective apron. There were seven (7) staff members present in the dining area during the meal service, yet no staff members offered to assist the resident with her meal. An observation of the lunch meal service in the dining area on the second floor of the facility, on 06/20/18 at 12:33 PM, revealed Resident #107, was having hand tremors, and was unable to feed	F 692	and evening shifts to ensure residents with difficulty feeding have needed assistance with meals. These observations will be daily, Monday through Friday, for two months. The Director of Nursing/Assistant Director of Nursing/Staff Development Nurse will report to QAAC monthly for two (2) months any problems identified with residents requiring additional assistance with feeding. The QAAC will make recommendations for further observations if needed.	

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F 692	Continued From page 30	F 692		

herself without spilling her food and tea. Resident #107 was wearing a protective apron during her meal time. Resident #107 was not assisted by staff until 30 minutes into meal service. At that time CNA #7 did offered assistance. Resident #107 had consumed less than twenty-five (25) percent (%) of her meal, five (5) percent (%) was still on her plate, and the other seventy (70) percent (%) had fallen onto the floor while the resident was trying to feed herself. The Resident did not eat any more of her meal, and the staff did not offer her anything else to eat.

An observation of the lunch meal service in the dining area on the second floor of the facility, on 06/21/2018 at 11:45 AM, revealed Resident #107 had been relocated to a different dining table. From the onset of the meal Licensed Practical Nurse (LPN) #2 did offer to assist the resident with her meal. Resident #107 had hand tremors, and was receptive to the assistance offered by LPN #2. Resident #107, consumed 75% of her meal with the assistance of LPN #2.

During an interview, on 06/20/2018 at 12:10 PM, with CNA #3, it was confirmed she was sitting at the table with Resident #107, while assisting another resident with her meal. CNA #3 stated she saw Resident #107 spilling her tea and food on her protective apron. CNA #3 also stated Resident #107 does not always want help with her meal, and the resident does not always have tremors. CNA #3 stated the resident has had these tremors for a while, but she doesn't remember for exactly how long. CNA #3 stated she hasn't reported the tremors to anyone, because she thought that the nurses already knew about it. CNA #3 also stated she did not assist the resident today, because she was

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F 692	Continued From page 31 helping another resident, but she did see that Resident #107 needed help during the lunch meal. CNA #3 stated a list of all the Resident's Activities of Daily Living (ADL) needs are provided every day to the CNA staff. CNA #3 stated Resident #107 was marked as supervision for eating on the ADL sheet that she was given. During an interview, on 06/20/2018 at 12:25 PM, with CNA #4, she confirmed she had been present in the second floor dining room for the lunch meals on 06/19/2018 and 06/20/2018. CNA #4 stated Resident #107 needs assistance with her meals, because her hands shake real bad sometimes. CNA #4 stated the nurses let them know if a resident loses weight. CNA #4 stated she was aware Resident #107 had recently lost weight, because it is on the daily care guide. CNA #4 stated the CNAs are given daily care guides with all of the Resident's ADL needs every day by the nurses. CNA #4 stated the CNAs keep the resident's daily care guides in their pockets. An interview, on 06/20/2018 at 12:37 PM, with LPN #2, revealed she was present in the 2nd floor dining area during the lunch meal on 06/19/2018. LPN #2 stated she did not notice Resident #107's tremors during the meal, and she needed assistance to feed herself. LPN #2 stated she was aware Resident #107 had recently lost weight. LPN #2 also stated the onset of hand tremors was not new. LPN #2 stated she was not sure when the resident started having hand tremors. An interview, on 06/20/2018 at 12:45 PM, with LPN #3, revealed she was in the second floor dining area during the resident's lunch meal on 06/20/2018. LPN #3 stated she observed	F 692		

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F 692	Continued From page 32 Resident #107 eating lunch, and that Resident #107 was having hand tremors. LPN #3 confirmed Resident #107 was spilling her tea and food on her protective apron. LPN #3 also stated Resident #107 refuses staff assistance at times when her hands are not shaking as badly. LPN #3 stated she thought one of the CNAs had asked the resident if she wanted help, and the resident probably refused. During an interview, on 06/20/2018 at 12:58 PM, with CNA #7, it was confirmed she was in the second floor dining area for the resident's lunch meal on 06/20/2018. CNA #7 stated she observed Resident # 107 needing assistance with her meals. CNA #7 stated she went to assist the resident when she saw Resident #107 was having trouble getting the food into her mouth. CNA #7 stated she assisted the resident to finish her meal, but she did not offer any other food at that time. CNA #7 stated Resident # 107 should have had assistance with all meals, and the staff should offer to help her even though she refuses sometimes. CNA #7 stated the resident did not refuse today when she offered to help her finish her meal. During a telephone interview, on 06/21/2018 at 3:10 PM, with the Nursing Practitioner (NP) revealed she became aware of the resident's weight loss three months or so ago. The NP stated she had written an order for the medication Remeron to be administered for use as an appetite stimulant. The NP stated she has not been made aware of the resident experiencing tremors. During an interview, on 06/22/2018 at 12:00 PM, with RN #3, it was confirmed Resident #107 had	F 692		

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F 692	Continued From page 33 been identified with a significant weight loss. RN #3 stated the resident had recently experienced hand tremors, and was having trouble with eating her meals. During an interview, on 06/22/2018 at 12:10 PM, with Registered Nurse (RN) #2/MDS Coordinator, RN #2 confirmed Resident #107 only required supervision and set up for eating prior to the resident's MDS assessment on 05/05/2018. RN #2 also confirmed no changes have been made to Resident #107's Care Plan regarding an actual weight loss, or the increased need for assistance with meals. Review of Resident #107's Departmental Notes revealed the following Registered Dietician (RD) notes: (1) 4/12/18, Resident has had significant weight loss in 30 and 90 days. Current weight is 156.4 pounds (#), which is a 5.44 % (percent) decrease from previous weight of 165.4# (3/5/18), and 7.13% decrease from 168.5# (1/2/18). Will add resident to weekly weight list to monitor closely. (2) 5/4/18, Resident has had significant weight loss in 90 and 180 days. Current weight is 151# which is a 10.86% decrease from previous weight of 169.4# (2/7/18) and 11.7% decrease from 171# (11/22/17). Will continue to monitor. (3) 6/12/18, Resident has had significant weight loss in 90 and 180 days. Current weight is 153.4# (6/10/18), which is 7.26% decrease from previous weight of 165.4# (3/5/18) and 10.81% decrease from 172# (12/4/18). Continue diet and supplement as tolerated. Will continue to monitor. Review of the Face Sheet revealed Resident #107 was admitted by the facility, on 08/27/2015, with the included diagnoses Dementia without	F 692		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	4540 MANHATTAN RD JACKSON, MS 39206

(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 692	Continued From page 34 behavioral disturbances, Type Two Diabetes Mellitus, and Chronic Kidney Disease. A review of Resident #107's 14 Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/12/2018, revealed Resident #107's Brief Interview Mental Status (BIMS) score was 6, indicating moderately impaired cognition.	F 692		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		7/27/18

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F 880	Continued From page 35 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record	F 880	Unit Manager/Registered Nurse	

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F 880	Continued From page 36 review, and facility policy review, the facility failed to use appropriate hand hygiene practices to prevent the possible spread of infection and/or cross contamination during Resident #64's incontinent care observation. This concern was identified for one (1) of five (5) incontinent care observations. Findings include: Review of the facility's policy titled, "Standard Precautions", dated 01/2015, revealed staff must wash their hands when visibly soiled, after contact with blood, body fluids, secretions, excretions, patient's intact skin or wound dressings, and contaminated items immediately after removing gloves and between patient contacts. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated items with mucus membranes and non intact skin. If hands move from a contaminated site to a clean body site during care, wash hands using a non-antimicrobial soap and water, antimicrobial soap and water, or alcohol based hand rub. Wash hands before direct contact with patients. During an observation, on 06/21/18 at 10:00 AM, revealed Certified Nursing Assistant (CNA)#1 washed Resident #64's face with a wet towel. CNA #1 applied Dove soap to the towel, and washed Resident #64's upper body and under her arms. CNA #1 washed the resident's vaginal area in a circular motion with the same soapy towel. CNA #1 failed to wipe from the perineal area from front to back. CNA #1 placed the soapy towel in the brief, and folded it between Resident #64 legs. CNA #1 took a dry towel and wiped the soap off the resident's upper body, but did not wipe the vaginal area therefore leaving	F 880	assessed Resident # 64 on 06/21/2018 and there were no complications from the hand washing and glove practices during the incontinent care observation. All residents who receive incontinent care have the potential to be affected. On 6/26/18 through 7/26/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Nurse in-serviced all CNAs and nurses on proper hand washing and changing of gloves between dirty to clean to prevent the possibility of infection. All CNAs had competency check offs beginning 6/27/18 through 7/26/18 on incontinent care and catheter care. These check-offs were conducted by the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse 6/26/18 - 7/26/18. Beginning 7/27/18, the Director of Nursing Services/ Assistant Director of Nursing Services/ Staff Development Nurse will do random observations on two CNAs on each floor (three floors)for following the facility's policy on changing gloves and washing hands. These observations will be each shift, each day, Monday through Friday for two months. The Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse will report to QAAC monthly for two (2) months any problems with staff washing hands or changing gloves per facility policy. The QAAC will make recommendations for further observations	

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F 880	Continued From page 37 soap in the vaginal area. CNA #1 left the room to get a clean brief, returned to the room, applied a clean pair gloves, and continued with incontinent care. CNA #1 failed to wash hands on her return to the room, and prior to applying the new gloves and continuing the incontinent care. CNA #1 turned Resident #64 over, and cleaned a small amount of bowel movement, placed a clean brief on the resident,, and put on a clean shirt on the resident wearing the same gloves. Interview with CNA #1, on 06/21/18 at 2:29 PM, confirmed she failed to change towels prior to cleaning Resident #64's vaginal area. CNA #1 also said she should have rinsed the soap off Resident #64's vaginal area to prevent possible infection. CNA #1 confirmed she cleaned Resident #64 with Dove soap, which is not a no rinse soap. CNA #1 stated she was nervous, and wanted to get the care over with. An interview, on 06/25/18 at 10:29 AM, with the Director of Nursing (DON) confirmed the CNA failed to prevent the possible spread of infection by leaving soap on Resident #64's vaginal area, and by not washing her hands or change her gloves after cleaning Resident #64's bowel movement. On 06/25/18 at 10:42 AM, an interview with Registered Nurse (RN) #1/Staff Development Nurse revealed CNA #1 failed to follow the facility's infection control policy due to failure to change her gloves and wash her hands after providing incontinent care, and touching other items with contaminated gloves. During an interview, on 06/25/18 at 2:38 PM, the Assistant Director of Nursing (ADON) confirmed	F 880	if needed.	

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F 880	Continued From page 38 CNA #1 failed to follow the facility's infection control policy by not washing her hands and changing gloves after soiling the gloves with bowel movement.	F 880		

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	255115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/20/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		7/27/18

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

Electronically Signed | 07/27/2018

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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K 321	Continued From page 1 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas in accordance NFPA 101 section 19.3.2.1. These deficiencies practice affected three (3) of 12 smoke compartments in the facility on the day of survey. Findings include: Observations during the building inspection on June 21, 2018 at 10:40 AM revealed air transfer grills in the doors to the storage rooms near the new elevator on the 1st, 2nd and 3rd Floors of the facility. These storage rooms were incapable of resisting the passage of smoke throughout the facility.	K 321	Air transfer grills on all three (3) storage room doors were enclosed on 6/22/18 to prevent smoke from passing throughout the facility. All residents have the potential to be affected. Maintenance staff was in-serviced on hazardous areas in accordance with NFPA 101 section 19.3.2.1 on 7/17/18 through 7/23/18 by the Executive Director. Facility had three doors with air transfer grills affected and the three air transfer grills were covered. Maintenance Directors will make walking rounds one time a week for two weeks to ensure air transfer grills on all three storage doors are still covered to prevent smoke from passing throughout the facility starting 6/22/18 through 7/23/18. Any negative findings will be reported to the Quality Assessment and Assurance Committee (QAAC). The QAAC will determine any need for additional monitoring.	
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of	K 342		7/27/18

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K 342	Continued From page 2 egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on testing, the facility failed to properly provide complete manual activation of the fire alarm system as required by NFPA 9.6.2.1. This deficiency affected two (2) of 12 smoke compartments and 28 of 174 residents in the facility on the day of survey. Findings include: While testing the fire alarm system on 6/21/18 at 11:30 AM, it was determined and observed the manual fire alarm pull stations located at the end of the North and South Halls on the 3rd Floor failed to initiate and activate the fire alarm system.	K 342	Manual Fire Alarm Pull Stations located on the north and south halls on third floor were replaced and put back in service on 6/20/18 by Systronic, Inc. All residents have the potential to be affected. Maintenance staff were in-serviced on NFPA 9.6.2.1 on 7/17/18 through 7/21/18 by the Executive Director on manual fire alarm pull station signal initiation. Systronic Inc checked all manual fire pull stations to ensure they were all working correctly 6/20/18. No other problems were identified. Maintenance Directors performed audits on two fire alarm pull stations weekly to ensure continued compliance for one month starting 6/22/18 through 7/23/18. No problems were identified. Systronics Inc. will continue to do yearly inspections on all fire pull stations and more often as needed. Any negative findings will be reported to the QAAC. The QAAC will determine the need for any additional monitoring.	

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E 000	Initial Comments Survey conducted on 6/20/18 revealed the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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