

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2019
NAME OF PROVIDER OR SUPPLIER DESOTO HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671	
(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 000	INITIAL COMMENTS Based on administrative review, and communication with CMS, the date of the exit from the facility was amended. The words repercussions were changed to fear of retaliation. Based on administrative review, and communication with CMS, the scope and severity of the Form-2567 was amended. The scope and severity of tags F600, F607, and F610 were lowered from the "K" level to the "G" level. F609 was lowered from thr "K" level to the "E" level. A Recertification survey was conducted by Healthcare Management Solutions, LLC (HMS) on behalf of the Mississippi State Department of Health from 04/01/19 through 04/07/19. During the survey, the facility was found not to be in substantial compliance with requirements of participation for Medicare and Medicaid, and deficiencies were cited at F550, F582, F584, F600, F607, F609, F610, F641, F656, F688, F804, and F808. The census at the time of survey was 106, and the facility held a license for 120 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		5/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/31/2019

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 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, observation, interview, and record review, the facility failed to promote and respect the rights for one (1) of 47 sampled residents, Resident (R) #10. R #10, who was cognitively intact, was not allowed beyond a locked door to exit the facility alone. The facility failed to follow their Resident	F 550	(1) Resident #10 was reassessed for wandering and risk for elopement on 4/15/19 by the Interdisciplinary Team, to include Director of Nursing, Assistant Director of Nursing and Quality Assurance Nurse and found to not be at risk for wandering or elopement. Resident's		

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F 550	Continued From page 2 Rights policy by denying R #10 to independently access the outside of the facility. Findings include: Review of the facility's policy titled, "Nursing Home Resident Rights," undated, revealed, residents of nursing homes have the rights that are guaranteed by the Federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination. The policy revealed, residents have the right of access to individuals, services, community members, and activities inside and outside the facility. The policy also revealed, residents have the right of access to participate in social, religious and community activities. During the resident group interview on 04/03/19 at 10:21 AM, R #10 stated he wanted to go outside off the facility grounds to smoke across the street, which was the same place the facility's staff smoked; however, he had spoken to the Administrator several times who had told him "No." Review of R#10's "Face Sheet," revealed the resident was admitted to the facility on 12/30/17, with diagnoses which included Pneumonia, Unspecified Speech Disturbances, Anemia, Nasal Congestion, Difficulty in Walking, Chronic Obstructive Pulmonary Disease (COPD), Anxiety Disorder, and Type 2 Diabetes Mellitus without complications. Review of the quarterly "Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 12/26/18, specified R#10 had a "Brief	F 550	wandering and elopement risk care plan was resolved. Resident does not wear a pink armband, he was removed from the Code Purple Elopement Risk book and was removed from visual monitoring. (2) All residents who are at risk for elopement or wandering have the potential to be affected by this deficient practice. (3) On 4/23/19, all eight residents currently identified as at risk for wandering and elopement risk were reassessed by the Quality Assurance Nurse to ensure they were not being denied independent access to the outside of the facility and there were no negative findings. On 4/24/19, the Quality Assurance Nurse initiated an in-service regarding Resident's Rights with Nursing, Social Services, Minimum Data Set Nurse, and Activities Departments to include rights to respect and dignity. Beginning 4/23/19, all residents at risk for wandering and elopement will be assessed quarterly in conjunction with the Minimum Data Set by the Interdisciplinary Team. (4) Residents who are assessed and trigger for at risk for elopement will be reviewed weekly in the High Risk meeting by the Interdisciplinary Team. All discrepancies will be brought to the Director of Nursing for further review and corrective action. Director of nursing will		

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F 550	Continued From page 3 Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated no cognitive impairment. The "MDS" specified the presence and frequency of wandering behavior was not exhibited. Review of R#10's "Care Plan", revealed a "Problem" onset date of 07/02/18, which indicated R #10 was at risk for leaving the facility unattended related to the resident wants to go to store/Walmart or across the "street" to smoke. The "Goal" documented R#10 would go to the store with staff. The approaches included: monitoring the resident for "tailgating" when visitors are in the building, key code on front lobby door, notify Social Services and Activities when resident requests to go to the store, staff will take resident to the store as requested, place picture in code purple book at desk, and visual monitoring every hour. Review of a "Wandering/Elopement Risk," assessment, dated 02/25/19, revealed R #10 was "above high risk for wandering/elopement." The assessment specified the resident was, "ambulatory or self-mobile in a w/c (wheelchair), cognitively impaired with poor decision-making skill, and/or diagnoses of Dementia with the resident making statements that they were leaving or seeking to find someone/something." Review of a "Wandering/Elopement Risk," assessment, dated 03/18/19, revealed, R #10 was at low risk for wandering/elopement, with no nursing action to prevent wandering was needed; however, interventions included visual monitoring, I.D (identification) Arm Band, Door Alarm/Code, and Activity Involvement were initiated. The assessment specified R #10 was ambulatory or	F 550	bring all discrepancies to Quality Assurance committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/19, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 550	Continued From page 4 self-mobile in a w/c, cognitively impaired with poor decision-making skill and/or diagnosis of dementia with the resident making statements that they were leaving or seeking to find someone/something. Alert but attempts to leave before the physician advises, opens doors to the outside and/or elopement attempted and the resident verbalizes wants freedom to go outside unsupervised. Observation and interview of R #10, on 04/05/19 at 12:16 PM, revealed, the resident had a pink arm band on his left wrist. When asked what the arm band was for, the resident stated nursing staff told him it was because he was a fall risk. The resident could not remember what specific nurse told him that, so he wanted to go ask again to make sure that was what he was told. R #10 was observed asking a nurse what the arm band was for. The nurse told the resident it was to let them know that he likes to go out the door. Continued observation revealed the resident asking the Maintenance Director for his knife to cut the arm band off. The Maintenance Director replied that he did not have a knife. Further observation revealed, the resident propelling back into his room where he pulled the arm band off and threw it in his trash can. During continued interview with the resident he stated, it was not what the nurses had originally told him, and it made him angry. R #10 stated, not being able to go out the facility's front doors frustrated him. The resident stated, he did not care if staff go with him outside, but he prefers to go independently. He stated, he knew there was a risk of falling while walking outside, but there was that same risk of falling while walking in the facility. R #10 stated he ambulated independently inside the facility and when on outings to Walmart, only using a cane.	F 550			

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F 550	Continued From page 5 The resident stated, "I just want to go walk outside, get fresh air, smoke a cigarette, and just to feel free and not locked up." The resident revealed he spent a lot of time during his life outside and to just sit up in a room, made him feel like he had lost his freedom, and that was something he was not used to. The resident stated he understood when he was first admitted to the facility, he was in no shape to walk independently, but the facility's physical therapy department worked with him and he was able to walk again. When asked if his felt his rights had been violated, the resident stated, that is a broad interpretation, but going by the resident rights posted at the facility, he did not think any one specific of those rights had been violated, but it was an inconvenience. Interview with Social Worker (SW) #90 on 04/05/19 at 12:37 PM, revealed R #10 did not have a guardian and was his own responsible party. SW #90 stated the resident did want to leave the facility. SW #90 stated the resident had control of his bank account and owed the facility money; however, even though he had the money in his checking account, he did not want to give the money up. She stated, the resident's "BIMS" score was 15, so he was fully intact cognitively. When asked if she thought R #10's rights had been violated, she stated, not in his case, because when he had been taken to Walmart, he had poor decision-making skills. SW #90 revealed one (1) poor decision the resident had made was when he had been taken to Walmart. He attempted to buy cigarettes and the Activity Director told him he could not buy them because they were tobacco free at the facility and resulted in the resident getting really mad. When asked if the resident had the right to discharge himself	F 550			

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F 550	Continued From page 6 from the facility, SW #90 stated, the resident had every right to discharge himself. During interview with the Activity Director (AD) on 04/05/19 at 1:27 PM, she recalled the incident where she took R #10 to Walmart and the resident wanted to buy cigarettes; however, she told the resident he could not buy them because it was a non-smoking facility. The AD revealed the resident then got really hostile towards her and she had to call the Administrator, who also said the resident could not buy them. The AD stated the resident was trying to purchase the cigarettes with his own money and the resident did have the right to buy them, but the facility did not want him to waste his money since he could not smoke them. The AD also stated she guessed his rights were violated. She stated the resident could go outside to the inner court yard, but he could not go outside the front doors. The AD revealed no resident of the facility can go out the front doors of the facility unless the family was with them. When asked if any residents of the facility ever went out of the facility alone, she stated, there was one (1) resident who calls a Taxi to take him places, such as getting a tattoo. Interview with Licensed Practical Nurse (LPN) #138 on 04/05/19 at 2:58 PM, revealed residents of the facility were not allowed to go outside to the front unless they had family with them or a staff person with them. She stated the facility was very strict on this policy Interview with the Administrator on 04/05/19 at 7:00 PM, revealed it was his expectation the Interdisciplinary Team (IDT) would meet the rights of the residents of the facility.	F 550			

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F 582	Continued From page 7	F 582			
F 582	Medicaid/Medicare Coverage/Liability Notice	F 582			5/24/19
SS=F	CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the				

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F 582	Continued From page 8 facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy statement review, the facility failed to provide the required, "Notice of Medicare Provider Non-Coverage (NOMNC) and/or "Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)" within a timely manner (48-hour notice of Medicare coverage ending) for three (3) of three (3) residents reviewed, Residents (R) #53, R #100, and R #261. Findings include: On 04/05/19 at 2:47 PM, the Administrator presented a facility policy statement, dated 04/04/19, confirming the facility had no policy regarding the "Advanced Beneficiary Notice", and that the facility follows the guidance of the Centers for Medicare and Medicaid Services (CMS). Resident #53 Review of R #53's NOMNC form, dated 03/15/19,	F 582	(1) For Residents #53, #100, and #261 nothing can be done (2)The facility determined that all residents receiving skilled care have the potential to be affected by the facility's failure to provide the required "Notice of Medicare Provider Non-Coverage and/or "Skilled Nursing Facility Advance Beneficiary Notice" (3)Social Services is responsible for making sure the "Notice of Medicare Provider Non-Coverage and/or Skilled Nursing Facility Advance Beneficiary Notice" is issued within 48 hours. An in-service was conducted on 4/15/19 by the Administrator with all Social Services staff to include that the Notice of Medicare Provider Non-Coverage and/or "Skilled Nursing Facility Advance Beneficiary Notice"		

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F 582	Continued From page 9 ending skilled services, indicated the notice was given to the Resident Representative and signed on 03/18/19. The notice was given three (3) days after the skilled services ended. 2. Review of R #100's NOMNC and SNF ABN forms, dated 03/07/19, ending skilled services, indicated the notices were given to the resident and signed on 03/07/19. The notice was given on the same day skilled services ended. 3. Review of R #261's NOMNC form, dated 10/12/18, ending skilled services, indicated the notice was given to the resident and signed on 10/12/18. The notice was given the same day skilled services ended. Resident #53, R #100, and R #261 were not provided with notices of at least 48 hours in advance of the resident's skilled services ending, per requirement. On 04/04/19 at 5:45 PM, an interview with Social Services Director (SSD) #2, indicated she was responsible for providing beneficiary notices to the residents whose skilled services were ending. She stated she was aware the notices had been provided on the same day or later. She stated this process was a learning experience for her and she now understood by providing the beneficiary notices on the same day or late, the facility was forfeiting the resident's right to appeal. On 04/04/19 at 6:00 PM, in an interview with the Administrator, regarding the beneficiary notices, he stated he was unaware residents were receiving their notices on the same day or late. He stated the company had a consultant whose expertise was in beneficiary notices and that	F 582	is to be provided within two days of the last anticipated covered day. (4)The Admission Social Worker began audits on 4/19/19 on all Notice of Medicare Provider Non-Coverage and/or "Skilled Nursing Facility Advance Beneficiary Notice" forms to ensure they are completed with in two days and turn the audits into the Quality Assurance Department weekly for review. The Quality Assurance Nurse will bring all discrepancies to the Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 582	Continued From page 10	F 582			
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		5/24/19	
SS=D	CFR(s): 483.10(i)(1)-(7)				
	§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 584	Continued From page 11 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, the facility failed to maintain the condition of a wheelchair for one (1) of 47 sampled residents, Resident (R) #47. Observations revealed the right arm of R #47's wheelchair was broken, with a jagged edge, which could result in injury to Resident #47's skin. Findings include: Review of the facility's policies revealed no policy related to maintaining resident equipment. On 04/05/19 at 5:45 PM, the facility presented a statement, on facility letterhead, that it was the facility's expectation that facility staff would remove any unsafe equipment and notify the Maintenance Director. On 04/01/19 at 9:00 AM, R #47 was observed in her wheelchair, outside the 300 Hall dining room. The right plastic arm rest on the wheelchair was broken and jagged. On 04/02/19 at 1:01 PM, R #47 was observed in her wheelchair on the 400 Hall; the right armrest of her wheelchair was broken, with a jagged edge. Review of R #47's "Face Sheet," revealed the facility admitted the resident on 07/27/13, with diagnoses which included Dementia, Parkinson's Disease, Depression, and Diabetes Mellitus (DM) type 2.	F 584	1)Resident # 47 s wheelchair was repaired on 4/2/19 by the Maintenance Director. Resident # 47 was assessed for injuries related to the broken wheelchair arm by the Assistant Director of Nursing on 4/2/19 and was found to have none. All wheelchairs in the facility were inspected for integrity on 4/2/2019 by the Interdisciplinary Team. Any chair with cracking or tearing present was removed from use immediately and replaced with a chair in good repair. 2)The facility has determined that all residents utilizing wheelchairs have the potential to be affected. 3)The Staff Development Coordinator initiated an in-service with all staff on 4/2/19 to include that any broken equipment is to be reported to the Maintenance Director immediately and should be moved to the back hall and tagged. 4)Maintenance Director began conducting preventative maintenance inspections of wheelchairs on 4/18/19 and will continue daily Monday through Friday for four weeks, then monthly. All discrepancies will be brought by Maintenance Director to Administrator. Administrator will bring all discrepancies		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 584	Continued From page 12 Review of R #47's quarterly "Minimum Data Set (MDS)", with an "Assessment Reference Date (ARD)" of 02/13/19, specified the resident had a "Brief Interview for Mental Status (BIMS)" score of 3 out of 15, which indicated severe cognitive impairment. The "MDS" specified the resident used a wheelchair for mobility. Interview with Certified Nursing Assistant (CNA) #112, on 04/02/19 at 1:01 PM, revealed she had reported the broken wheelchair arm to Maintenance and they stated it was fine, since it was not sharp; however, she did not remember when she reported it or whom she reported it to. At 1:55 PM, CNA #112 was asked where R #47's wheelchair was and she stated, "I had Maintenance to look at the resident's wheelchair again." Interview with the Maintenance Director, on 04/02/19 at 2:00 PM, revealed CNA #112 reported the wheelchair's broken arm rest to him today. He stated today was the first time it had been reported to the Maintenance Department. He stated as soon as he saw the wheelchair arm, he immediately repaired it, due to the wheelchair arm being broken, sharp, and jagged. The Maintenance Director stated the sharp, jagged, wheelchair arm could cause a skin tear to the resident. He stated, after reviewing his maintenance log book, it had never been reported to the Maintenance Department. Interview with the Administrator on 04/05/19 at 7:00 PM, revealed it was his expectation the resident's equipment would be in good repair. He stated the facility staff are in-serviced that everyone is to be looking around their surroundings to identify such issues. The	F 584	to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 584	Continued From page 13 Administrator stated there was a maintenance log book at each of the nurses' stations that staff were to complete for problems; however, if it was something that was a risk for the residents, they should assist the resident out of the equipment and notify Maintenance immediately.	F 584			
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on facility policy review, interview and record review, the facility failed to recognize and prevent abuse and neglect, and failed to immediately protect residents after allegations of abuse and neglect were reported to staff, for three (3) of 47 sampled residents, Residents (R) #55, R #157, and R #158. Two (2) allegations of verbal abuse and one (1) allegation of neglect were reported to staff, by cognitively intact residents. Certified Nursing Assistant (CNA) #143 was identified to be involved in one (1) allegation of verbal abuse on 1/30/19, and again in the	F 600	(1)Resident #55 was discharged from the facility on 3/21/19. Director of Care Transition spoke to the resident's daughter on 3/25/19 and 4/24/19 and they had no complaints about care. Certified Nursing Assistant # 143 is no longer employed at the facility. Licensed Practical Nurse #142 is no longer employed at the facility. Resident #158 was discharged from facility on 10/27/18. The Director of Care	5/24/19	

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F 600	Continued From page 14 allegation of neglect on 02/04/19. The neglect of Resident #55 rose to the harm level, when the resident voiced concerns about fear of retaliation. Resident #55: CNA #143 neglected to take the resident to the bathroom, per request, for four (4) hours on 02/04/19. This was reported to the staff on 02/04/19, by the resident. Director of Nursing (DON) #30 counseled the CNA and signed the section of the grievance form "Corrective Action Complete" on 02/06/19. (This was two (2) days after the event). CNA #143 continued to work. The resident voiced concerns about fear of retaliation for reporting the staff. Resident #158: Licensed Practical Nurse (LPN) #142 verbally abused the resident on 09/30/18, and the resident reported the abuse to staff on 10/01/18. DON #30 counseled the LPN and signed the section of the grievance form "Corrective Action Complete" on 10/03/18. (This was three (3) days after the alleged event). LPN #142 continued to work. Resident #157: CNA #143 verbally abused the resident on 01/30/19, which was reported to staff by the roommate on 01/30/19, and confirmed by Resident #157. DON #30 counseled the CNA and signed the section of the grievance form "Corrective Action Complete" on 02/03/19. (This was four (4) days after the alleged event). CNA #143 continued to work. Findings include: The facility "Abuse Policy," with an implemented date of 1/11/18, reads: Policy: It is the policy of this facility that abuse will be handled as follows: The facility will: -Prevent, identify, investigate and	F 600	Transition was unable to reach the resident or responsible party. Licensed Practical Nurse #142 is no longer employed at the facility. Resident #157 was discharged from the facility on 2/1/19. The Director of Care Transition spoke to the resident's responsible party on 2/1/19 had they had no complaints and was appreciative of care. Certified Nursing Assistant # 143 is no longer employed at the facility. Director of Nursing #30 is no longer employed at the facility. Social Worker #90 is no longer the Grievance Officer (2)Residents who report grievances have the potential to be affected by facility's failure to recognize and prevent abuse and neglect. (3)On 04/04/19, all grievances filed from 02/2018 until 04/06/19 were reviewed by Administrator, Risk Manager , Registered Nurse #12, Regional Nurse Consultant and Quality Assurance Nurse. No further allegations of abuse or neglect were identified. Beginning on 04/04/19 interviews were initiated for eighty-five interviewable residents and assessments were conducted for eighteen non interviewable residents regarding abuse and neglect. Interviews were conducted by four Social Workers and assessments were conducted by Medicare Nurse and Unit Manager and there were no new		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 15 report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property ... -Protect the resident during an abuse investigation ... Guidelines included: 3. Prevention... The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. b. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Any instances of abuse of any residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish, includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. c. Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability ...	F 600	allegations of abuse and neglect and Medical Director was notified of results. On 04/04/19, In-Services were conducted by Regional Nurse Consultant with the Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager , Quality Assurance Nurse, Medicare Nurse , two Minimum Data Set Nurses, and Social Worker on the Abuse Policy to include examples of abuse, reporting and investigating abuse. On 04/04/19 In-services were initiated with all staff by the Risk Manager and Staff Development Nurse on the Abuse and Neglect Policy. Examples of abuse and how to identify abuse were reviewed. Reviewed with staff that investigations were to start immediately following allegations. Reporting to the appropriate State Agencies immediately but no later than two hours if the violation involves abuse or results in serious bodily injury or twenty-four hours if alleged violation does not involve abuse and does not result in serious bodily injury. No staff will be allowed to work until in-serviced. (4)Beginning 4/17/19, staff will be asked in morning stand-up meeting daily Monday through Friday, by the Assistant Director of Nursing/Risk Manager, if they are aware of any allegations of Abuse and Neglect. This will be documented on the abuse and neglect audit form and investigated immediately by the Director		

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F 600	Continued From page 16 5. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response/ investigating as described below. 6. Protection: a. The facility will protect residents from harm during an investigation by: i. [sic] Suspending the accused employee until facility has conducted its own investigation and no evidence of abuse was found ... Procedure for Response, Reporting, Investigation Allegations of Abuse/Neglect/Exploitation... When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: Response ... c. Notify the Director of Nursing Services and Administrator ... f. Complete an initial report on Abuse/Neglect/Exploitation form and initiate an investigation. Reporting ... The complaint must be reported immediately to the Administrator, Director of Nursing, and the Nursing Supervisor on duty ... " Review of the facility's Grievance Log for the last six (6) months revealed 26 grievances that were documented. Review of each of the grievances revealed two (2) allegations of verbal abuse (for Resident #157 and Resident #158) and one (1) allegation of neglect (for Resident #55). The three (3) allegations were reviewed and discussed with the Risk Manager, DON #30, Social Worker (SW) #90 (who was also the Grievance Officer), and the Administrator. During the interviews, it was discovered that DON #30 and SW #90 did not follow the facility policy by failing to identify abuse	F 600	of Nursing and Assistant Director of Nursing/Risk Manager. Risk Manager will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 600	Continued From page 17 and neglect for the three (3) residents. DON #30 counseled the employees and allowed them to continue working. The DON did not thoroughly investigate the allegations, nor did she report the abuse and neglect to the Administrator and the State Agency. Resident #55 Review of R #55's Electronic Medical Record (EMR) revealed an undated "Face Sheet." The "Demographics" section indicated an admit date of 01/22/19. The "Diagnoses" section listed: Need for assistance with personal care, Muscle weakness, Chronic obstructive pulmonary disease (COPD), Parkinson's disease, and Mild cognitive impairment. Review of R #55's admission "MDS" with an "ARD" of 02/04/19, specified the resident had a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. R #55 did not exhibit any behavioral symptoms. R #55 required extensive assistance of one (1) staff member with bed mobility, transfers, toileting and personal hygiene. R #55 was frequently incontinent of bladder and occasionally incontinent of bowel. R #55 was discharged home on 03/21/19. Review of a "Grievance Investigation", dated 02/04/19 at 8:00 AM, Speech Language Pathologist (SLP) #3 documented, on either 02/03/19 and 02/04/19 at 3:00 AM, R #55 called for CNA #143 because she needed to go to the bathroom. CNA #143 came by and told the resident she was making rounds and she would get her when it was her turn. CNA #143 came back at 5:28 AM, (the buzzer went off at the desk) and asked her what she needed. R #55 told her she needed help going to the bathroom. CNA			F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 18 #143 came in to the resident's room and told her to roll over. The resident asked why. CNA #143 said she was going to change her pad. The resident asked why she was going to change her pad. R #55 said no, she needed help going to the bathroom. The CNA told her that the patients could not get up to go to the bathroom during the night. The resident said, "Then I will take myself." CNA #143 went out of the room mad and mouthing off complaints to the nurse, or whomever, and said the resident was refusing to cooperate. LPN #144 then came in and asked if she said she was going to walk to the bathroom herself. The resident said "No, I wouldn't do that." The resident sat on the edge of the bed, still LPN #144 nor CNA #143 helped her to the bathroom or helped her get her leg back in bed. The resident was finally able to pull her leg back into the bed to stretch out. No one helped her to the bathroom until the 7:00 AM shift came on. The resident was concerned for fear of retaliation. When the day shift came, she told the CNA, "My diaper will probably drag the floor, it was so full." The resident also said CNA #143 said they couldn't take her to the bathroom at night until therapy said they could. The resident said this had happened every night since she came, and they come in and expect her to use the pad. The section titled "Details of Investigation", revealed, "Spoke w/aide regarding this incident. Educated aide that residents should get up to the restroom anytime they need to go ..." This was signed by the DON. The DON signed the grievance form indicating the corrective actions were completed on 2/6/19, which was two (2) days after the alleged event. The CNA continued to work.	F 600			

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F 600	Continued From page 19 On 04/03/19 at 1:15 PM, DON #30 was given the "Grievance Investigation" for R #55 and was asked to classify the allegation. She stated, "I don't have a good answer." She looked at the policy again and stated, "According to the "definition", could be neglect." Resident #158 Review of R #158's EMR revealed an undated "Face Sheet." The "Demographics" section identified an admit date of 09/20/18. The "Diagnoses" section listed, Mild cognitive impairment, Type 2 diabetes, and Pain. Resident #158's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/03/18, specified the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment. R #158 did not exhibit any behavioral symptoms. R #158 required extensive assistance of one (1) staff member with activities of daily living (ADLs) for bed mobility, transfers, dressing, and toileting. The MDS specified R #158 had an ostomy bag. R #158 was discharged home on 10/27/18. A "Grievance Investigation" documented by SW #90, dated 10/01/18 at 9:20 AM, revealed, on 09/30/18 at 3:00 PM, R #158 stated she turned on the call light. She needed a nurse to look at her bag [colostomy] because she thought it was leaking. At the same time R #158 felt her blood sugar dropped. At 3:30 PM, LPN #142 came in and checked her blood sugar. It was 95. LPN #142 told the resident to eat a couple more M&Ms, but did not check the colostomy bag. LPN #142 told the resident she would return later. The resident was concerned about her bag. A friend of	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 20 R #158 called the facility and said that R #158 needed help. At 6:58 PM, LPN #142 returned to the room and yelled, "I told you I was coming back. Don't you ever call and tell someone I am not doing my job." The resident stated that the DON must have texted her. The section titled "Details of Investigation" revealed, "Spoke with employee regarding this and counseled with her on appropriate customer service. She will take someone with her from now on." This was signed by DON #30. The DON signed the corrective actions were completed on 10/3/18, this was three (3) days after the alleged event. On 10/10/18, no time indicated, SW #90 documented on the "Additional Comments," of the Grievance form, "BSW [Bachelor of Social Work] spoke w/[with] resident on 10/10/18, regarding nurse. Resident stated that at first she was a little disappointed to see the nurse back in her room ..." During an interview with DON #30 on 04/03/19 at 1:00 PM, she was asked if she could define abuse. She said she would need to look at the policy for the definition. DON #30 was given the "Grievance Investigation" and was asked to how should would classify R #158's allegation. She stated, it could have been "disparaging for the resident and it is verbal abuse." She was asked if the "Details of Investigation" she had documented addressed verbal abuse and if she had spoken with the resident regarding the allegation. She replied, the counseling provided to LPN did not include the situation was verbal abuse, because she had not recognized it as such. She confirmed she had not spoken to the resident about the	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2019
NAME OF PROVIDER OR SUPPLIER DESOTO HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671		
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F 600	Continued From page 21 incident to verify the information. She failed to provide protection to other residents. Resident #157 Review of R #157's EMR revealed an undated "Face Sheet" under the "Demographics" section with an admit date of 10/06/17, and a re-admit date of 11/01/18. The "Diagnoses" section listed: Acute upper respiratory infection, Muscle weakness, Alzheimer's disease, Unspecified dementia without behavioral disturbance, and Anxiety disorder. R #157's admission "MDS" with an "ARD" of 11/14/18, specified the resident had a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. R #157 did not exhibit any behavioral symptoms. R #157 required extensive assistance of two (2) staff members for transfers, dressing and toileting R #157 was frequently incontinent of bowel and bladder. R #157 was discharged home on 02/01/19. Review of a "Grievance Investigation", documented by SW #83 on 01/30/19 at 8:45 AM, revealed, on 01/30/19 at 4:00 AM, R #260 stated CNA #143 was very rude to his roommate (R #157) that morning. R #157 went to the bathroom and was going back to bed when CNA #143 came into the room. CNA #143 went to R #157's closet and got a pair of pants out and threw them on the bed. R #260 stated CNA #143 told R #157, "You will put these dam [sic] pants on." She then walked out of the room. SW #83 asked R #157 if his roommate's statement was true. R #157 said it was true, and he did not understand why he had to change his pants. The section titled "Details of Investigation" revealed, "Counseled w/[with] aide regarding incident, that this language is not acceptable at	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 600	Continued From page 22 all. Verbalized understanding and stated it will not happen again ...signed by DON #30. The DON signed the corrective actions were completed on 2/3/19, which was four (4) days after the alleged event. During interview on 04/03/19 at 1:08 PM, with DON #30, she was shown the "Grievance Investigation" for R #157 and was asked how she would classify the allegation. She stated, "It is verbal abuse." She stated she did not counsel the aide on verbal abuse because she had not considered it to be abuse, until she read the policy and definition of abuse. The DON stated the CNA was pulled from Resident #157's room and told not to go back to that room. She confirmed she had not talked with R #157 or R #260 about the allegation to verify the situation, and she had not provided protection to residents at the time of the allegation, because she did not investigate the allegation. Review of R #260's admission "MDS" with an "ARD" of 01/23/19, specified the resident's hearing was adequate and vision was adequate but wore corrective lenses. R #260 had a "BIMS" score of 13 out of 15, which indicated no cognitive impairment. R #260 did not exhibit any behavioral symptoms. R #260 was a resident at the time of the survey. During group interview on 04/03/19 at 10:00 AM, R #260 recalled the event with his old roommate, R #157. He stated, "The staff member was mean to him." During an interview on 04/03/19 at 2:11 PM, SW #90 stated she was also the Grievance Officer. SW #90 was asked what that entailed, and she	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 23 stated that she would take the grievance by talking with the resident and then take the grievance to the department in which the grievance was with. SW #90 added, she would follow up in a few days with the resident to see if everything had been worked out to their satisfaction. SW #90 was asked what she would do if she received any allegations of abuse or neglect. She stated she would take them to the Administrator and DON. She reviewed the three (3) allegations (for R #55, R #157, and R #158) and was asked what category she thought them to fall in. SW #90 stated, "Re-reading them now, "they are abuse and neglect." When asked why they appear that way now, SW #90 stated that she had received the others from DON #30, and was told they were worked through. SW #90 stated that she was aware they (grievances) had not been taken to the Administrator. She stated there was a discussion of grievance and allegations usually at the morning meeting. SW #90 stated she just did not catch it, that those had not been discussed. During an interview on 04/03/19 at 3:00 PM, the Administrator was shown the three (3) "Grievance Investigations" and asked how they appeared to him. The Administrator stated he thought they were abuse and neglect. He was asked if had seen them before. He stated, "No. I should have." He stated that DON #30 never showed those to him He stated the residents were no longer here.	F 600			
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		5/24/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 607	Continued From page 24 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of the facility's "Abuse Policy", the facility failed to implement their policy and procedures to protect residents from abuse and to thoroughly investigate and report allegations of abuse and neglect to the State Agencies for three (3) of 47 sampled residents, Resident (R) #55, R #157, and R #158. Two (2) allegations of verbal abuse and one (1) allegation of neglect were reported to staff, which rose to the harm level due to the Resident #55's fear of retaliation. Resident #55, a cognitively intact resident, was neglected by Certified Nursing Assistant (CNA) #143 (second incident) on 02/04/19, when the CNA failed to assist the resident to the bathroom over a four (4) hour period. R #55 reported the neglect to staff on 02/04/19. Corrective actions were not documented until 2/6/19. Resident #55 had concerns of fear of retaliation. Resident #158, a cognitively intact resident, was verbally abused by Licensed Practical Nurse (LPN) #142 on 09/30/18, and, reported it to staff on 10/01/18. Corrective actions for staff were not documented until 10/3/18. Resident #157, a cognitively intact resident, was	F 607	(1)Resident #55 was discharged from the facility on 3/21/19. Director of Care Transition spoke to the resident's daughter on 3/25/19 and 4/24/19 and they had no complaints about care. Certified Nursing Assistant # 143 is no longer employed at the facility. Licensed Practical Nurse #142 is no longer employed at the facility. Resident #158 was discharged from facility on 10/27/18. The Director of Care Transition was unable to reach the resident or responsible party. Licensed Practical Nurse #142 is no longer employed at the facility. Resident #157 was discharged from the facility on 2/1/19. The Director of Care Transition spoke to the resident's responsible party on 2/1/19 had they had no complaints and was appreciative of care. Certified Nursing Assistant # 143 is no longer employed at the facility. Director of Nursing #30 is no longer employed at the facility. Social Worker #90 is no longer the Grievance Officer		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 25 verbally abused by CNA #143 on 01/30/19. The resident's roommate reported the allegation to staff on 01/30/19, and the resident confirmed the allegation. Corrective actions for staff were not documented until 2/3/19. Interviews with Administrative staff confirmed the three (3) allegations were not thoroughly investigated, the staff involved in the allegations continued to work, and the allegations were not reported to the Administrator and to the appropriate State Agencies in accordance with the facility's policy. Findings include: The facility "Abuse Policy," with an implemented date of "1/11/18," read, "Policy: It is the policy of this facility that abuse will be handled as follows: The facility will: -Prevent, identify, investigate and report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property ... -Protect the resident during an abuse investigation ... Guidelines... 3. Prevention... The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional	F 607	(2)Residents who report grievances have the potential to be affected by facility's failure to implement policy and procedures to protect residents, recognize and prevent abuse and neglect. Beginning on 04/04/19, interviews were initiated for eighty-five interviewable residents and assessments were conducted for eighteen non interviewable residents regarding abuse and neglect. Interviews were conducted by four Social Workers and assessments were conducted by Medicare Nurse and Unit Manager and there were no new allegations of abuse and neglect and Medical Director was notified of results. (3)On 04/04/19, all grievances filed from 02/2018 until 04/06/19 were reviewed by Administrator, Risk Manager , Registered Nurse #12, Regional Nurse Consultant and Quality Assurance Nurse. No further allegations of abuse or neglect were identified. On 04/04/19 In-Services were conducted by Regional Nurse Consultant with the Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager , Quality Assurance Nurse, Medicare Nurse , two Minimum Data Set Nurses, and Social Worker on the Abuse Policy to include examples of abuse, reporting and investigating abuse. On 04/04/19, In-services were initiated with all staff by the Risk Manager and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 26 distress. b. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Any instances of abuse of any residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish, includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. c. Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability ... 5. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response/ investigating as described below. 6. Protection: a. The facility will protect residents from harm during an investigation by: i. [sic] Suspending the accused employee until facility has conducted its own investigation and no evidence of abuse was found ... Procedure for Response, Reporting, Investigation Allegations of Abuse/Neglect/Exploitation... When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: Response ... c. Notify the Director of Nursing Services and	F 607	Staff Development Nurse on the Abuse and Neglect Policy. Examples of abuse and how to identify abuse were reviewed. Reviewed with staff that investigations were to start immediately following allegations. Reporting to the appropriate State Agencies immediately but no later than two hours if the violation involves abuse or results in serious bodily injury or twenty-four hours if alleged violation does not involve abuse and does not result in serious bodily injury. No staff will be allowed to work until in-serviced. (4)Beginning 4/17/19, staff will be asked in morning stand-up meeting daily Monday through Friday by the Assistant Director of Nursing/Risk Manager, if they are aware of any allegations of abuse and neglect. This will be documented on the Abuse and Neglect audit form and investigated immediately by Director of Nursing and Assistant Director of Nursing/Risk Manager. Risk Manager will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 27 Administrator ... f. Complete an initial report on Abuse/Neglect/Exploitation form and initiate an investigation. Reporting ... The complaint must be reported immediately to the Administrator, Director of Nursing, and the Nursing Supervisor on duty. Initial report should be documented on the Initial Report on Abuse/Neglect/Exploitation Form by the person making the report, reviewed by the Nursing Supervisor on duty and turned into the Director of Nursing Services. Initial Report on Abuse/Neglect/Exploitation Forms will be kept in a red folder at each nurse's station. The report should include: 1. Name, address, telephone number of the person making the report. 2. Name and room number of the resident believed to be the victim of abuse, neglect, or exploitation. 3. All statements made by the resident. 4. Details of the incident to include: Observations, beliefs, date, time, place. 5. Name of all individuals believed to have knowledge of the incident. 6. Name of the individual believed to be responsible for the incident and their connection to the resident. The complaint must be reported to: The State Department of Health By phone within 24 hours of discovery, excluding Saturdays, Sundays, and Holidays In writing within 72 hours of discovery The Medicaid Fraud Control Unit (Attorney General) via AGO website Investigating Any report of abuse, neglect or exploitation will be investigated by Director of Nursing Services or	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 28 designee. Investigation shall include but is not limited to 1. Interviewing: a. The resident involved when appropriate b. Staff members i. working in that area at the time of the incident ii. suspected of abuse, neglect, or exploitation iii. who might have knowledge of the reported complaint c. Any visitor or family member who might have knowledge of the incident 2. Documenting interviews ..." Review of the "Abuse Policy" indicated that the Administrator and Director of Nursing (DON) were to be contacted immediately and a thorough investigation to include interviews from residents, staff, and witnesses were to be included in the investigation. Through review of 26 grievances, two (2) grievances alleged verbal abuse (Resident #157 and #158) and one (1) grievance alleged neglect (Resident #55). Interviews were conducted with staff, which confirmed the grievances were not thoroughly investigated and reported in accordance with the facility policy. The facility policy for reporting had not been updated to include current timeline requirements for reporting to the State. Resident #55 Review of R #55's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on 01/22/19. The resident was cognitively intact, with a BIMS of 15, and required extensive assistance of one (1) staff member for bed mobility, transfers, toileting, and personal hygiene. R #55 was frequently incontinent of	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 29 bladder and occasionally incontinent of bowel. Review of a "Grievance Investigation", dated 02/04/19 at 8:00 AM, revealed Speech Language Pathologist (SLP) #3 documented, on either 02/03/19 and 02/04/19 at 3:00 AM, R #55 called for CNA #143 because she needed to go to the bathroom. CNA #143 came by and told the resident she was making rounds and she would get her when it was her turn. CNA #143 came back at 5:28 AM, (2 ½ hours later) and asked her what she needed. R #55 told her she needed help going to the bathroom. CNA #143 told R #55 to roll over, so she could change her pad. R #55 said no, she needed help going to the bathroom. The CNA told her that the patients could not get up to go to the bathroom during the night. The resident said, "Then I will take myself." CNA #143 went out of the room mad and mouthing off complaints to the nurse and said the resident was refusing to cooperate. LPN #144 then came in and asked if she said she was going to walk to the bathroom herself. The resident said "No, I wouldn't do that." The resident sat on the edge of the bed, still LPN #144 nor CNA #143 helped her to the bathroom or helped her get her leg back in bed. The resident was finally able to pull her leg back into the bed to stretch out. No one helped her to the bathroom until the 7:00 AM shift came on (4 hours after the resident had requested to go to the bathroom). The resident was concerned for fear of retaliation. When the day shift came, she told the CNA, "My diaper will probably drag the floor, it was so full." The resident also reported that CNA #143 said they couldn't take her to the bathroom at night until therapy said they could. The resident said this had happened every night since she came, and they come in and expected her to use the pad.	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 30 The section titled "Details of Investigation" revealed, "Spoke w/aide regarding this incident. Educated aide that residents should get up to the restroom anytime they need to go ..." This was signed by the DON. The DON documented the corrective actions were completed on 2/6/19, which was two (2) days after the allegation. Staff continued to work during this time. This was the second allegation against CNA #143. Interview with SW #90 on 04/03/19 at 2:11 PM, revealed she was the Grievance Officer for the facility. SW #90 was shown the grievance for R #55 and was asked how she would classify the allegation. She stated, "Re-reading it now, it is neglect." She was asked if the allegation had been investigated. She stated she gave the grievance to DON #30 and she had given it back to her and told her it was worked through. She stated they had not caught this grievance in the morning meeting. During an interview with DON #30 on 04/03/19 at 1:00 PM, DON #30 was asked if she had investigated the allegation. She stated she talked with CNA #143 and told her residents should get up to the bathroom whenever they needed to. She was asked if she had done any further investigation, she stated she had not. Interview with the Administrator on 04/03/19 at 3:00 PM, revealed he had never seen the grievance for R #55. He confirmed the allegation had not been investigated and reported to himself or to the Mississippi State Department of Health. Resident #158 Review of R #158's electronic medical record	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607	Continued From page 31 (EMR) revealed the resident was admitted to the facility on 09/20/18. The resident was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #158 required extensive assistance of one (1) staff member for bed mobility, transfers, dressing, and toileting. The resident had a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall to bypass a damaged part of the colon.) R #158 was discharged home on 10/27/18. A "Grievance Investigation", documented by SW #90, dated 10/01/18 at 9:20 AM, revealed, on 09/30/18 at 3:00 PM, R #158 stated she turned on the call light. She needed a nurse to look at her bag [colostomy] because she thought it was leaking. At 3:30 PM, Licensed Practical Nurse (LPN) #142 came in and checked her blood sugar. It was 95. LPN #142 told the resident to eat a couple more M&Ms, but, did not check the colostomy bag. LPN #142 told her she would return later. The resident was concerned about her bag. A friend of R #158 called the facility and said that R #158 needed help. At 6:58 PM, LPN #142 returned to the room and yelled, "I told you I was coming back. Don't you ever call and tell someone I am not doing my job." The section titled "Details of Investigation" revealed, "Spoke with employee regarding this and counseled with her on appropriate customer service. She will take someone with her from now on." This was signed by DON #30. The corrective actions were documented 10/3/18, which was four (4) days after the allegation. LPN #142 continued to work during this time.	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER DESOTO HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671		
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F 607	Continued From page 32 On 10/10/18, no time indicated, SW #90 documented on the "Additional Comments," "BSW [Bachelor of Social Work] spoke w/[with] resident on 10/10/18, regarding nurse. Resident stated that at first she was a little disappointed to see the nurse back in her room ..." Interview with SW #90 on 04/03/19 at 2:11 PM, revealed she was the Grievance Officer for the facility. SW #90 stated when a resident had a grievance she would speak with the resident to gather the information and then she would take the grievance to the department in which the grievance was with. She stated she would follow up with the resident in a few days to see if everything had worked out to the resident's satisfaction. SW #90 was shown the grievance for R #158 and was asked how she would classify the allegation. She stated, "Re-reading it now, it is abuse." She was asked if the allegation had been investigated. She stated, she gave the grievance to DON #30 and she had given it back to her and was told it was worked through. She stated they have a morning meeting, in which they discuss grievances and allegations, but she did not catch that this grievance had not been discussed. During an interview with DON #30 on 04/03/19 at 1:00 PM, DON #30 was asked if she had investigated the allegation. She stated she talked with LPN #2 about customer service and had told her to take another staff member in the room with her in the future. DON #30 stated she had not done any further investigation related to the grievance and the resident was no longer in the facility. Interview with the Administrator on 04/03/19 at 3:00 PM, revealed he had never seen the	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 607	Continued From page 33 grievance for R #158. He confirmed the allegation had not been investigated and reported to himself or to the Mississippi State Department of Health. Resident #157 Review of R #157's EMR revealed the resident was admitted to the facility on 10/06/17, with a re-admission date of 11/01/18. The resident was cognitively intact, with a BIMS of 15, and required extensive assistance of two (2) staff members for transfers, dressing, and toileting. R #157 was frequently incontinent of bowel and bladder. R #157 was discharged home on 02/01/19. Review of a "Grievance Investigation", documented by SW #83 on 01/30/19 at 8:45 AM, revealed, on 01/30/19 at 4:00 AM, R #260 [R #157's roommate] stated Certified Nursing Assistant (CNA) #143 was very rude to his roommate (R #157) that morning. R #157 went to the bathroom and was going back to bed when CNA #143 came into the room. CNA #143 went to R #157's closet and got a pair of pants out and threw them on the bed. R #260 stated CNA #143 told R #157, "You will put these dam [sic] pants on." She then walked out of the room. SW #83 asked R #157 if his roommate's statement was true. R #157 said it was true, and he did not understand why he had to change his pants. The section titled "Details of Investigation" revealed, "Counseled w/[with] aide regarding incident, that this language is not acceptable at all. Verbalized understanding and stated it will not happen again ...signed by DON #30. The DON documented the corrective actions were completed on 2/3/19, which was four (4) days after the allegation. Staff continued to work during this time.	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 607	Continued From page 34 Review of R #260's EMR revealed he was admitted to the facility on 12/21/19, and had a re-admission date of 01/10/19. The resident was cognitively intact, with a BIMS of 13. During group interview on 04/03/19 at 10:00 AM, R #260 recalled the event with his old roommate, R #157. He stated, "The staff member was mean to him." Interview with SW #90 on 04/03/19 at 2:11 PM, revealed she was the Grievance Officer for the facility. SW #90 was shown the grievance for R #157 and was asked how she would classify the allegation. She stated, "Re-reading it now, it is abuse." She was asked if the allegation had been investigated. She stated she gave the grievance to DON #30 and she had given it back to her and was told it was worked through. She stated, they have a morning meeting, in which they discuss grievances and allegations, but she did not catch that this grievance had not been discussed. During an interview with DON #30 on 04/03/19 at 1:00 PM, DON #30 was asked if she had investigated the allegation. She stated she talked with CNA #143 about inappropriate language. She was asked if she had done any further investigation, she stated she had not. Interview with the Administrator on 04/03/19 at 3:00 PM, revealed he had never seen the grievance for R #157. He confirmed the allegation had not been investigated and reported to himself or to the Mississippi State Department of Health. During an interview, on 04/03/19 at 12:40 PM, the	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 607	Continued From page 35 Risk Manager was asked what the procedure was if there was an allegation of abuse or neglect. She stated that the Administrator and DON had to be notified immediately. The Risk Manager went on to say that a full investigation would have to be conducted. First, make sure that the resident is okay and safe, the employee must leave the resident, and it should be reported to the DON and Administrator. She stated the incident is reviewed and "call the State within 24 hours." The Risk Manager was shown the three (3) allegations (for Resident #55, Resident #157, and Resident #158), and was asked if she had any knowledge of the incidents. She stated she had no knowledge of the incidents. She stated that the incidents were either verbal abuse or neglect. She stated that two (2) of them occurred after January 2019, when she took over investigations, and she should have been made aware of them. During an interview on 04/03/19 at 1:00 PM, DON #30 was asked what was to happen if an allegation of abuse or neglect is made. She said that she was usually called, or texted if not in the building, and that it should be reported to the Administrator. DON #30 was asked how to proceed once it was reported to the Administrator. She stated that it was to be thoroughly investigated and then a call made to the State within 24 hours. DON #30 was asked what took place when the Administrator was made aware of the allegations. DON #30 stated, "These did not go to the Administrator." DON #30 was asked if that was per policy, she stated, "No." During an interview on 04/03/19 at 3:00 PM, the Administrator was asked what the policy stated about reporting allegations of abuse and neglect. He stated, when they came in they were to be	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 607	Continued From page 36 brought to his attention immediately. Then they were to investigate and report to the State within 24 hours. He stated that DON #30 never showed the three (3) allegations to him and they should have been thoroughly investigated at the time they occurred. He stated now it's too late. Those residents are no longer here.	F 607			
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		5/24/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 609	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on facility policy review, interviews, and review of facility investigations related to abuse, neglect, and misappropriation of resident property, the facility failed to report the allegations to the Administrator and/or the State Agency within two (2) hours. Facility staff were aware of allegations of abuse and neglect of seven (7) of 47 sampled residents. Residents (R) R #6, R #17, R #24, R #29, R #55, R #157, and R #158. Specifically, R #6 and R #24 were involved in a resident to resident incident with one another, and R #17 and R #29 were involved in resident to resident altercation with one another. R #157 and R #158 alleged verbal abuse from staff, and R #55 alleged neglect. In addition, the facility identified and investigated potential medication diversion/misappropriation for Resident #32 and Resident #73 on 2/15/19, by LPN #141, Nine (9) other residents were identified for possible misappropriation during the facility investigation, which included R #68, R #160, R #161, R #163, R #165, R #166, R #167, R #168, and R #169. The facility thoroughly investigated and provided corrective measures, however, the facility failed to report the allegation to the State Agency. Findings include: The facility "Abuse Policy," with an implemented date of "1/11/18," read, "Policy: It is the policy of this facility that abuse will be handled as follows: The facility will: -Prevent, identify, investigate and report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown	F 609	1)For Resident #158: The allegation of abuse was reported to the Administrator and Attorney General on 4/4/19 and the State Department of Health on 04/05/19 by Director of Nursing #30. For Resident #157: The allegation of abuse was reported to the Administrator and Attorney General on 4/4/19 and the State Department of Health on 04/05/19 by Director of Nursing #30. For Resident #55 The allegation of abuse was reported to the Administrator, Attorney General and the State Department of Health on 04/05/19 by the Risk Manager. For Resident # 17 and Resident #29, Resident's were immediately separated. Resident #17 was placed on every one hour visual monitoring and was transferred to a geriatric psychiatric facility for evaluation and treatment as ordered by the Provider. For Resident #6 and Resident #24, Resident's were immediately separated. Both residents were placed on every one hour visual monitoring and Resident #24 was transferred to a geriatric psychiatric facility for evaluation and treatment as ordered the Provider. For Resident R #32, R #73, R #68, R #160, R #161, R #163, R #165, R #166, R #167, R #168, and R #169 on 4/5/19 the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 609	Continued From page 38 sources and misappropriation of resident property ... -Protect the resident during an abuse investigation ... Guidelines ... 5. ...Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response/investigating as described below. The complaint must be reported to The State Department of Health by phone within 24 hours of discovery, excluding Saturday, Sundays, and Holidays. In writing within 72 hours of discovery." Review of grievances, facility investigations, and interviews revealed the facility had not reported allegations of abuse, neglect, resident to resident altercations, and misappropriation of property to the State Agency within two (2) hours and/or 24 hours, and the facility policy was not updated to meet current regulatory requirements. 1. Resident #158, a cognitively intact resident, alleged she was verbally abused by Licensed Practical Nurse (LPN) #142 on 09/30/18, and reported it to staff on 10/01/18. The allegation involved LPN #142 making the statement, " "I told you I was coming back. Don't you ever call and tell someone I am not doing my job." 2. Resident #157, a cognitively intact resident, alleged he was verbally abused by Certified Nursing Assistant (CNA) #143 on 01/30/19. The resident's roommate reported the allegation to staff on 01/30/19, and the resident confirmed the allegation. The allegation involved CNA #143 went to R #157's closet and got a pair of pants out and threw them on the bed. R #260 stated	F 609	allegation of medication diversion was reported to the State Department of Health on 4/5/19. Director of Nursing #30 is no longer employed at the facility. (2)Residents who report grievances or receive narcotic analgesics have the potential to be affected by the facility's failure to report allegations of abuse and neglect to the Administrator and/or State Agency. (3) On 04/04/19, all grievances filed from 02/2018 until 04/06/19 were reviewed by Registered Nurse #12, Regional Nurse Consultant and Quality Assurance Nurse. No further allegations of abuse or neglect were identified. On 02/15/19, Audits of all Narcotic Records was completed by Quality Assurance Nurse and Risk Manager . No further signs of potential drug diversion or misappropriation of property were identified. On 4/4/19, the Abuse and Neglect Policy was updated by the Quality Assurance Committee to include the time frame when alleged violations are to be reported. On 04/04/19, In-Services were conducted by Regional Nurse Consultant Registered Nurse with the Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager Registered Nurse, Quality Assurance Nurse, Medicare Nurse		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 39 CNA #143 told R #157, "You will put these dam [sic] pants on." 3. Resident #55, a cognitively intact resident, alleged she was neglected by CNA #143 on 02/04/19, when CNA #143 failed to assist the resident to the bathroom, per her request, over a four (4) hour period. R #55 reported the neglect to staff on 02/04/19. During an interview with DON #30 on 04/03/19 at 1:00 PM, she confirmed the allegations for Residents # 158, #157 and Resident #55 had not been reported to the State Agency. Interview with the Administrator on 04/03/19 at 3:00 PM, revealed he had never seen the grievances for Resident #158, #157, and R #55. He confirmed the allegation had not been reported to himself or to the State Agency. Resident #29/Resident #17 4. Review of an "Accident/Incident Skin Tear/Bruise/Injury Report & Investigation," dated 09/11/08 at 6:50 PM, revealed, R #29 stated, "He was in his wc [wheelchair] on the way up to the nursing station and R #17 [named resident] charged after him by ramming his wheelchair into his lower extremities hurting [right] stump and verbally abusing him." A "Facility Investigation Report for Resident Abuse/Neglect/Exploitation," related to the incident on 9/11/18, was dated 09/12/18 at 10:00 AM. The documentation revealed, the facility investigated the incident and implemented corrective actions; however, the incident was not verbally reported to the State Agency until 1:56 PM on 09/12/18, not within the required two	F 609	Registered Nurse, two Minimum Data Set Nurses, and Social Worker on the Abuse Policy to include examples of abuse, reporting and investigating abuse. (4)Beginning 4/17/19, staff will be asked in morning stand-up meeting daily Monday through Friday by the Assistant Director of Nursing/Risk Manager if they are aware of any allegations of abuse and neglect. This will be documented on the Abuse and Neglect audit form and investigated immediately. Risk Manager will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the QA Committee as the need arises.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 40 (2)-hour timeframe for reporting. Resident #6/Resident #24 5. Review of the facility's investigation regarding a resident to resident abuse allegation between R #6 and R #24, indicated the allegation was first identified and reported to have occurred on 02/19/19 at 12:50 PM. The facility started the investigation and reported to the State Agency on 02/22/19 at 9:45 AM, according to the fax receipt provided by the State Agency as verification. Interview with Director of Nursing (DON) #30 on 04/02/19, during general interviews regarding abuse and neglect protocols, she stated, the reason why the resident to resident abuse allegation was not called to the State Agency within two (2) hours was because the facility was under the impression they had 24 hours to call them in. The facility policy review also stated, 24 hours. She stated they were unaware the regulation stated within two (2) hours. Resident #32 and Resident #73 6. On 02/15/19, the Quality Assurance Nurse and the Risk Manager RN, conducted audits of medication carts and narcotic records on the skilled nursing unit where RN #141 was assigned to work. The audits resulted in suspected misappropriation of medications for Resident #32 and R #73. The audit revealed Registered Nurse (RN) #141 had signed out nine (9) doses of Oxycodone 5/325 milligram (mg) tablets from Resident #32's narcotic record from 02/01/19 - 02/12/19. Resident #32 did not normally receive the prn medication, or complain of pain, or exhibit signs and symptoms of pain. One dose of Oxycodone 5/325 mg had been administered to Resident #32 during February by another nurse.	F 609			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 41 For Resident #73, Registered Nurse #141 had documented on 02/08/19, that there was a hole in the back of the Ambien card and wasted the medication. Resident #73 was administered the Ambien on 02/08/19 at 11:00 PM. On 02/15/19, Registered Nurse #141 was immediately suspended by the Administrator and sent for a Urine Drug Screen, which was negative. The Board of Nursing, Attorney General's office, and Board of Pharmacy were notified on 2/15/19. The residents included in the facility's audit were: R #32, R #73, R #68, R #160, R #161, R #163, R #165, R #166, R #167, R #168, and R #169. At the time of the survey, R #32 and R #73 remained in the facility. The "Medication Administration Records (MARs)" of the 11 residents were reviewed and revealed the facility had conducted a thorough investigation of the suspected drug diversion and had taken appropriate corrective actions based on their investigation. However, the facility failed to report the suspected drug diversion to the State Agency as required. On 04/03/19 at 1:00 PM, interview with DON #30 confirmed she had not reported the allegations of possible drug diversion to the State Agency.	F 609			
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		5/24/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 42 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, interview and record review, the facility failed to thoroughly investigate and report to the State Agency allegations of abuse and neglect for three (3) of 47 sampled residents, Residents (R) #55, R #157, and R #158). Two (2) allegations of verbal abuse and one (1) allegation of neglect were reported to staff. On 02/04/19, R #55, a cognitively intact resident, reported to staff that CNA #143 neglected to take her to the bathroom, per her request, over a four (4) hour period, on 02/04/19, and that she feared retaliation. On 10/01/18, R #158, a cognitively intact resident, reported to staff that she was verbally abused by Licensed Practical Nurse (LPN) #142 on 09/30/18. On 01/30/19, the roommate of R #157, reported to staff that Certified Nursing Assistant (CNA) #143 verbally abused R #157. Resident #157, a cognitively intact resident, confirmed the allegation. Resident #55 was concerned about repercussions, which rose to a harm level deficiency. Findings include: The facility "Abuse Policy," with an implemented	F 610	(1)Resident #55 was discharged from the facility on 3/21/19. Director of Care Transition spoke to the resident's daughter on 3/25/19 and 4/24/19 and they had no complaints about care. Certified Nursing Assistant # 143 is no longer employed at the facility. Licensed Practical Nurse #142 is no longer employed at the facility. The allegation of abuse was reported to the Attorney General and the State Department of Health on 04/05/19 by the Risk Manager. Resident #158 was discharged from facility on 10/27/18. The Director of Care Transition was unable to reach the resident or responsible party. Licensed Practical Nurse #142 is no longer employed at the facility. The allegation of abuse was reported to Attorney General on 4/4/19 and the State Department of Health on 04/05/19 by Director of Nursing #30. Resident #157 was discharged from the facility on 2/1/19. The Director of Care		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 610	Continued From page 43 date of "1/11/18," read, "Policy: It is the policy of this facility that abuse will be handled as follows: The facility will: -Prevent, identify, investigate and report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property ... -Protect the resident during an abuse investigation ... Guidelines... 3. Prevention... The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. b. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Any instances of abuse of any residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish, includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. c. Verbal Abuse means the use of oral, written or gestured language that willfully includes	F 610	Transition spoke to the resident's responsible party on 2/1/19 had they had no complaints and was appreciative of care. Certified Nursing Assistant # 143 is no longer employed at the facility. The allegation of abuse was reported to the Attorney General on 4/4/19 and the State Department of Health on 04/05/19 by Director of Nursing #30. Director of Nursing #30 is no longer employed at the facility. (2)Residents who report grievances have the potential to be affected by failure to thoroughly investigate and report to the State Agency allegations of abuse and neglect. (3)On 04/04/19, all grievances filed from 02/2018 until 04/06/19 were reviewed by Administrator, Risk Manager , Registered Nurse#12, Regional Nurse Consultant and Quality Assurance Nurse. No further allegations of abuse or neglect were identified. Beginning on 04/04/19, interviews were initiated for eighty-five interviewable residents and assessments were conducted for eighteen non interviewable residents regarding abuse and neglect. Interviews were conducted by four Social Workers and assessments were conducted by Medicare Nurse and Unit Manager and there were no new allegations of abuse and neglect and Medical Director was notified of results.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 44 disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability ... 5. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response/ investigating as described below ... Investigating Any report of abuse, neglect or exploitation will be investigated by Director of Nursing Services or designee. Investigation shall include but is not limited to 1. Interviewing: a. The resident involved when appropriate b. Staff members i. working in that area at the time of the incident ii. suspected of abuse, neglect, or exploitation iii. who might have knowledge of the reported complaint c. Any visitor or family member who might have knowledge of the incident 2. Documenting interviews ..." The facility's "Grievance Log" for the last six (6) months revealed two (2) allegations of verbal abuse, and one (1) allegation of neglect which had been reported to staff. Review of the three (3) grievances and interviews with staff confirmed the facility did not thoroughly investigate the allegations, protect the residents, or report them to the State Agency. Resident #55 Review of a "Grievance Investigation" form, dated 02/04/19 at 8:00 AM, revealed Speech Language Pathologist (SLP) #3 completed the form when R #55 reported to her she had been neglected from	F 610	On 04/04/19, In-Services were conducted by Regional Nurse Consultant with the Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager , Quality Assurance Nurse, Medicare Nurse , two Minimum Data Set Nurses, and Social Worker on the Abuse Policy to include examples of abuse, reporting and investigating abuse. On 04/04/19, In-services were initiated with all staff by the Risk Manager and Staff Development Nurse on the Abuse and Neglect Policy. Examples of abuse and how to identify abuse were reviewed. Reviewed with staff that investigations were to start immediately following allegations. Reporting to the appropriate State Agencies immediately but no later than two hours if the violation involves abuse or results in serious bodily injury or twenty-four hours if alleged violation does not involve abuse and does not result in serious bodily injury. No staff will be allowed to work until in-serviced. (4)Beginning 4/17/19, staff will be asked in morning stand-up meeting daily Monday through Friday if they are aware of any allegations of abuse and neglect. This will be documented on the abuse and neglect audit form and investigated immediately. Risk Manager will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 45 3:00 AM until 7:00 AM that morning, when CNA #143 would not take her to the bathroom at her request. (This was the second incident that involved CNA #143). She also reported that the LPN came into the room and also didn't take her to the bathroom during that time. Resident #55 was concerned about retaliation. The "Details of the Investigation" section of the form revealed, Director of Nursing (DON) #30 documented, "Spoke w/aide regarding this incident. Educated aide that residents should get up to the restroom anytime they need to go ..." The "Corrective Action Complete" section of the form, was dated 02/06/19, and was signed by DON #30. This was two (2) days after the grievance was reported to SLP #3. CNA #143 continued to work. Resident #55's admission "MDS" with an "ARD" of 02/04/19, specified the resident had a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. R #55 did not exhibit any behavioral symptoms. R #55 required extensive assistance of one (1) staff member with most ADLs and was independent with set up assistance only with eating. R #55 was frequently incontinent of bladder and occasionally incontinent of bowel. Incidents that did not rise to harm level: Resident #158: Review of a "Grievance Investigation" form, dated 10/01/18 at 9:20 AM, revealed Social Worker (SW) #90 completed the form when R #158 reported to her she was verbally abused by LPN #142 on 09/30/18. R #158 stated LPN #142 came into her room and yelled, "I told you I was coming	F 610	The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 46 back. Don't you ever call and tell someone I am not doing my job." This was due to Resident #158 had asked for her colostomy bag to be checked on 9/30/18, around 3:30 PM, and the LPN informed the resident she would be back later. The LPN returned at 6:58 PM, over three (3) hours after the request. The "Details of the Investigation" section of the form revealed, Director of Nursing (DON) #30 documented, "Spoke with employee regarding this and counseled with her on appropriate customer service. She will take someone with her from now on." The "Corrective Action Complete" section of the form, was dated 10/03/18, and was signed by DON #30. This was two (2) days after the grievance was reported to SW #90, and the LPN continued to work. Resident #158's admission "Minimum Data Set (MDS)", with an "Assessment Reference Date (ARD)" of 10/03/18, specified the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated no cognitive impairment. R #158 did not exhibit any behavioral symptoms. R #158 required extensive assistance of one (1) staff member with most activities of daily living (ADLs) and supervision of one (1) staff member with eating. R #158 had an ostomy bag. Resident #157 Review of a "Grievance Investigation" form, dated 01/30/19 at 8:45 AM, revealed SW #83 completed the form when R #260 reported to her that Certified Nursing Assistant (CNA) #143 was very rude to his roommate (R #157) at 4:00 AM that morning. R #260 stated, CNA #143 told R #157, "You will put these dam [sic] pants on." She then walked out of the room. SW #83 asked R	F 610			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 47 #157 if his roommate's statement was true. R #157 said it was true, and he did not understand why he had to change his pants, because they were not wet. The "Details of the Investigation" section of the form revealed, Director of Nursing (DON) #30 documented, "Counseled w/[with] aide regarding incident, that this language is not acceptable at all. Verbalized understanding and stated it will not happen again. Aide was pulled from room immediately upon notification and will not go back in the room." The "Corrective Action Complete" section of the form, was dated 02/03/19, and was signed by DON #30. This was four (4) days after the grievance was reported to SW #83, and the CNA was allowed to continue work. Resident #157's admission "MDS" with an "ARD" of 11/14/18, specified the resident had a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. R #157 did not exhibit any behavioral symptoms. R #157 required extensive assistance of one (1) staff member with most ADLs and was independent with set up assistance only with eating. R #157 was frequently incontinent of bowel and bladder. Review of R #260's "MDS" with an "ARD" of 01/23/19, documented a "BIMS" score of 13 out of 15, which indicated no cognitive impairment. R #260 did not exhibit any behavioral symptoms. During group interview on 04/03/19 at 10:00 AM, R #260 recalled the event with his old roommate, R #157. He stated, "The staff member was mean to him." During an interview, on 04/03/19 at 12:40 PM, the	F 610			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 48 Risk Manager was asked what the procedure was if there was an allegation of abuse or neglect. She stated that the Administrator and DON had to be notified immediately. Then, based on what they came up with, they would notify her. The Risk Manager went on to say that a full investigation would have to be conducted. First, make sure that the resident is okay and safe, the employee must leave the resident, and it should be reported to the DON and Administrator. The incident is reviewed and "call the State within 24 hours." The Risk Manager was shown the three (3) allegations (for Resident #55, #157, and #158) and was asked if she had any knowledge of the incidents. She stated she had no knowledge of the incidents. She stated that the incidents were either verbal abuse or neglect. She stated that two (2) of them occurred after January 2019, when she took over investigations, and she should have been made aware of them. During an interview on 04/03/19 at 1:00 PM, DON #30 was asked what was to happen if an allegation of abuse or neglect is made. She said that she was usually called or texted, if not in the building, and that it should be reported to the Administrator. DON #30 was asked how to proceed once it was reported to the Administrator. She stated that it was to be thoroughly investigated and then a call made to the State within 24 hours. She was asked if there was additional documentation related to the investigation of the three (3) allegations (for Residents #55, #157, and #158). She stated, there was no other documentation. She was asked if she had completed a thorough investigation based on the facility policy. She confirmed she had not thoroughly investigated the allegations because she had not considered	F 610		

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F 610	Continued From page 49 them as verbal abuse or neglect at the time. DON #30 was asked what took place when the Administrator was made aware of the allegations. She stated, "These did not go to the Administrator." When asked if that was per policy, she stated, "No." During an interview on 04/03/19 at 3:00 PM, the Administrator was shown the three (3) allegations (for Residents #55, #157, and #158) and asked how they appeared to him. The Administrator stated that he thought they were abuse and neglect. He was asked if he had seen them before. He stated, "No. I should have." He stated that DON #30 never showed those to him and they should have been thoroughly investigated at the time they occurred. He stated now it's too late, because those residents are no longer here.	F 610			
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 policy review, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment, for one (1) of 47 sampled residents reviewed for MDS assessments, Resident (R) #36. This deficient practice had the potential to affect the identification and provision of care needs of residents. Findings include: Review of facility policies revealed no policy	F 641	(1) For Resident # 36 a correction assessment was completed by the Minimum Data Set Nurse on 4/08/19 and accepted on 4/10/19. (2) All residents have the potential to be affected by facility's failure to ensure the accuracy of the Minimum Data Set (MDS) assessment. (3) Beginning on 4/17/19, the Interdisciplinary Team, to include	5/24/19	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 641	Continued From page 50 related to the accuracy of "MDS" assessments. On 04/05/19 at 4:00 PM, the facility presented, on facility letterhead, expectations for the MDS to be accurately coded as outlined in the "Resident Assessment Instrument" (RAI) manual. Review of the "MDS" with an "Assessment Reference Date (ARD)" of 11/14/18, for R #36, revealed a significant change when the resident was placed on Hospice care. The following quarterly "MDS" did not indicate the Hospice care. Family interview and staff interview revealed the resident was still receiving Hospice care. Review of R #36's Electronic Medical Record (EMR) revealed an undated "Face Sheet." The "Demographics" section indicated an admit date of 03/30/17. The "Diagnoses" section listed, Anemia, Hypertension, Anorexia, Pain, Muscle weakness, and a History of falling. Review of the "Physician Orders" in the EMR, revealed a verbal order dated 11/14/18, to admit R #36 to Hospice care. Review of R #36's significant change "MDS" with an "ARD" of 11/14/18, specified the resident received Hospice care. Review of R #36's quarterly "MDS" with an "ARD" of 02/02/19, revealed it did not specify the resident received Hospice care. During an interview on 04/02/19 at 2:18 PM, Family (F) #1 stated R #36 was receiving Hospice care. During an interview on 04/05/19 at 10:54 AM, Licensed Practical Nurse (LPN) #25 stated she	F 641	Minimum Data Set Nurses, Social Services, Activities Director, Certified Dietary Manager and Director of Nursing were in serviced by the Quality Assurance Nurse to include that all residents are to receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. (4) The accuracy of MDS coding will be reviewed weekly during the Transmission meeting by reviewing the Resource Utilization Group analysis and Quality Indicator worksheets. All discrepancies will be reviewed by the MDS Coordinator and Assistant Director of Nursing for corrective actions needed. The Assistant Director of Nursing will bring all discrepancies to the Quality Assurance Committee monthly for further review and any corrective action as needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 641	Continued From page 51 had done the assessments and did not know why she had missed it (Hospice), because the order had not been discontinued. She stated it was an oversite. During an interview on 04/05/19 at 1:10 PM, Director of Nursing (DON) #12 confirmed R #36's MDS should have been coded as the resident receiving Hospice care. DON #12 stated a transmission meeting was held weekly, in which the DON goes over the assessments, and signs off that they are accurate.	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 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	F 656			5/24/19

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F 656	Continued From page 52 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: Based on observation, interview, and clinical record review, the facility failed to implement the care plans for two (2) residents, Resident (R) #14 and R #75, out of 71 sampled residents reviewed for care plans. Specifically, the facility failed to assist R #14 out of bed to the "Geri Chair" for meals, range of motion (ROM), positioning, and toileting which resulted in R #14 developing bilateral upper and lower extremity impairment in ROM and bilateral upper and lower extremity contractures; and, the facility provided R #75 with thin liquids when the care plan revealed the resident was to receive nectar thick liquids. Findings Include: Resident #14 Review of R #14's "Care Plan" problem, dated with a goal and target date of 06/28/19, indicated the Problem: " ...Requires total dependence with	F 656	(1) Resident #14's responsible party was contacted on 4/2/19 by the Minimum Data Set Nurse and stated that she did not have a preference for when the resident got up in the gerichair, but that they did want her to get up daily. Resident's care plan was updated by the Minimum Data Set Nurse to reflect that the resident is to be up to gerichair daily on 4/15/19. Resident # 14 was evaluated by the Restorative Nurse on 4/19/19 for a treatment plan to include Passive Range of Motion and application of bilateral hand splints. Splints were ordered on 4/24/19. Treatment plan was initiated on 4/29/19. Resident # 75 was assessed on 4/1/19 by Registered Nurse and Respiratory Therapist and found to have no negative consequences from receiving thin liquids.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2019
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F 656	Continued From page 53 activities of daily living (ADLs), transfers and mobility. ...See Care guide ADL for individual needs." There were no interventions for restorative services to offer ROM for upper and lower extremities. A review of R #14's "Face Sheet" in the clinical record, indicated R #14 was admitted to the facility on 06/14/16, with diagnoses of, but not limited to, Alzheimer's disease, Dementia in Other Disease Without Behaviors, Urinary Tract Infection (UTI), Major Depressive Disorder, Pain, Hospice, and Primary Hypertension (HTN). Review of the admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 06/21/16, specified the resident required extensive assistance of one (1) to two (2) staff members for bed mobility, transfers, and activities of daily living (ADLs). The "MDS" specified R #14 had no ROM impairment to her upper and lower extremities. The "MDS" indicated no ROM services were provided and R #14 used no mobility devices. Review of the annual "MDS" with an "ARD" of 05/12/18, specified ROM impairment bilaterally to the upper and lower extremities and indicated no ROM or therapy services. The "MDS" specified the resident was dependent on staff for all ADLs and indicated transfer activity had not occurred during the assessment period. On 07/16/18 a "Physical Therapy Screen" note documented, "Pt [sic] (patient) has not had any changes in functional status to warrant PT (Physical Therapy) eval [sic] (evaluation)." On 10/03/18, an "Occupational Therapy Quarterly	F 656	The Nurse Practitioner was notified of resident receiving thin liquids and no new orders were received. Practical Nurse (Licensed Practical Nurse) #105 received a one on one in-service from the Assistant Director of Nursing to include ensure tray card is checked thoroughly for special diet needs or liquids prior to giving them. (2) All residents using gerichairs and receiving thickened liquids have the potential to be affected by failure to implement the care plans (3) Staff Development Coordinator began in-servicing staff on 4/15/19 to include that the resident's care plan should be followed and tray cards are to be checked prior to serving liquids. (4) On 04/18/19 all residents with thickened liquids were monitored by the Quality Assurance Nurse and Assistant Director of Nursing to ensure all residents with thickened liquids order received thickened liquids. On 4/18/19 the Quality Assurance Nurse began auditing meal services to ensure that resident's received the appropriate diet and fluids. The meal service observing orders for liquids audit will be completed on ten residents daily Monday through Friday by the Quality Assurance Nurse and on the weekend by the Treatment Nurse for one month, then weekly.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 54 Screen" note documented, "Pt [sic] (patient) at baseline. Eval [sic] (evaluation) is not recommended." On 12/19/18 an "Occupational Therapy Quarterly Screen" note documented, "Pt. [sic] (patient) would benefit from hand splint to decrease risk of skin breakdown." On 12/20/18 a "Multidisciplinary Screen" note documented, "Pt [sic] (patient) has not experienced a functional change in area of PT and ST (Speech Therapy). Recommendation OT (Occupational Therapy) to eval [sic] (evaluation) to address new contractures to B [sic] (bilateral) hands." Observation during the initial tour on 04/01/19 at 6:30 AM, revealed R #14 was in her room in bed. Her bilateral arms and hands were contracted with bilateral hand rolls in place. Observations on 04/01/19 at 8:00 AM, 12:11 PM, 12:45 PM, and 2:00 PM, revealed, R #14 was in bed with the head of the bed slightly elevated and she was lying on her backside with her legs crossed, contracted, and angled upward, not touching the bed. Her bilateral arms and hands were contracted with hand rolls in place. Observation of Resident #14, and interview with Certified Nursing Assistant (CNA) #14, on 04/02/19 at 9:08 AM, revealed R #14 was in bed with the head of the bed upright. CNA #14 stated R #14 was unable to grab or hold anything with her hands due to the contractures. Interview with CNA #14 on 04/02/19 at 10:30 AM, revealed R #14 was considered extensive	F 656	All audits will be presented to the Assistant Director of Nursing for corrective actions needed. The Assistant Director of Nursing will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. On 4/15/19 the Assistant Director of Nursing began an geri chair audit Monday through Friday to ensure the resident was up in the Geri chair daily. This audit will continue daily Monday through Friday for four weeks. The Assistant Director of Nursing will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 656	Continued From page 55 assistance of two (2) staff members and required a lift for transfer. She stated R #14 did not get out of the bed every day. In an interview with R #14's "Power of Attorney" (POA) [daughter] on 04/03/19 at 9:30 AM, she stated the family wanted R #14 out of bed daily and to the Geri chair for social activities and meals. She stated the family would never ask for the resident to not get out of bed unless the resident was not tolerating being up. She stated they used to get R #14 up to the chair more than they do now. She stated R #14 was not admitted with contractures to bilateral upper and lower extremities. She stated R #14, to her knowledge, had never received therapy or restorative services. She stated the family would like the resident to receive any type of ROM services to help with comfort. On 04/03/19 at 10:45 AM, in an interview with Director of Nursing (DON) #30, she stated she was unaware the care plan for R #14 was not being implemented. She indicated, if the care plan stated to get a resident out of bed for meals, ROM, positioning, and toileting, then the staff should be getting the resident up daily and if not, a reason should be documented in the clinical record. She stated the reason for the care plan was for staff to know what care the resident needed and how to implement those care needs. She confirmed R #14's care plan had not been implemented appropriately. She confirmed R #14 had developed upper and lower extremity contractures and the facility had missed the opportunity to place the resident on a restorative program for ROM. On 04/04/19 at 9:50 AM, the Director of Therapy,	F 656			

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F 656	Continued From page 56 Occupational Therapist (OT) #1 stated she was familiar with R #14 and confirmed R #14 had developed contractures to her upper and lower extremities. She stated the therapy department had screened the resident for being at risk for contractures and had concluded she would benefit from hand splints and a restorative ROM and positioning program, to reduce the development of contractures; however, they had not followed through to see if it was completed. Resident #75 Review of R #75's "Care Plan," revealed, a problem onset date of 06/27/17, which indicated the resident was at risk for weight loss due to dx (diagnosis) of Dementia and Depression. The resident had a "Goal" to consume 50%-75% of meals thru [sic] (through) next review, with a goal date of 06/01/19. The "Care Plan" revealed approaches which directed: "Nectar thick liquids per MD [medical doctor] order." Review of current April 2019 "Physician Orders," revealed R #75 had a physician's order, dated 06/29/17, for a mechanical soft diet with nectar thick liquids. Observation on 04/01/19 at 12:13 PM, during the lunch meal in the main dining room, revealed R #75 was served thin liquids by Licensed Practical Nurse (LPN) #105. Resident #75 took a drink of the liquids and immediately started coughing. LPN #105 removed the liquids from the resident. Interview with LPN #105, on 04/01/19 at 12:14 PM, revealed she mistakenly served R #75 thin fluids. During interview with LPN #105 on 04/01/19 at 1:26 PM, she stated she was going too fast during the lunch meal service and poured	F 656			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 57 thin liquids for F #75. She stated before she could catch her mistake, R #75 drank the thin liquid (iced tea). LPN #105 stated the resident started coughing immediately as soon as she took a drink. She stated it was important the resident received nectar thickened, and not thin liquids, to prevent her from aspirating and getting pneumonia. The LPN notified the RN, who came and assessed the resident along with the in-house Respiratory Therapist.	F 656			
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure Resident (R) #14, one (1) of 26 sampled residents, reviewed for limited range of motion (ROM), received the appropriate services	F 688	(1) Resident # 14 was evaluated by the Restorative Nurse on 4/19/19 for a treatment plan to include Passive Range of Motion and application of bilateral hand splints. Treatment plan was initiated on	5/24/19	

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F 688	Continued From page 58 and equipment to maintain or improve ROM, including: 1. Failure to follow therapy recommendations for the use of hand splints to reduce the risk of developing bilateral hand contractures. 2. Failure to follow therapy recommendations to place R #14 on a restorative program to reduce the risk of developing contractures. The failed practices resulted in actual harm to R #14, who developed bilateral upper and lower extremity impairment in ROM, and bilateral upper and lower extremity contractures. Findings Include: A review of the facility's policy titled, "Range of Motion Policy" undated, indicated the facility provided ROM services, " ...to move the resident's joints through a full ROM as possible, to improve or maintain joint mobility, and to prevent contractures." A review of R #14's "Face Sheet" in the clinical record, indicated R #14 was admitted to the facility on 06/14/16, with diagnoses of, but not limited to, Alzheimer's disease, Dementia in Other Disease Without Behaviors, Urinary Tract Infection (UTI), Major Depressive Disorder, Pain, Hospice, and Primary Hypertension (HTN). Review of the admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 06/21/16, specified R #14's cognition was severely impaired-never or rarely made decisions. Resident #14's "Brief Interview for Mental Status (BIMS)" score was unable to be completed, due the resident's cognitive status. The resident required extensive assistance of	F 688	4/24/19. (2) All residents of the have the potential to be affected by the facility's failure to follow Therapy recommendations for the use of hand splints and place residents on a restorative program to reduce the risk of developing contractures. (3) Beginning on 4/18/19 the Minimum Data Set (MDS) Nurses initiated Range of Motion assessments on all residents in the facility. Any residents found to have limited range of motion will be referred to therapy services for screening and recommendations. Residents will receive services from restorative aides or therapists as needed. On 4/24/19, Minimum Data Set Nurses, Restorative Nurse, and Therapy Department were in serviced by the Quality Assurance Nurse to include that Licensed Nurses will assess resident s range of motion (such as current extent of movement of his/her joints and the identification of limitations) on admission/readmission, quarterly, and upon a significant change. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the Therapy Department for a focused assessment of range of motion. Residents will receive services from Restorative Aides or Therapists as needed. (4) This corrective action will be monitored by the Director of Nursing beginning		

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F 688	Continued From page 59 one (1) to two (2) staff members for bed mobility, transfers, and activities of daily living (ADLs). The "MDS" specified R #14 had no ROM impairment to her upper and lower extremities. The "MDS" indicated no ROM services were provided and R #14 used no mobility devices. Review of the admission "Interim Care Plan", undated, revealed, no contractures were indicated, and transfer and bed mobility were an assist of one (1) staff. Review of R #14's "Therapy Services Screening" notes, dated from 06/16/16 through 03/18/19, indicated the following: 06/16/16 - "Multidisciplinary Screen" notes indicated, "Pt [sic] (patient) is on hospice and skilled services are not appropriate at this time." 06/20/16 - "Physical Therapy Screen" notes indicated, "Recommend restorative screen..." There was no therapy screening or recommendation documentation provided from 06/20/16 through 01/23/18. 01/23/18 - "Physical Therapy Quarterly Screen" notes indicated, "Patient at baseline. Eval [sic] (evaluation) not warranted." 04/03/18 - "Multidisciplinary Screen" notes indicated, "No change in function. PT [sic] (patient) not warranted at this time." Review of the annual "MDS" with an "ARD" of 05/12/18, specified ROM impairment bilaterally to the upper and lower extremities and indicated no ROM or therapy services. There was no change in R #14's cognition of severely impaired-never or rarely made decisions. R #14's "BIMS" was 99, which indicated the mental status interview could not be completed. The "MDS" specified the resident was dependent on staff for all ADLs and	F 688	4/25/19, by reviewing all therapy recommendations for a Restorative program for range of motion and splinting daily Monday through Friday except holidays for three months. The Director of Nursing will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

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F 688	Continued From page 60 indicated transfer activity had not occurred during the assessment period. Review of the "Care Plan Sign - In Sheet" dated, 05/17/18, indicated the interdisciplinary team (Registered Nurse (RN), MDS Coordinator, Social Services (SS), Activities, Dietary, and a CNA) and family were present for the care plan meeting. There were no therapy services representatives listed. On 07/16/18 - "Physical Therapy Screen" notes indicated, "Pt [sic] (patient) has not had any changes in functional status to warrant PT (Physical Therapy) eval [sic] (evaluation)." On 10/03/18 - "Occupational Therapy Quarterly Screen" notes indicated, "Pt [sic] (patient) at baseline. Eval [sic] (evaluation) is not recommended." On 12/19/18 - "Occupational Therapy Quarterly Screen" notes indicated, "Pt. [sic] (patient) would benefit from hand splint to decrease risk of skin breakdown." On 12/20/18 - "Multidisciplinary Screen" notes indicated, "Pt [sic] (patient) has not experienced a functional change in area of PT and ST (Speech Therapy). Recommendation OT (Occupational Therapy) to eval [sic] (evaluation) to address new contractures to B [sic] (bilateral) hands." On 03/15/19 - "Occupational Quarterly Screen" notes indicated, "Pt [sic] (patient) has history of refusing therapy and she does not get out of bed ..." Review of R #14's clinical record, indicated no	F 688			

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F 688	Continued From page 61 documentation that R #14 had refused therapy or had a history of refusing therapy. On 03/18/19 - "Physical Therapy Quarterly Screening" notes indicated, "Patient presents at baseline and will not benefit from physical therapy." There were no documented therapy screenings or recommendations between the dates of 12/20/18 through 03/15/19. A review of R #14's "Care Plan" problem, dated with a goal and target date of 06/28/19, indicated, the Problem; " ...Requires total dependence with activities of daily living (ADLs), transfers and mobility. ...See Care guide ADL for individual needs." There were no interventions for restorative services to offer ROM for upper and lower extremities. A review of R #14's Hospice collaborative plan of care "Hospice Notes", dated from 01/03/18 through 04/01/19, indicated no restorative ROM program or services. A clinical record review of the "Physician Orders" (PO), dated for April 2019, indicated R #14 had no orders for restorative or therapy services for ROM and the care plan had been reviewed and agreed upon. Observation during the initial tour on 04/01/19 at 6:30 AM, revealed R #14 was in her room in bed. Her bilateral arms were contracted inwards toward her chest and bilateral hands were fully contracted with hand rolls in place. Observations on 04/01/19 at 8:00 AM, 12:11 PM,	F 688			

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F 688	Continued From page 62 12:45 PM, and 2:00 PM, revealed, R #14 was in bed, with the head of the bed slightly elevated, and she was lying on her backside with her legs crossed, contracted, and feet and lower legs angled upward, not touching the bed. Her bilateral arms and hands were contracted inward toward her chest with hand rolls in place. Observation and interview on 04/02/19 at 9:08 AM, revealed R #14 was in bed with the head of the bed upright. CNA #14 stated R #14 was unable to grab or hold anything with her hands due to the contractures. R #14's position, while in bed lying on her backside, revealed an upward inverted angle of her body, not allowing her to lay flat on the bed. This body position was due to her upper and lower extremity contractures. Interview with CNA #14 on 04/02/19 at 10:30 AM, revealed R #14 was considered extensive assistance of two (2) staff members and required a lift for transfer. She stated R #14 did not get out of the bed every day. In an interview with R #14's "Power of Attorney" (POA) [daughter] on 04/03/19 at 9:30 AM, she stated R #14 was not admitted with contractures to bilateral upper and lower extremities. She stated R #14, to her knowledge, had never received therapy or restorative services, nor had it been discussed with the family. She stated the family would like the resident to receive any type of ROM services to help with comfort. In an interview with the "Restorative Program" Licensed Practical Nurse (LPN) #38 on 04/03/19 at 10:00 AM, she stated she was new to the position and did not have knowledge of what the prior Restorative Nurse had done. She stated the	F 688			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2019
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F 688	Continued From page 63 process for a resident to be placed on the restorative program was when therapy made weekly rounds they would refer residents to the program. She stated nursing could also refer residents who may have had a decline in ADLs. She confirmed R #14 had bilateral upper and lower extremity contractures and should have been recommended, and placed on restorative services for ROM, prior to her developing them. She stated nursing administration would be the ones to refer residents. In an interview with Director of Nursing (DON) #30, on 04/03/19 at 10:45 AM, she stated, regarding not following therapy recommendations from 06/20/16 and 12/20/18, she could not speak to that and wasn't sure what happened, but confirmed nursing had not followed up on the recommendations. She stated it was not normal for Hospice residents to be on therapy or restorative caseload, but couldn't see a reason why they could not be. She confirmed R #14 had upper and lower contractures and that "they" (meaning the facility) missed the opportunity to place R #14 on a restorative program for ROM, to reduce the risk of developing contractures and a decline in her ROM. The DON could not confirm the date R #14's contractures developed. In an interview with the Director of Therapy (DOT), Occupational Therapist (OT) #1, on 04/04/19 at 9:50 AM, she stated she was familiar with R #14 and confirmed R #14 had developed upper and lower extremity contractures. She stated the therapy department had screened R #14 for being at risk for contractures, and had concluded she would benefit from hand splints and a restorative ROM and positioning program, to reduce the development of contractures;	F 688			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 688	Continued From page 64 however, they had not followed through to see if it was completed. The DOT could not confirm the date R #14's contractures developed. In an interview with the MDS Coordinator, Licensed Practical Nurse (LPN) #105, on 04/04/19 at 12:27 PM, she stated to her knowledge, the completed MDS assessments for R #14 were accurate. She stated she was not completely familiar with R #14. She stated Hospice services attend the care plan meetings and collaborate with the facility care plans. She stated residents who are referred to nursing restorative services were discussed in the "Transmission" meeting along with Interdisciplinary Team (IDT) meetings. She stated she was not sure how the facility missed R #14 for restorative services, but confirmed R #14 should have been placed on a ROM program.	F 688			
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, interview and record review, the facility failed to ensure that one (1) of three (3) residents who received dialysis outside the facility, Resident (R) #29, received a meal that was appetizing and at the	F 804	(1) Resident # 29 had requested that his dinner tray be left in his room on dialysis days. On 4/15/19, The Director of Nursing offered Resident #29 an early tray with a snack upon return from dialysis on	5/24/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 804	Continued From page 65 appropriate temperature when he returned from dialysis on Monday, Wednesday and Friday evenings. Specifically, staff would deliver R #29's dinner tray to his room, during the evening meal service, and leave it at the bedside until the resident returned at 9:00 PM, from dialysis; then he would eat the meal. Findings include: The facility documented on letter head, dated 04/07/19, there was no policy to address the concern of leaving meals in the resident's room, however; the noted expectations were for staff to assist residents with meals as needed. Observation on 04/01/19, revealed R #29 left the facility at 4:30 PM, for his dialysis treatment. During interview with R #29 on 04/02/19 at 9:45 AM, he stated when he returns from dialysis on Monday, Wednesday and Friday evenings at 9:00 PM, his meal tray will be waiting for him. He stated the staff re-heated his meal. He stated the food "sucks and tastes terrible." During this same interview, R #29's roommate verified staff brought R #29's tray into the room during the evening meal service and they just left it there. During an observation on 04/03/19 at 5:58 PM, R #29's evening meal tray was setting on the bedside table while the resident was at dialysis. During an interview on 04/05/19 at 1:30 PM, Director of Nursing (DON) #12 was asked if it was appropriate for R #29's meal tray to be delivered to his room and left at the bedside when he was at dialysis. DON #12 stated it was very inappropriate to leave the tray at the bedside. The	F 804	dialysis days, and resident was agreeable with this. (2) The facility has determined that all residents on dialysis have the potential to be affected by facility's failure to receive a meal that was appetizing and at the appropriate temperature. All residents on dialysis were interviewed on 4/24/19 by the Assistant Director of Nursing/Risk Manager regarding meals on dialysis days one resident will receive an early dinner tray and the other resident will take a sack lunch with her to dialysis. (3) On 4/24/19, Nursing, Social Services and Dietary staff was in serviced by the Quality Assurance Nurse to include that if a resident is out of the facility for an appointment during meal time arrangements are to be made for the resident to receive an early or late tray for that meal. (4) On 4/15/19, The Director of Nursing began monitoring tray delivery to ensure that the resident received an early tray on dialysis days and that tray is not left in room Monday through Friday; and will continue to monitor for four weeks. The monitoring sheet will be turned in to the Quality Assurance Department weekly for further review. The Quality Assurance Nurse will bring all discrepancies to the Quality Assurance Committee monthly for further review and any corrective actions needed.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 804	Continued From page 66 DON stated the resident should receive a fresh tray upon his return.	F 804	The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, interview, and record review, the facility failed to ensure therapeutic diet orders were followed for one (1) of 47 sampled residents, Resident (R) #75, as evidenced by R #75, who had a physician's order to receive nectar thickened liquids, was served and consumed thin liquids. Findings include: Review of the facility's policy titled, "Thickened Liquids Policy," undated, revealed, ". . . thickened liquids will be utilized with specific physician's order to indicate the desired consistency, thickener to be added by dietary with meals and	F 808	(1) Resident # 75 was assessed on 4/1/19 by Registered Nurse and Respiratory Therapist and found to have no negative consequences from receiving thin liquids. The Nurse Practitioner was notified of resident receiving thin liquids and no new orders were received. Practical Nurse (Licensed Practical Nurse) #105 was given a one on one in-service by the Risk Manager the to include ensure tray card is checked thoroughly for special diet needs or liquids prior to giving them. (2) All residents on thickened liquids have	5/24/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 808	Continued From page 67 by nursing staff with other liquids, and pre-thickened liquids may be used when available." Observation on 04/01/19 at 12:13 PM, during the lunch meal in the main dining room, revealed R #75 was served liquids by Licensed Practical Nurse (LPN) #105. R #75 took a drink of the liquids and immediately started coughing. LPN #105 removed the liquids from the resident. Interview with LPN #105, on 04/01/19 at 12:14 PM, revealed she mistakenly served R #75 thin fluids. During interview with LPN #105 on 04/01/19 at 1:26 PM, she stated she was going too fast during the lunch meal service and poured thin liquids for R #75. She stated before she could catch her mistake, R #75 drank the thin liquid (iced tea). LPN #105 confirmed the resident started coughing immediately, as soon as she took a drink. She stated it was important the resident received nectar thickened, and not thin liquids, to prevent her from aspirating and getting pneumonia. The LPN notified the RN, who came and assessed the resident along with the in-house Respiratory Therapist. Based on observations and interviews, the facility failed to implement their policy and ensure thickened liquids were utilized to conform with specific physician's orders for the correct consistency. Review of R #75's "Face Sheet," revealed the resident was admitted to the facility on 06/27/17, with diagnoses which included: Dementia without behavioral disturbances, Major Depressive Disorder, Mild Cognitive Impairment, Functional Dyspepsia, and Other Speech Disturbances.	F 808	the potential to be affected by the facility's failure to ensure therapeutic diet orders are followed. (3) Staff Development Coordinator began in-servicing nursing, dietary and therapy staff on 4/15/19 to include that tray cards are to be checked prior to serving liquids. On 04/18/19, all residents with thickened liquids were monitored by the Quality Assurance Nurse and Assistant Director of Nursing to ensure all residents with thickened liquids order received thickened liquids, no deficiencies were identified. (4) On 4/18/19, the Quality Assurance Nurse began auditing meal services to ensure that resident's received the appropriate diet and fluids. The audit will be completed on ten residents daily Monday through Friday by the Quality Assurance Nurse and on the weekend by the Treatment Nurse for one month, then weekly. All audits will be presented to the Assistant Director of Nursing for corrective actions needed. The Assistant Director of Nursing will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 808	Continued From page 68 Review of "Physician Orders," dated April 2019, revealed R #75 had a physician's order, dated 06/29/17, for a mechanical soft diet with nectar thick liquids. Review of R #75's "Meal Card," dated 04/01/19, revealed the resident was to have nectar thick liquids. Review of R #75's "Care Plan," revealed, a problem onset date of 06/27/17, which indicated the resident was at risk for weight loss due to dx (diagnosis) of Dementia and Depression. The resident had a "Goal" to consume 50%-75% of meals thru [sic] (through) next review, with a goal date of 06/01/19. The "Care Plan" revealed approaches which directed: "RD (Registered Dietitian) consult when needed, encourage fluids with meals, supplement as needed and nectar thick liquids per md [medical doctor] order." Interview, on 04/05/19 at 7:00 PM, with the Administrator, revealed it was his expectation staff would have checked the resident's tray ticket prior to serving the liquids for Resident #75. The Administrator stated it was important the resident would receive the correct fluid consistency, to prevent negative outcomes, such as aspiration.	F 808	by continued monitoring will be presented to the Quality Assurance Committee as the need arises.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2019
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/26/2019

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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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/5/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000			

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