STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255169	A. BUILDING _____ B. WING _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

(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 A recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health, at the facility from 4/15/19 to 4/18/19. During the survey, the facility was found not to be in substantial compliance with the requirements of participation for Medicare and Medicaid. The facility was cited regulatory deficiencies at F576, F656, F679, F689, F695, and F921. The facility's census on 4/15/19 was 77 residents, and the facility held a license for 100 beds.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal	F 576		5/27/19

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

Electronically Signed | 05/27/2019

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F 576	Continued From page 1 service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to assure that the facility provided 25 of 25 residents who attended the Resident Group meeting their mail on the weekend. This failure had the potential to affect all residents in the facility. Findings include: The facility did not have a policy for weekend mail; however, the management provided a document (undated, but received on 4/17/19 at 3:40 PM) which read, "Adams County Nursing Center does not have a policy for weekend mail. Adams County Nursing Center expects the Weekend RN [Registered Nurse] Supervisor or Weekend Social Liaison (when applicable) to distribute weekend mail to residents as needed." On 4/17/19 at 10:15 AM, a group meeting was conducted with 25 residents to discuss facility	F 576	a. The Administrator met with the facility Residents on 4/19/19 to notify each one individually that weekend mail received by the facility would be delivered to them. b. All residents who reside in the facility have the potential to be affected by this deficient practice. c. The Administrator provided in-service training to the weekend Registered Nurse supervisors on 4/19/19 to sort and distribute each resident□s mail to individual residents during the weekend shift. d. The Administrator and the Activities Director interviewed various residents on 4/22/19 continuing weekly for four (4) weeks to ensure the mail is being distributed during weekend shifts and then	

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F 576	Continued From page 2 practices. During the meeting the residents were asked if they received their mail on Saturday. The 25 residents in the group responded unanimously that no mail was received on weekends. On 04/17/19 at 1:48 PM, an interview was initiated with the Activity Director (AD) who verified mail received during the weekend was not distributed to residents until the following Monday. He stated that he attended an AD's training meeting and was taught that residents were supposed to receive their mail on Saturdays and it was his responsibility to assure that happened. He added he was not sure how long residents have not been receiving mail on Saturdays, but it was at least since he was hired in December 2018. During the interview, on 04/17/19 2:53 PM, the Administrator stated it was his expectation the charge nurse would make sure mail was delivered on Saturday; however, it had been brought to his attention that this was not happening.	F 576	twice (2) per month for six (6) months after. Any areas of concern will be brought by the Administrator and the Activities Director to the quarterly Quality Assessment and Improvement Committee for review. Additional training and/or disciplinary action will be considered as warranted.	
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 -	F 656		5/27/19

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F 656	Continued From page 3 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, the facility failed to initiate and implement the care plans for three (3) of 23 sampled residents (Residents #33, #62, and #67). Specifically, Resident #33's care plan for activities, Resident #62's care plan was not implemented for activites or fall prevention, and Resident #67 did not have a care plan initiated for	F 656	a. The Director of Nursing and the Administrator conducted a review of the care plan for Residents #33, #62, and #67 to ensure care plan completion of each deficiency found on 5/23 /19. The Activity care plan for Resident #33, #62, and #67 was individualized and revised on 5/23/19. The fall intervention for Resident #62 was	

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F 656	Continued From page 4 activities. Findings include: 1. Review of the facility's policy titled, "Documentation-Activity Screening Policy: Activity Assessment and Interest List," revised on 11/17 indicated the activity needs and interests would be identified by an "Activity Screening" which should be completed within seven days of admission. The purpose of the policy was to assure that each resident's interests were identified, and activities would be provided. The procedure further indicated the interest and pleasures would be kept current and updated through the care plan process and the "Minimum Data Set (MDS)". Review of the facility's policy titled, "Care Plan Process" revised 08/17 indicated a comprehensive assessment of a resident's functional capacity and needs which included customary and routine needs should be done at regular intervals. The results of the assessment should be used to develop, review, and revise a person-centered comprehensive plan of care. The "Care Plan Process" further revealed the facility must develop a comprehensive care plan that included measurable objectives to meet the needs of the resident's medical, nursing, mental, and psychosocial needs. The care plan must describe the services that were to be furnished to attain or maintain the highest practicable psychosocial well-being. The comprehensive care plan was an interdisciplinary communication tool that included disciplines such as activities, as appropriate. The "Care Plan Process" further revealed the care plan included a problem, desired goals, and interventions that should	F 656	implemented on 4/16/19. b. All residents who reside in the facility have a potential to be affected by this deficient practice. c. Individual education and in-service training was provided to the Activity Director on 4/19/19 by the Administrator related to the process of care planning, person-centered care plans, and care plan updates. The Administrator conducted an audit of resident activity care plans of residents admitted after 1/1/19. The audit was completed on 5/23/19. The Director of Nursing completed an audit of all admitted residents with falls beginning 11/1/18 to ensure care plans have been updated with the person-centered care plan interventions related to the fall. The audit was completed on 5/23/19. d. The Director of Nursing will provide a weekly care plan review of admitted residents who may have a fall for individualized interventions weekly for four (4) weeks for compliance and then monthly for six (6) months beginning 4/26/19. Any areas of concern will be brought by the Director of Nursing to the quarterly Quality Assessment and Improvement Committee for review. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We	

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F 656	Continued From page 5 promote meeting the goals and interventions. Review of the electronic admissions section of the "Minimum Data Set (MDS)" revealed Resident #67 was readmitted with diagnoses of Cerebrovascular Accident, Hemiplegia, Seizures, Aphasia, and she had a Gastrostomy Tube. Review of the significant change "MDS", with an Assessment Reference Date (ARD) of 12/21/18 and the quarterly "MDS" with an ARD of 03/13/19 indicated Resident #67 had a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15, which indicated severe cognitive impairment. Review of the "Preference for Customary Routine and Activities" revealed Resident #67 liked music activities. Review of the "Care Area Assessment (CAA)" revealed activities had triggered and would be care planned. Review of the "Activity Screening" document dated 03/03/19 indicated Resident #67 was interested in going outdoors, liked music and bingo activities. Review of Resident #67's "Comprehensive Care Plan" revealed there was not a care plan for activities. Interview, on 04/17/19 at 1:55 PM, with the Registered Nurse (RN) Case Manager confirmed that Resident #67's care plan did not address activities. She further revealed there had been an activity care plan for Resident #67, but it was discontinued on 11/08/18, and not reinstated when the resident was readmitted. The RN Case Manager stated there should be a care plan for activities, and it was the responsibility of the	F 656	reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations	

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F 656	Continued From page 6	F 656		

Activity Director (AD) to initiate a care plan for activities.

Interview with the AD, on 04/17/19 at 4:11 PM, revealed he had not initiated an activity care plan for Resident #67, and he knew he was responsible for the initiation of the activity care plan.

2. Review of Resident #33's undated, "Diagnosis/History", form indicated an admission date, of 05/12/18, with diagnoses of Hemiplegia (paralysis) affecting right nondominant side, Seizures, Speech, Language deficit following a Cerebral Vascular Infarction (CVA), and Dementia.

Review of the quarterly "MDS", with an ARD of 02/07/19, revealed a BIMS score of zero (0) out of 15, which indicated severe cognitive impairment. No behaviors were exhibited.

Review of Resident #33's care plan, dated 05/14/18, and a review date of 02/13/19 indicated the problem, "Resident has little involvement in activities due to cognitive impairment related to CVA. Resident does attend some social events such as church and music in the dining room ... Goal, Resident will participate in at least one activity per week through next review...Approaches: Approach resident warmly and positively. Offer at least one activity to resident in which resident has shown interest as needed. Determine residents [sic] interests ..."

During an interview, on 04/18/19 at 10:12 AM, the AD was asked about Resident #33's activities, he stated that he had tried to pull him into activities. He stated the resident sits and does not engage.

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F 656	Continued From page 7	F 656		

He could not provide any documentation that the resident had attended any activities since he took over in December 2018.

3. Resident #62's care plan, initiated on 01/31/19, identified the resident was at risk for social isolation and would have one on one activities through next review. Approaches included an activity calendar in his room; have one on one activities such as music, TV, conversation, touch therapy, exercise; would have assist with turning TV on/changing channels and volume as needed; and would invite resident to church, bingo, and group discussion.

Review of Resident #62's admission "MDS", with an ARD of 02/07/19, documented Resident #62's eye sight was severely impaired. Resident #62 had told the MDS person it was very important for him to keep up with the news, do things with groups of people, go outside, and to participate in religious services or practices. The MDS documented Resident #62 had been admitted by the facility on 01/31/19 .

During an interview, on 04/16/19 at 8:24 AM, Resident #62 was asked if he would like to go outside. The resident stated that he would like to go outside more and also would like to have audio books since he could not see to read. Resident #62 stated that he would also need an audio player to play the books and have assistance with operating it since he could not see.

Interview, on 04/17/19 at 10:07 AM, revealed the AD stated that Resident #62 could only see shadows now and had loved to read before his stroke. The AD stated that he had always placed

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F 656	Continued From page 8	F 656		

a calendar in every residents' room. The AD was told when Resident #62 was interviewed regarding what activities he would like to do had told the surveyor he would like to have audio books because he used to love to read. The AD stated that he had not thought of audio books but said that was a good idea.

The AD stated that he did not keep a record of the daily activities the residents attended, and that Resident #62 would occasionally go to birthday parties.

The interim Director of Nursing (DON) was interviewed on 04/18/19 at 3:00 PM. She stated that she expected the care plan to reflect the resident's current likes and needs from every department.

Further review of Resident #62's care plan, initiated on 01/31/19, identified the resident at risk for falls related to cognitive deficits and impaired mobility. The goal was for Resident #62 to be free of injury and complications through the next review due on 05/31/19. Approaches included to have a concave mattress on Resident #62's bed.

Review of nurse's notes, dated 02/06/19 at 8:46 AM, documented "Resident found on floor during breakfast by therapy. Resident states he thinks he was having a nightmare and is unsure how he got on the floor, but he fell out of bed."

The Administrator, on 04/16/19 at 10:01 AM, was asked to come to the resident's room. The Administrator was asked if Resident #62 was to have a concave mattress on his bed. The Administrator stated that he knew the concave mattress had been on the resident's bed at one

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F 656	Continued From page 9 time but saw it was not on there now.	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, record reviews, and interviews, the facility failed to provide an ongoing activity program, tailored to meet the needs of the residents for four (4) of the 23 sampled residents (Residents #33, #47, #62, and #67). Findings include: Record review of the facility's policy titled, "Documentation-Activity Screening Policy: Activity Assessment and Interest List", revised on 11/17, indicated the activity needs and interests would be identified by an "Activity Screening" which should be completed within seven days of admission. The purpose of the policy was to assure that each resident's interests were identified, and activities would be provided. The procedure included meeting with the resident by the Resident Activity Director on admission and data would be collected. The procedure further	F 679	a. The Activities Director interviewed Resident #33, #47, #62, and #67 on 4/20/19 to gain knowledge of specific types of in-room activities which was desirable for each individual resident and implemented in-room activities beginning 4/22/19. b. All residents who reside in the facility have a potential to be affected by this deficient practice. c. The Administrator in-serviced the Activity Director on 4/20/19 on various types of in-room activities which could be provided to individual residents. d. The Administrator and the Social Services Director will review the documentation of the activities of residents who receive in-room activities	5/27/19

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F 679	Continued From page 10 revealed the Resident Activity Director would continue to gather information pertinent to the resident's past and present interests. The activity information was to be recorded in the initial activity screening and on the Minimum Data Set (MDS). The procedure further indicated the interest and pleasures would be kept current and updated through the care plan process and the MDS. 1. Medical record review of Resident #33's, undated, "Diagnosis/History" form indicated an admission date of 05/12/18 with diagnoses of Hemiplegia (paralysis) affecting right nondominant side, Seizures, Speech, Language deficit following and Cerebral Vascular Infarction (CVA), and Dementia. Review of the quarterly Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 02/07/19, revealed a Basic Interview for Mental Status (BIMS) score of 0 out of 15, which indicated severe cognitive impairment. No behaviors were exhibited. Review of Resident #33's care plan, dated 05/14/18 and a review date of 02/13/19, indicated the problem to be, "Resident has little involvement in activities due to cognitive impairment related to CVA. Resident does attend some social events such as church and music in the dining room ...Goal, Resident will participate in at least one activity per week through next review...Approaches: Approach resident warmly and positively. Offer at least one activity to resident in which resident has shown interest as needed. Determine residents [sic] interests ..." During an observation, on 04/15/19 at 9:30 AM,	F 679	weekly for four (4) weeks for compliance and then monthly six (6) months beginning 4/26/19. Any areas of concern will be brought by the Administrator and the Social Services Director to the quarterly Quality Assessment and Improvement Committee for review. Additional training and/or disciplinary action will be considered as warranted.	

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Resident #33 was in his chair in his room. The television was on, but the resident was asleep.

Another observation, on 04/16/19 at 2:40 PM, revealed Resident #33 was asleep in the chair, in his room. The television was on.

During an observation, on 04/17/19 at 8:20 AM, Resident #33 was asleep in his room sitting in the chair the television was not on.

In an interview, on 04/18/19 at 10:12 AM, the Activity Director (AD) was asked about Resident #33's activities. He stated he had tried to pull him into activities. He stated the resident sits and does not engage. He could not provide any documentation that the resident had attended any activities since he took over as AD in December 2018.

During an interview, on 04/18/19 at 2:15 PM, Licensed Practical Nurse (LPN) #1 stated that she will bring him in the hall sometimes, but he cusses so it isn't that often.

2. Medical record review of Resident #47's, undated, "Diagnosis/History" form indicated an admission date of 03/20/15 with diagnoses of Dementia without behavioral disturbance, Anxiety, Insomnia, Urinary Tract Infection, Blind, and Muscle Wasting.

Review of the quarterly MDS, with an ARD of 03/04/19, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. No behaviors were documented.

Review of Resident #47's care plan, dated

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09/13/16 with a review date of 03/07/19, indicated the problem to be, "RT [Resident] has poor involvement in activities R/T [related to] cognitive impairment; RT enjoys socializing with staff. RT will sit quietly in activities during entertainment. RT does not activity participate in activities. Activities director will stroll RT around facility in w/c [wheelchair] to encourage socialization. Goal: Participate in activities appropriate to current health condition...Approaches: Initiate conversation with resident as frequently as possible. Supervise resident in activity areas. Ensure that resident is clean and wearing clean clothing for activities. Encourage family and friends to visit often as possible. Staff will address resident by preferred name. Assistance to activity area of choice. Maintain calm, quiet conversation throughout visit."

During an observation, on 04/15/19 at 3:15 PM, Resident #47 was in the hall near the nurse's station taking off her socks, and wearing a blanket over her head.

Another observation, on 04/16/18 at 9:30 AM, revealed Resident #47 was at the end of the hall, near the nurse's station, sleeping in her chair with a blanket pulled over her head.

On 04/18/19 at 8:56 AM, Resident #47 was observed at the end of the hall, near the nursing station. She was pulling off her socks and talking about being cold. She was moved into her room by staff.

During an interview, on 04/18/19 at 10:17 AM, the AD stated he had a hard time redirecting the resident and stated, "She was a teacher in the past and sometimes she thinks she's teaching a

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class." He was asked if he provided any one to one activity. He stated that he had five (5) to six (6) residents he did one (1) to one (1) activities with, but Resident #47 was not one of them. He had no documentation to show that he provided any activities since assuming the AD role in December of 2018.

3. Review of Resident #62's Minimum Data Set (MDS) admission assessment, with an assessment reference date (ARD) of 02/07/19, documented Resident #62's eye sight was severely impaired. The MDS documented Resident #62 had been admitted by the facility on 01/31/19. When Resident #62 was interviewed by the AD, for the activity portion of the MDS, Resident #62 told him it was very important for him to keep up with the news, do things with groups of people, go outside, and to participate in religious services or practices.

Review of the "Activity Screening" dated 02/07/19, documented the resident interests included reading, but he is blind now and needs someone to read to him; he enjoyed being outdoors when the weather permits; and prefers small groups of people. The screening also documented Resident #62 was easily distracted and needed assistance to/with activities.

Resident #62's care plan, initiated on 01/31/19, identified the resident was at risk for social isolation and would have one (1) on one (1) activities through next review on 05/01/19. Approaches were for an activity calendar in his room to encourage self-initiated activities; maintain calm, quiet, conversation throughout visit; one on one activities with music, TV, touch therapy, and exercise; assist with turning TV

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on/changing channels, volume as needed; provide res (resident) with reading materials of their choice; allow resident time to respond; invite resident to church, bingo, and group discussion.

On 04/15/19, the first day of the survey, Resident #62 was not observed to go to any activities.

Resident #62, on 04/16/19 at 8:24 AM, was asked if he would like to go outside more. He said he would but would also like to have audio books to listen to. He said when he could see, he loved to read, and audio books would be nice, now that he couldn't see to read.

On 04/16/19, Resident #62 was not observed to attend any of the activities. He would be taken into the dining room only to eat his meals and returned to his room.

The AD was interviewed on 04/17/19 at 10:07 AM, and was asked what type of activities the resident liked. The AD said the resident was only able to see shadows since his stroke and could not read. The AD said the resident liked to go outside and attend parties. The AD was asked what good an activity calendar did on the wall in the resident's room if he could not see to read it. The AD said he put an activity calendar in every residents' room. The AD was informed the activity care plan did not address Resident #62's choices. The AD said he had not known how to do care plans, but last week he had been to training which should help him provide personalized care plans for residents now. The AD was told what Resident #62 discussed with the surveyor about wanting audio books. The AD said that was a good idea. The AD was informed the resident had not been observed attending any of the activities during the

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survey, and he was asked if he kept a record of the activities the residents attended. He said he had not known he needed to keep a record of the activities the resident attended until he had gone to the training the previous week.

The interim Director of Nursing (DON) was interviewed on 04/18/19 at 3:00 PM. The DON said she expected individualized activities be provided to the residents per the residents' choice.

4. Record review of the electronic admissions section revealed Resident #67 was readmitted, on 12/05/19, with diagnoses of Cerebrovascular Accident or a Stroke, Hemiplegia, Seizures, Aphasia, and she had a Gastrostomy Tube.

Record review of the significant change "MDS", with an Assessment Reference Date (ARD) of 12/21/18, indicated the resident had a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15, which indicated severe cognitive impairment. Resident #67 required total dependence of two (2) people for transfers and locomotion on the unit did not occur. Record review of the Preference for Customary Routine and Activities of the MDS revealed Resident #67 liked music activities.

Record review of the quarterly "MDS", with an ARD of 03/13/19, for Resident #67, revealed she was totally dependent with a two (2) person assist for transfers and a one (1) person assist for locomotion on the unit.

Record review of an "Activity Screening" document, dated 03/03/19, indicated Resident #67 was interested in going outdoors and liked

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music and bingo activities.

Observation of Resident #67, on 04/15/19 at 11:00 AM, revealed she was lying in the bed in her room, on her right side with the head of bed up. Observation further revealed Resident #67 was unable to verbally respond when spoken to, but she did move her left arm.

Observation, on 04/16/19 at 10:10 AM, revealed Resident #67 was again lying in bed in her room with the television on; however, a music activity was taking place in the dining room, which was down the hall past the nurse's station.

Observation, on 04/16/19 at 10:53 AM, revealed Resident #67 continued to lie in her bed in her room and the music activity was still being provided in the dining room.

Observation, during the skin assessment, on 04/17/19 at 9:00 AM, revealed Resident #67 was lying in her bed in her room, and smiled at the staff when she was spoken to.

Review of the comprehensive care plan, with multiple goal dates, revealed there was not a care plan for activities for Resident #67.

Interview, on 04/17/19 at 11:38 AM, with the Activity Director (AD), revealed Resident #67 had not gone to any activities since he had become the AD, which was December 2018. The AD stated he did not know why Resident #67 did not go to activities, "she just doesn't come". The AD confirmed he had not informed staff to bring Resident #67 to the music activity. The Activity Director stated he had just gone to a training last week and found out he had to keep an

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F 679	Continued From page 17 attendance log, which he had not been doing. The AD stated he needed to have more activities with Resident #67, but he was the only one that did activities, and sometimes it was hard to work with high functioning residents concurrently with lower functioning residents. Interview, on 04/17/19 at 1:53 PM, with the Assessment Registered Nurse (RN), revealed activities should be geared toward the resident and as specific as possible for that person. Interview, on 04/17/19 at 1:55 PM, with RN Case Manager, revealed she did not see a current care plan for activities and there should be one. She further revealed there had been an activity care plan for Resident #67, but it was discontinued on 11/08/19, and not reinstated when the resident was readmitted. The RN case Manager revealed Resident #67 had been admitted to Hospice on 12/11/18, but that did not mean the resident should not have activities.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews, and review of the facility's policy, the facility failed to evaluate and implement	F 689	a. The Director of Nursing conducted a review of the care plan for Resident #62 to ensure care plan documentation of	5/27/19

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F 689	Continued From page 18 measures and interventions documented on the resident's care plan to prevent falls for one (1) of four (4) sampled residents, Resident #62, reviewed for falls. Findings include: Review of the facility's policy titled, "Fall Prevention and Management Program", indicated, "...The residents fall risk should be integrated into the initial interdisciplinary care plan and each care plan review thereafter...Examples of initial approaches may include exercise, balance training, frequent staff contact, toileting program, medication management, medical management, etc ..." Review of Resident #62's medical record revealed the resident was admitted by the facility on 01/31/19. Review of the "Admission Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 02/07/19, documented had severely impaired eye sight (sees only light, colors or shapes), required two (2) plus persons physical assist with transfers and bed mobility, had impairment on both sides of upper and lower extremities, believed he is capable of increased independence of some activities of daily living, scored a five (5) on his Brief Interview for Mental Status, meaning he had a severely impaired cognition, and had fallen since being admitted. Review of Resident #62's care plan, with a problem onset date of 01/31/19, documented the resident was at risk for falls related to his cognitive deficits and impaired mobility. The goal was that Resident #62 would be free of injuries and complications through the next review date of 05/31/19. The approaches included to place the	F 689	each fall intervention on 5/09/19. The care plan intervention of the concave mattress is documented on the care plan. The fall intervention of the concave mattress for Resident #62 was re-implemented and the concave mattress was replaced on Resident 62's bed on 4/16/19. Resident 62's bathroom call light cord was replaced on 4/18/19 b. All residents who reside in the facility have a potential to be affected by this deficient practice. c. Individual education and in-service training was provided to the Director of Nursing on 5/09/19 by the Administrator related to the process of care planning, documenting, and implementing fall interventions. The Director of Nursing completed an audit of all admitted residents with falls beginning 4/18/19 to ensure interventions for care plans had been documented, implemented, and in place with the person-centered interventions related to the fall. The audit was completed on 5/24/19. Maintenance Director audited call light cords in each resident's position in rooms and bathrooms to insure compliant length and function completed on 5/10/19. d. The Director of Nursing will provide a weekly care plan review of admitted residents who may have a fall for individualized interventions weekly for four (4) weeks for compliance and then monthly for six (6) months beginning 4/26/19. The Administrator audit resident	

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F 689	Continued From page 19 call light within his reach and anticipate his needs. An intervention documented after a fall on 02/06/19, was to have concave mattress put on his bed. Review of a care plan, with a problem onset date 01/31/19, documented the resident had severely impaired vision. The goal was for the resident to be free of injury and complications related to impaired vision through the next review on 05/31/19. Approaches included, "Place items that resident frequently uses in reach." Review of a nurse's note, dated 2/06/19 at 8:46 AM, revealed "Resident found on floor during breakfast by therapy. Resident states he thinks he was having a nightmare and is unsure how he got on the floor, but he fell out of bed." Resident has slight reddening to his forehead and has complaints of neck pain. Resident's physician was notified and gave an order to send to ER [emergency room] for eval [evaluation] since he hit his head. The resident's responsible party was also notified. Further review of the nurse's notes revealed Resident #62 returned to the facility on 2/6/19 at 1:59 PM with new orders for Tramolol for pain and Macrobid (antibiotic) for complain of dysuria (difficulty urinating) at the ER. Review of a nurse's note, dated 02/06/19 at 4:42 PM, revealed "2:15 PM resident calling out, Help me I've fallen." Resident was found on the floor by the writer, lying on his left side. Resident stated he is only experiencing pain in his neck. States he did not hit his head. Resident transferred to Geri-chair with Hoyer lift, and was brought up to nurses' station. Resident requested Tylenol for neck pain, and it was administered. The physician and Resident #62's responsible	F 689	room and bathroom call light cords weekly for four (4) weeks for compliance and then monthly for six (6) months beginning 4/26/19. Any areas of concern will be brought by the Director of Nurses and the Administrator to the quarterly Quality Assessment and Improvement Committee for review. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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party were notified.

A "Resident Incident Report," dated 02/06/19 at 2:15 PM, documented Resident #62 fell in his room. The narrative documented, "Resident hollering out, "Help, I've fallen!" Resident found on the floor by nurse beside his bed. Nurse asked resident what he was doing. The resident stated, "I was trying to get out of bed." Resident complained of pain to his neck rating it a four (4) out of 10 (10 being the worst). A head to toe assessment was completed with no injury noted. Resident picked up off floor using proper lift technique and placed in Geri-chair.

Review of the "Resident Incident Follow Up", signed and dated 2/15/19, by the Director of Nursing (DON), revealed the Additional Follow Ups included 2/6/19 Resident to have concave mattress on bed and bed against wall.

Review of a nurse's note, dated 2/8/19 at 12:48 PM, revealed the nurse was asked to come to the room because Resident #62 was on the floor. Three (3) Certified Nursing Assistants (CNAs), and two (2) nurses were in the room with the resident. Resident #62 was lying on his back, and had a small laceration to his head. Resident #62 stated he wiggled his way out of the chair, and that he was trying to get up. Resident #62 was lifted into bed with the Hoyer lift. Neuro checks were started. A nurse remained with Resident #62 until the ambulance arrived to take him to the Emergency Room (ER). Resident #62 was able to eat lunch prior to transport. Resident #62 left the facility at 12:10 PM. Further review of the nurse's notes revealed, on 2/8/19 at 10:11 PM, Resident #62 returned to the facility at 3:30 PM. Resident #62 had three (3) stitches to the

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middle of his forehead. No complaints voiced. When asked what happened, resident stated he fell out of his bed two (2) times today and busted his head.

Review of the facility's "Resident Incident Report" documented Resident #62 had fallen on 02/08/19 at 11:01 AM. The report documented the resident had an unobserved fall from a Geri-chair in his room. Resident #62 had an injury from the fall with pain and a "superficial" laceration. The narrative documented, "Nurse asked to come to room because resident was on the floor. Upon entering room, 2 nurse and 3 CNAs [certified nurse assistants] were in room with res. He was laying on back with small laceration to head. Res (Resident) stated that he wiggled out of chair and that he was trying to get up. Res was immediately cleaned and lifted from floor with total lift and placed into bed. Nurse stayed with resident and performed neuro checks until (name of ambulance company) came. Res also was able to eat lunch while waiting. Small laceration to forehead."

A nurse's note, dated 03/14/19 at 10:47 PM, documented, "Earlier in the shift, resident got out of his W/C [wheelchair], sat on the floor and scooted across the floor on his buttocks to get some chewing gum. When I asked resident how he fell resident stated, 'I did not fall, I wanted to get some gum.' Resident was chewing on 5 pieces of gum..."

A nurse's note, dated 03/25/19 at 1:46 PM, documented, "1:30 PM - Summoned to residents room by speech therapy. Resident is sitting upright on the floor next to his bed with shoes on. He denies any injury and reports that he did not

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hit his head...Resident reports trying to transfer himself from wheelchair to bed stating 'I know better'...Neuro checks started at this time ..."

Interview with Resident #62, on 04/16/19 at 8:47 AM, revealed the resident had fallen three (3) times. Resident #62 stated one time he had to go to the Emergency Room and received stitches on his head. The resident stated he did not feel he was getting the help he needed resulting from waiting two (2) hours for someone to help him while he hollered and screamed. The resident stated he liked to chew gum, and the gum is kept in his dresser about six (6) feet away

Observation revealed there was no concave mattress on the resident's bed during the first three (3) days of the survey.

During an interview, on 04/16/19 at 10:01 AM, the Administrator stated Yes, Resident #62 had a concave mattress on his bed. During an observation with the Administrator of the resident's room. The Administrator said he knew the concave mattress had been on the bed at one time, but confirmed the mattress was not on Resident #62's bed now. The Administrator said he would get a concave mattress on Resident #62's bed immediately. The Administrator also confirmed the resident's chewing gum was not within reach which could lead to the resident trying to get out of bed by himself.

Interview with the Charge Registered Nurse (RN), on 04/18/19 at 9:55 AM, revealed she had not been present when the falls had occurred when he had first been admitted. The Charge RN stated Resident #62 had fallen trying to get to his gum. She said they try to keep the gum near him

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at all times, but the gum is kept in a drawer across the room from his bed. She said he has gotten better now on hollering, but he gets out of bed to the wheelchair or vice versa by himself, but is encouraged not to do that, and to use call light to get assistance.

Interview with the Social Worker (SW), on 04/18/19 at 10:15 AM, revealed she stated she was unaware of him being found in the floor trying to get to his gum. She stated, "never read the resident nurses notes." The SW said things like that [falls] are usually brought to her attention during the stand-up meetings held daily. The SW was asked if she had thought about maybe moving Resident #62's gum closer to his bed would have prevented some of the falls, or moving the resident closer to the nurses' station since his room was at the far end of the hall. She stated, "No." The SW said there was a room available now near to the nurses' station, but she had not talked to the family or the resident regarding a move. The SW was asked if it was her responsibility to think of these things, and she stated, "Yes."

Observation of Resident #62's bathroom, on 04/18/19 at 11:10 AM, revealed the call light cord string had broken off, and was now only two to-three inches in length. The cord was an old string which was yellowish brown in color.

Interview with CNA #3, on 04/18/19 at 11:20 AM, revealed she was one of the aides who took care of Resident #62. CNA #3 was asked if she could remember when the concave mattress for Resident #62 had been removed. She said sometimes Resident #62 liked it off the bed. CNA #3 was asked who would remove the mattress.

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(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 689	Continued From page 24 CNA #3 said sometimes his father would when he visited. CNA #3 was asked where would he put it when he took it off the bed. She stated she did not know. She said he would let the nurse know. On 4/18/19 at 11:30 AM, the Charge RN was told what was reported about Resident #62's concave mattress being removed periodically by the resident's father. The Charge RN stated, "I have never heard of such as thing as that." She said no one had ever come to her and reported the resident wanted his concave mattress removed or that it had been removed from his bed. On 4/18/19 at 11:35 AM, the Charge RN and the interim Director of Nursing (DON) was shown the call light cord in the resident's bathroom. They were asked how the resident, who was a fall risk, would be able to use the call light if he was on the floor. They both said he wouldn't be able to pull it. The Charge RN was asked who was responsible for checking the call light cords. She said the Maintenance Man. On 4/18/19 at 12:00 PM, the Maintenance Man was interviewed. He was asked how often he checked the call lights. He stated he and another man checked them randomly one time a month. On 4/18/19 at 12:15 PM, the Administrator stated, "We'll get it fixed right away."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		5/27/19

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	255169	A. BUILDING _____ B. WING _____	04/18/2019

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F 695	Continued From page 25 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacturer's specifications, revealed that the facility failed to assure an oxygen (O2) concentrator was maintained in accordance with manufacturers' specifications for one (1) of 22 residents, Resident #17. Findings include: Review of the manufacturer's specification for Resident #17's O2 concentrator titled, "Operator's Manual - Invacare Platinum Series," documented on page 16 "NEVER block the air openings of the product or place it on a soft surface, such as a bed or couch, where the air opening may be blocked. Keep the openings free from lint, hair and the like. Keep unit as least 3 inches away from walls, draperies, furniture and the like." Review of the facility's policy titled, "Infection Control Oxygen Equipment Cleaning," dated 3/18 indicated, "Oxygen concentrator large particle filters should be checked weekly for dust and debris and cleaned as needed...a. Visibly soiled large particle filters will be removed from the unit, rinsed thoroughly under cool running tap water until all visible particles are removed, blotted dry and replaced on the unit..." On 04/16/19 at 4:39 PM, an observation of the oxygen (O2) concentrator in Resident #17's room revealed the O2 concentrator was equipped with	F 695	a. The area around the oxygen concentrator was cleaned and cleared to provide at least three (3) inches of adequate ventilation of the oxygen concentrator when in use by the Staff Development Nurse and Director of Nurses on 4/16/19. The filters for the oxygen concentrator were replaced with dust free and properly fitting filters to provide clean and filtered air flowing through the oxygen concentrator by the Staff Development Nurse and Director of Nurses on 4/16/19. The Director of Nurses conducted an assessment on Resident #17 with no ill effects found and orientation of person, place, and time. This was completed on 4/16/19. b. All residents who reside in the facility and use oxygen concentrator’s have a potential to be affected by this deficient practice. c. In-service training was provided to the Licensed Practical Nurses, the Registered Nurses, and the Certified Nursing Assistants on 5/09/19 and completed on 5/23/19 by the Director of Nursing. The DON and Staff Development Nurse audited, on 4/16/19, the environment surrounding of in use oxygen concentrator’s to ensure at least three (3)	

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F 695	Continued From page 26 bilateral exterior filters. Both filters were soiled with dust and hair on the right filter surface. The filters were too small to cover the air intake openings on the both sides of the O2 concentrator, as they were cut too short in length by three (3) inches and too narrow by one-half (1/2) to one (1) inch along a jagged edge rather than a straight or smooth edge. The poorly sized air filters allowed unfiltered air to be drawn into the O2 concentrator. Additionally, the O2 concentrator was positioned between a solid wood bedside table and a stack of boxes with clothing laying across the top with less than an inch clearance between both air inlets and solid objects. Observation, on 04/16/19 at 4:51 PM, of Resident #17's O2 concentrator with the Director of Nursing (DON), the DON verified the dust and hair on the surfaces of the air filters. She also verified the air filters on both sides of the O2 concentrator were too small to prevent dust and hair from being drawn into the O2 concentrator. She also verified the positioning of the concentrator between the wood bed table and the stack of boxes did not allow at least three (3)inches of clearance between the machine and solid objects. She stated that she was unaware of clearance requirements around O2 concentrators. She reported the Certified Nurse Aides (CNA) were expected to check the filters on a daily basis, but added it could be the maintenance staff's responsibility to complete routine checks of the filters and the positioning of the O2 concentrators. No further information was provided from the DON on this subject throughout the remainder of the survey. Interview on 04/18/19 at 10:33 AM, revealed	F 695	inches of ventilation of the oxygen concentrator's and at least weekly observation and cleaning of each in use oxygen concentrator's filter and ensure proper fitting of the filters. Prior to placing any oxygen concentrator in use, the filters will be checked for proper fit and cleanliness. Once an oxygen concentrator is implemented for use, the environment surrounding it will have at least three (3) inches of space to allow adequate ventilation. Any newly hired Licensed Practical Nurses, the Registered Nurses, and the Certified Nursing Assistants will also be trained to on this procedure. d. The Director of Nursing or Staff Development Nurse will check all in use oxygen concentrator's for four (4) weeks for compliance and then monthly for six (6) months to ensure the filters are cleaned and properly fitting and at least there is at least three (3) inches of space to allow adequate ventilation. The Any areas of concern will be brought by the Director of Nursing or Staff Development Nurse to the quarterly Quality Assessment and Improvement Committee for review. Additional training and/or disciplinary action will be considered as warranted.	

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F 695	Continued From page 27 Registered Nurse (RN) #1 stated the O2 concentrators are monitored by a contracted oxygen equipment supplier. She stated, "They come monthly and change the internal filters, but they expect the facility's nursing staff to monitor and clean the external filters between visits." She stated the filters were checked and cleaned when necessary and replaced when deteriorated. She held a replacement filter which exactly fit the inlet. RN #1 compared it to the filter first observed on the O2 concentrator. She had no explanation for the use of the improperly sized filter first observed on the O2 concentrator.	F 695		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of the facility's policy, the facility failed to ensure that one (1) oxygen E cylinder (tank) was left secured in Resident #71's room, for one (1) of three (3) residents. Findings include: Review of the facility's policy titled, "Oxygen-Administration, Concentrator, Storage, Assemblage", revised 10/17 read, "Purpose: To provide tissue oxygenation by providing supplemental oxygen...Oxygen Safety...2. Each tank must be individually secured by a chain, on a cart or on a stand ..."	F 921	a. An oxygen carrier was immediately attached and secured to the back the wheelchair for Resident #71 and the oxygen E cylinder was properly placed and secured inside of the oxygen carrier, which was attached to the wheelchair, for safety and portability by the Director of Nurses on 4/18/19. b. All residents who reside in the facility and use oxygen E cylinders have a potential to be affected by this deficient practice. At the time, two (2) residents occasionally use oxygen E cylinders during mobility.	5/27/19

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F 921	Continued From page 28 During an observation in Resident #71's room on 04/15/19 at 2:52 PM, on 04/16/19 at 9:07 AM and on 04/17/19 at 8:17 AM, revealed that next to the wall was a freestanding oxygen E cylinder tank which was not on a cart or in a caddy. During an observation and interview, on 4/17/19 at 8:08 PM, Licensed Practical Nurse (LPN) #5 was shown the E cylinder tank was against the wall in Resident #71's room. LPN #5 was asked if it was appropriate for the tank to be left free standing in the resident's room. LPN #5 replied that it was probably left because the resident used to have a wheelchair that the tank was attached too, but then she got a new wheelchair and there was no place to attach the cylinder. LPN #5 stated that they are usually in a cart, and that it was not appropriate that the tank was left freestanding and not secured. During an interview, on 4/18/19 at 2:00 PM, the Maintenance Manager was asked about the freestanding tank. He stated the tanks should be secured on the wheelchair or in the oxygen caddy. The oxygen tank should never be left freestanding. During an interview, on 4/18/19 at 2:15 PM, LPN #1 was asked about the freestanding oxygen tank. LPN #1 stated that the oxygen tank should be placed on the holder on the chair or carried in the caddy. During an interview, on 4/18/19 at 2:40 PM, the Administrator was asked about the tank freestanding in a resident's room, he stated, "That is not good."	F 921	c. In-service training was provided by the Director of Nurses to the Licensed Practical Nurses, Registered Nurses, and Certified Nurse Assistants were in-serviced on 5/23/19 and completed on 5/23/19 on ensuring the oxygen E cylinder tank is properly secured in the oxygen carrier and attached and secured to the back the wheelchair when in use. Any newly hired Licensed Practical Nurses, the Registered Nurses, and the Certified Nursing Assistants will also be trained to on this procedure. d. The Director of Nursing or Staff Development Nurse will check all in use oxygen E cylinder, beginning 4/26/19, for four (4) weeks for compliance and then monthly for six (6) months to ensure the oxygen E cylinder is properly secured in the oxygen carrier, attached and secured to the back the wheelchair when in use. Any areas of concern will be brought by the Director of Nursing or Staff Development to the quarterly Quality Assessment and Improvement Committee for review. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations	