

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

PRINTED: 07/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
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F 000	INITIAL COMMENTS A standard survey was conducted by Healthcare Management Solutions (HMS) on behalf of the MS State Department of Health from 05/20/19 through 05/23/19. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance: F553, F576, F580, F584, F610, F656, F679, F686, F688, F690, F755, F758, F801, F804, F812, F842, and F883. The facility's census on 05/20/19 was 90 residents and the facility held a license for 120 beds.	F 000			
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		7/15/19	

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

TITLE

(X6) DATE

Electronically Signed

06/21/2019

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 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on policy review, interviews and record review, the facility failed to ensure residents, or their representatives, were invited to participate in the development and implementation of their person-center plan of care for four (4) of 19 sampled residents, Residents #1, #12, #56 and #80. Findings include: Review of the facility policy titled, "Resident Assessment," dated 6/1/00, revealed, ". . . Residents and/or their representative (sponsors) will be encouraged to participate in the initial, quarterly, and annual assessments. This facility will notify the resident and/or sponsor in advance of the scheduled assessment or review. . ." Resident #1 An interview on 05/20/19 at 2:50 PM, revealed Resident #1 had never been invited or attended a care plan meeting. The resident stated his son was his Resident Representative, but they were both involved in decisions about his care.	F 553	This plan of correction affirms our allegations that Plaza Community Living Center is in substantial Compliance with regulations & standards. This plan of correction has been respectfully developed as required for compliance with the Federal & State Regulations. This plan of correction does not constitute an admission of any deficient practice, admission or argument of truth of the facts, alleged or conclusions set forth in the statement of deficiencies F553 483.10 (C) (2) 1. Resident #1 and their Resident representative were informed of their rights to participate in their care plan conference by the Social Services Director, who is a Master Social Worker, on 6/20/19 and the facility is awaiting their decision on time and date for care plan conference. Resident #12 and their		

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F 553	Continued From page 2 Review of Resident #1's undated "Face Sheet" (a document with demographic and diagnoses information) revealed the resident was admitted to the facility on 9/14/16, with diagnoses that included Vascular Dementia, Muscle Wasting and Atrophy, Weakness, Schizoaffective Disorder, and Anxiety Disorder. The Annual Minimum Data Set (MDS) assessment, dated 2/12/19, revealed the resident was cognitively intact and required limited assistance with activities of daily living (ADL). Review of Resident #1's medical record revealed there was no documentation that indicated the resident was invited or attended any care conference meetings; or of any documented care conferences since his admission in 2016. Telephone interview, on 5/21/19 at 4:02 PM, with Family Member #1, revealed she did not remember being invited to care conferences in the past; however, she had received a notice of invitation for a care conference meeting scheduled on 5/29/19. An interview with the Director of Nursing (DON) on 5/22/19 at 4:45 PM, confirmed there was no documentation of care conferences for Resident #1. The DON confirmed the facility's "Resident Assessment" policy had not been followed. Resident #12 An interview was conducted with a Family Member #1, of Resident #12, on 5/20/19 at 10:39 AM, which revealed she had not been invited to a care conference for the resident.	F 553	Resident representative were informed of their rights to participate in their care plan conference by the Social Services Director, who is a Master Social Worker, on 5/20/19 and a care plan conference was held on 5/29/19. Resident #56 and their Resident representative were informed of their rights to participate in their care plan conference by the Social Services Director, who is a Master Social Worker, on 6/20/19 and a care plan conference was held on 7/3/19. Resident #80 and their Resident representative were informed of their rights to participate in their care plan conference by the Social Services Director, who is a Master Social Worker, on 6/20/19 and a care plan conference was held on 6/26/19. 2. The facility recognizes that all residents have the potential to be affected by the same deficient practice. The Nursing Home Administrator informed residents in the facility Resident Council meeting held on June 13, 2019 of their right to attend care plan meetings. A summary of Resident Rights was distributed to all facility residents by the Director of Social Services, who is a Master Social Worker, on June 20, 2019. The facility Social Services staff members were in-serviced by the Nursing Home Administrator on June 19, 2019 regarding the requirements to ensure that all facility residents and their Representatives are invited to the resident's care plan meeting. 3. The Social Services Director, who is a Master Social Worker, will ensure care		

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F 553	Continued From page 3 Review of Resident #12's "Admission Record" revealed the facility admitted the resident on 10/30/17. Review of Resident #12's MDS assessment, dated 2/25/19, revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident had moderate cognitive impairment. Review of the "Progress Notes" dated, July 2018 through May 2019, revealed no documented evidence Resident #12's Representative had been invited to the care conferences. An interview was conducted with a Social Services (SS) representative on 5/22/19 at 11:44 AM. The SS representative stated she reviewed the binder which held the notifications to the residents and families for care conference meetings and there was no evidence the family member for Resident #12 was invited to participate in these meetings on a quarterly basis. Resident #56 During an interview on 5/21/19 at 2:15 PM, Resident #56 was sitting in wheelchair in his room with the TV on. He stated he did not recall ever being invited or attending care conference meetings. Review of Resident #56's undated "Face Sheet" revealed he was admitted to the facility on 6/26/18, with diagnoses that included Nontraumatic Subarachnoid Hemorrhage, Hemiplegia and Hemiparesis following Cerebral Infarction, Depression and Diabetes.	F 553	plan invitations will be mailed to all responsible parties and the resident s will be notified of the care plan meetings beginning 5/20/19. Copies of the care plan letters will be maintained in a file in the social services department by the Social Services Director. 4. The Social Services Director, who is a Master Social Worker, will audit that Resident Representatives and the Resident have been informed of care plan conferences per the Minimum Data Set schedule on a weekly basis for 12 weeks. The results of this audit will be brought to the monthly Quality Assurance Committee meeting by the Social Services Director for review, revision, and/or resolution.		

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F 553	Continued From page 4 The MDS significant change assessment, dated 4/4/19, indicated the resident had severe cognitive impairment and required extensive assistance for ADLs. During an interview with the DON on 5/22/19 at 4:45 PM, an "Interdisciplinary Care Conference" note dated 4/10/19, was reviewed. It revealed a nurse, therapist and family member attended. The documentation lacked any specific information regarding which nurse, family member or therapist attended the care conference; and lacked any resident specific care planning interventions or goals. Resident #80 In an interview on 05/20/19 at 3:35 PM, Resident #80 revealed she had not been invited to any care plan meetings. Review of Resident #80's undated "Face Sheet" revealed the resident was admitted to the facility on 9/25/17, with diagnoses that included End Stage Renal Disease, Dependence on Renal Dialysis, Anxiety Disorder, Transient Ischemic Attack and Cerebral Infarction. Review of Resident #80's significant change MDS assessment, dated 3/23/19, indicated the resident was cognitively intact and could be reliably interviewed about her care and services. Medical record review revealed there was no documentation that there had been any care conferences, or that Resident #80 had ever been invited to any care conferences, since her admission in 2017. This was confirmed in an interview with the DON on 05/23/19 at 9:15 AM.	F 553			

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F 576	Continued From page 5	F 576			
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 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	F 576 F 576			7/15/19

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F 576	Continued From page 6 access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and interviews, the facility failed to ensure residents' rights of receiving mail on Saturday for seven (7) of seven (7) residents who attended the Resident Council Meeting, which had the potential to affect all 90 residents in the facility. The facility also did not provide privacy for phone communication on the South Unit for Resident #80 or the other 59 residents on the South Unit. Findings include: Review of the facility's policy titled "Resident Rights", dated 11/28/16, revealed: "The resident has the right to send and receive mail. . ." Review of the facility's policy titled "Telephone" dated June 1, 2000, indicated telephones were available to residents to make and receive private telephone calls. The policy also revealed there was a cordless telephone on the North Unit. There was no indication of any telephones that could be used privately on the South Unit. On 5/21/19 at 9:38 AM, a Resident Council meeting and group interview was conducted. The resident group consisted of seven (7) cognitively intact residents that could be reliably interviewed about their care and services. When asked if they received their mail on Saturdays, all seven (7) residents stated they did not receive their mail on Saturdays. On 5/21/19 at 10:36 AM, the Business Office	F 576	F 576 1. A Resident Council meeting was held on June 13, 2019 by Nursing Home Administrator informing residents of their right to have mail delivered within 24 hours of receipt and that a designated phone for private use is available on the Transitional Care Unit in the Communications Room and is located in a private office on the Nursing Administrative Hallway on the North Unit. A notification regarding the accessibility of a private phone, Resident Rights, and the delivery of personal mail was distributed to all in-house residents on June 28th, 2019 by Social Services Director. Residents were educated of posted signage that also listed the designated location by the Social Services Director. 2. All residents receiving mail or wishing to make/receive private phone calls have the potential to be affected. 3. Director of Nursing conducted staff in-services that were completed on June 21, 2019 regarding the right of residents to have private use of a phone. Social Service Director was in-serviced on June 19 and the Activity Department was in-serviced on June 18th by the Nursing Home Administrator on the requirement to distribute resident mail within 24 hours of receipt. Mail distribution will be		

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F 576	Continued From page 7 Manager was asked if the residents always received their mail on Saturdays. She stated, "No", because the Activities Coordinator did not work on Saturdays. When asked if her mail at home was delivered on Saturdays, the Business Office Manager stated, "Yes." When asked if the residents at the facility should have the same right to receive their mail on Saturdays, she stated, "Yes." Resident #80 During an interview on 05/20/19 at 3:35, with the resident in her new room, she stated there was no place on the South Unit to have a private telephone conversation. Review of Resident #80's Significant Change Minimum Data Set (MDS) assessment, dated 3/23/19, revealed the resident was cognitively intact. The resident was her own representative and was involved in decisions about her care and services. A random observation of another resident on the South Unit, on 5/22/19 at 3:15 PM, revealed the resident talking on the telephone that rested on the nurses' station counter. There was no privacy for the resident during the call. At the time of the observation, Registered Nurse (RN) #58 confirmed there was no place on the South Unit for residents to talk on the telephone privately. An interview with the Assistant Director of Nursing (ADON) on 5/21/19 at 4:00 PM, confirmed there was no place on the South Unit for the residents to have privacy with their phone calls.	F 576	documented by the weekend staff and documentation will be maintained in the Receptionist's Office. Residents will be reminded monthly at the Resident Council Meeting of their right to request the private use of a phone and the location of the designated phone. 4. Administrator to review mail distribution documentation beginning June 19, 2019 1X weekly for four weeks and 1X monthly for two months to ensure continued compliance with any negative findings to be reported in the monthly Quality Assurance meeting for review, revision, and/or resolution. Administrator will review Resident Council meeting minutes monthly beginning July 2019 for 4 months to ensure continued compliance and report any negative findings in the Quality Assurance meeting for review, resolution, and/or revision.		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		7/15/19	

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F 580	Continued From page 8 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580			

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F 580	Continued From page 9 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, record review, and interviews, the facility failed to notify the resident of a room change. This affected one (1) resident of 19 sampled residents, Resident #80. Findings include: Review of the facility's policy titled "Room to Room Transfers", dated June 3, 2009, specified that residents would be provided information regarding the decision to make a room transfer prior to the room transfer. During an interview on 5/20/19 at 3:35 PM, Resident #80 revealed she was in a new room. The resident stated she returned from dialysis today and found her room was changed, without notification of any kind. There was no documentation in her medical record to indicate the resident had been notified of a room change. Review of Resident #80's undated "Face Sheet" (a document with demographic and diagnoses information) revealed the resident was admitted to the facility on 9/25/17, with diagnoses that included End Stage Renal Disease, Dependence	F 580	F580 1. Resident # 80 was notified of the facility's obligation to provide notification of room changes by the facility Administrator on 05/25/19. This notification was documented by the facility Social Worker and is in the Resident's Electronic Health Record under the Social Services notes. 2. The facility recognizes that all residents have the potential to be affected. The Nursing Home Administrator informed the Resident Council for residents in attendance of their right to be informed of room or roommate changes on 6/14/19. The Social Services Director will ensure all residents are informed of room or roommate changes as of 5/25/19. 3. The Social Services and Activities staff members were in serviced by the Nursing Home Administrator on June 19, 2019 regarding the requirements for notification of room changes. All nursing staff members were in serviced by the Director		

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F 580	Continued From page 10 on Renal Dialysis, Anxiety Disorder, and Cerebral Infarction. Review of Resident #80's significant change MDS assessment, dated 3/23/19, indicated the resident was cognitively intact and could be reliably interviewed about her care and services. An interview with Registered Nurse (RN) #58 on 5/22/19 at 3:20 PM, verified the resident's room was changed when she returned from dialysis on Monday 5/20/19. She did not know if the resident had been notified. She stated she was the nurse working when the resident left for dialysis on Monday 5/20/19, and she had not notified the resident. An interview with the Director of Nursing (DON) on 5/22/19 at 3:45 PM, confirmed there was no documentation that the resident had been notified of the room change prior to the facility changing her room, and that the facility's policy had not been followed.	F 580	of Nursing regarding the facilities policies and procedures for room changes and proper notification as of June 5, 2019. The Social Services Director, a Master Social Worker, will fill out and present a Notification of Room Change to all resident changing rooms as of 6/5/19. 4. Beginning July 15, 2019, the Nursing Home Administrator will audit all Notification of Room Change sheets to ensure residents are informed of room changes and reason for the room changes weekly for four weeks, monthly for two months. The Nursing Home Administrator will bring the results of the Notification of Room Change audit to the monthly Quality Assurance Committee meeting for review, revisions, and/or resolution.		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment 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	F 584		7/15/19	

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F 584	Continued From page 11 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, 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 facility policy review, observations, and interviews, the facility failed to ensure the furniture and wheelchairs were in good repair and were clean. This affected four (4) residents, Residents #1, #56, #57 and #240, of 24 sampled residents. Findings include: A request was made for the facility's policy	F 584	F584 483.10 (i) (1) 1. On June 14, 2019 the tape was removed, wheelchair cleaned, and brakes repaired for Resident #1. On June 14, 2019 the wheelchair was cleaned and armrest replaced for Resident #56. On June 14, 2019 the wheelchair was cleaned for Resident #57. On June 14,		

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F 584	Continued From page 12 regarding furniture and wheelchair maintenance. During an interview with the Maintenance Director on 5/23/19 at 4:00 PM, he provided a document titled "Cleaning/Repairing Carpeting and Cloth Furnishings", dated May 30, 2012. The Maintenance Director confirmed this was the only policy regarding furniture. On 5/21/19 at 3:30 PM, the Administrator submitted a statement that confirmed there was no specific policy on wheelchair cleaning/repair. An environmental tour with the Maintenance Director on 5/21/19 began at 2:42 PM, confirmed the following random environmental observations made throughout the survey: Resident #1 Resident #1 was observed on 5/20/19 at 2:30 PM, in his bed, with a wheelchair (wc) at the bedside. The armrests of the wc had thick tape bilaterally. The tires of the wheelchair had thick tape on them. The resident complained that his wc brakes were too difficult to put on. During the observations of Resident #1's wc, the maintenance man stated he was aware of the resident's dissatisfaction with the wheelchair. Resident #56 Resident #56 was observed in his room on 5/21/19 at 2:15 PM, sitting in his wheelchair. The right armrest of the wheelchair was missing. The resident's arm was resting on the frame of the right side of the wheelchair. The resident stated he was not bothered by the condition of the chair. The Maintenance Director confirmed the wc needed repair, at the time of the observation. Resident #57 Resident #57 was observed on 5/21/19 at 8:20	F 584	2019 both wardrobes and nightstands in the room of Resident #240 were repaired and refinished. 2. All residents have the potential to be affected. The Maintenance Department conducted a 100% audit of facility on June 14, 2019 for furniture in need of repair/refinish and wheelchairs for cleanliness and safety. Maintenance began corrective actions of cleaning, repairing & refinishing items identified in the audit on June 14, 2019 and were completed on June 18, 2019. 3. Staff in-services were held on June 5, 6, 7 and 13 2019 by the facility Director of Nursing regarding the facility policies and procedures to ensure a clean, safe, homelike environment. Wheelchairs will be cleaned weekly by the nursing staff. The Maintenance Department will perform weekly walking rounds beginning June 25 to observe for additional repairs. 4. The Administrator will conduct walking rounds observing the condition of the furnishings and equipment in the facility 2X a week for three weeks, 1X a week for two weeks, and every two weeks for 2 months to ensure continued compliance. Any negative findings will be noted and reported by the Administrator to Quality Assurance Meetings monthly for review, revision, and/or resolution.		

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F 584	Continued From page 13 AM, self-propelling in his wheelchair, on the North Unit. The wheelchair had a large amount of dirt and dried spillage build-up. The Maintenance Director confirmed the wheelchair was dirty and needed to be cleaned, at the time of the observation. Resident #240 Resident #240 was observed in his room on 5/20/19 at 2:29 PM. The resident commented on the poor condition of the furniture, and specifically two (2) wardrobes and two (2) night stands that had chips and scrapes. The Maintenance Director confirmed the furniture needed to be repaired or replaced, at the time of the observation.	F 584			
F 610 SS=D	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. §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	F 610		7/15/19	

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F 610	Continued From page 14 by: Based on facility policy review, record reviews, observation, and interviews, the facility failed to investigate, document, and report an injury of unknown origin for one (1) of four (4) residents reviewed for wounds, Resident #36. Findings include: Review of the facility's policy titled "Incidents and Accidents," undated, specified the facility was to investigate wounds to determine the origin, including if the source of the injury is unknown ...the location of the injury could indicate the facility did not provide appropriate care ..." The policy further specified that any accident/incident or injury required documentation that the physician and the resident representative were notified. Observation of Resident #36 on 5/21/19 at 2:41 PM, with the Assistant Director of Nursing (ADON) present, revealed a scabbed wound approximately two (2) centimeters (cm) x five (5) cm on the resident's left shin. The ADON stated she was unaware of the shin wound or how it occurred, at the time of the observation. The resident could not be interviewed about the wound or its origin due to her cognitive impairment. Review of Resident #36's undated "Face Sheet"(a document with demographic and diagnoses information) revealed an admission date of 10/4/17, with diagnoses including Cerebral Palsy and Dementia. Resident #36's Quarterly Minimum Data Set (MDS) assessment dated, 1/1/19, revealed	F 610	F 610 Investigate, prevent, correct alleged violations. 483.12 (c) (2) 1) Upon notification, the Wound Care Nurse performed a complete body audit on Resident #36, noted one scabbed area to left shin on 05/23/19. On 5/23/19, the facility notified Resident# 36 Responsible Party, Physician, and obtained a new order for Resident #36 to treat the area. The facility opened an investigation for injury of unknown origin for Resident #36 and began investigation as of 5/28/19. The investigation and conclusion for the incident of unknown origin for Resident #36 was completed on 05/28/19 by the Assistant Director of Nursing with Resident #36 stating how the injury occurred. 2) A 100% Audit of all Incidents & Accidents for the last 30 days was conducted by the Assistant Director of Nursing, as of June 26, 2019 to ensure that an investigation has been conducted into any injuries of unknown origin the facility did not identify any additional injuries of unknown origin. All residents could be affected by the same deficient practice. Full body audits of all residents was completed by 7/11/19 by nurses to identify any other injuries of unknown origin. The Director of Nursing will open and investigate any findings of injuries of unknown origin. 3) All staff were inserviced by the Director of Nursing and the Assistant Director of Nursing on the facility policies for		

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F 610	Continued From page 15 Resident #36 was unable to complete the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. The resident was completely dependent on staff for all activities of daily living (ADLs) including transfers between the bed and wheelchair, repositioning, and mobility. Interview with Registered Nurse #58 on 5/21/19 at 2:43 PM, revealed she had not performed Resident #36's skin assessment during her bath that morning, but instead documented information given to her by someone else, that the resident had no alteration in her skin integrity (no wounds). Review of the clinical record, including the progress notes and the weekly skin assessments, dated 5/12/19 through 5/23/19, for Resident #36, revealed no documentation of the observed shin wound or of any skin integrity issues for the resident. Interview with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/23/19 at 9:05 AM, revealed she had been made aware of a skin concern for Resident #36 that morning, and she planned to assess it later in the day. Interview with the Administrator and Director of Nursing (DON) on 5/23/19 at 1:50 PM, revealed they were unaware of Resident #36's wound, including the lack of documentation regarding the identification, assessment, and management of the wound. The Administrator confirmed he was unaware of the facility's failure to report and investigate the injury of unknown origin as the facility policy directs.	F 610	Incidents & Accidents as of June 13, 2019 to ensure that all injuries of unknown origins are identified, investigated, and reported as required. The Social Services Director posted notifications throughout the facility directing staff and visitors to report resident injuries to the nurse's station on June 13, 2019. The Assistant Director of Nursing will review all new incidents at the clinical morning meeting Monday through Friday. The Director of Nursing will open and begin investigating of all noted injuries of unknown origin. 4) Beginning July 15, 2019, the Director of Nursing and/or Assistant Director of Nursing will review new orders, and incident reports Monday through Friday to ensure incident reports and investigations are completed on all injuries. The Administrator will review investigations weekly to ensure all injuries are investigated timely and reported appropriately. The Director of Nursing will bring findings to the Quality Assurance Committee monthly for review, revision, and/or resolution.		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		7/15/19	

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F 656	Continued From page 16 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656			

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F 656	Continued From page 17 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 facility policy review, record reviews, observations, and interviews, the facility failed to implement a resident centered care plan for three (3) residents (Residents #3, #54, and #74) of 24 sampled residents. The facility failed to implement the medical care and assessment needed from the care plan for Resident #54 regarding pressure ulcers. As a result, the resident sustained harm as evidenced by a stage II pressure deteriorated to an unstageable pressure ulcer. Additionally, the facility failed to ensure the care plan was implemented to meet the activity interests for Resident #74, and Resident #3 for not getting an inhaler medication as ordered. Findings include: A facility policy entitled, "Resident Assessment" dated 6/1/00, indicated "...Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning and may include: ...Special treatments or procedures (treatments and procedure that are not part of basic services provided to independent residents). For example, treatment for pressure sores. ..." The policy also included: "Activities potential (the resident's ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being; includes activities which provide benefits in the areas of. . .pleasure and lifetime preferences. . ."	F 656	F 656 Care Plans 483.10 (C) (2) 1) The care plan for resident #54 was reviewed and updated by the Minimum Data Set Coordinator to address wound care treatments and documentation on 6/24/2019. The care plan for Resident #74 was reviewed and updated by the Minimum Date Set Coordinator addressing one on one activities 6/24/2019. The care plan for resident #3 was reviewed and updated by the Minimum Data Set Coordinator to address medications to be administered as ordered by the physician on 6/24/2019. 2) This deficient practice has the potential to affect all residents in the facility with care plans for pressure areas, activity interests, and respiratory medications. A 100% audit of residents requiring wound care, one on one activities, and residents ordered a respiratory inhaler was conducted by the Care Plan Coordinator and/or her assistant and was completed by June 28, 2019 to ensure that care plans reflect wound care as ordered by physician, one on one activities that meet the interest of the residents, and administer respiratory inhalers as ordered by the physician. The Life Connections Coordinator has reviewed residents to ensure one on one in room activities were addressed in the care plan including		

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F 656	Continued From page 18 Resident #54 Review of a "Care Plan" dated 3/25/19, documented Resident #54 had a Stage 2 pressure ulcer. The care plan directed clinical staff to document weekly the condition of the wound, provide measurements, depth, width, length, type of tissue, and if there was exudate (drainage) or not and to administer treatments as ordered. Review of a "Care Plan", dated 4/19/19, revealed Resident #54 had an unstageable pressure ulcer to her right heel. There had been no care plan revisions to update and implement clinical interventions to prevent the wound from deteriorating and promote healing from the time the pressure ulcer was identified on 3/7/19, until the wound had deteriorated to unstageable on 4/19/19. Review of Resident #54's "Admission Record", located in the Electronic Health Record (EHR) revealed the resident was admitted to the facility on 3/5/19, with a diagnosis of Moderate Protein-Calorie Malnutrition. Review of a "Weekly Pressure Injury Record", revealed that on 3/7/19, Resident #54 was assessed to have a Stage 2 pressure ulcer (partial thickness loss to skin or may appear as an intact or open/ruptured serum filled blister) to the right heel. The Stage 2 pressure ulcer was identified as two (2) centimeters (cm) by two (2) cm in length and two (2) cm by two (2) cm in width. There was no depth, tunneling, and/or exudate identified with this assessment. The wound to the right heel was described as "a fluid filled blister." The "Weekly Pressure Injury Records" dated 3/14/19, and 3/21/19,	F 656	interventions and being done on a routine basis. Care plans were audited by the Life Connections Coordinator, and Director of Nursing and completed by June 28, 2019. Residents with pressure areas, prescription inhalers, will be audited to ensure that the care plan has been implemented and is being followed. Care plans for any new admissions within the last 60 days will be audited to ensure that all orders for inhalers are included, pressure areas are addressed, as well as one on one activities are addressed to meet the resident needs. 3) The Director of Nursing In-serviced the nursing staff, Minimum Data Set staff and the Life Connections Coordinator as of June 13, 2019 regarding the facility policies for individual activities, person centered care plans, and ordering and receiving medications from the dispensing pharmacy. All nursing staff received an in-service regarding implementation and following plan of care for each individual resident from the Director of Nursing that was completed on 06/13/19. Care plans and care task will be reviewed and updated by the Minimum Data Set nurse and the Medical records nurse with every comprehensive assessment to ensure that adequate interventions are in place. 4) Beginning July 15, 2019, the Wound Care Nurse will audit all wound pressure wound care plans weekly for four weeks, then monthly for two months. The Life Connection Coordinator will audit all residents requiring one on one activities		

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F 656	Continued From page 19 documented no change in the measurements and description of the wound. There were no "Weekly Pressure Injury Records" or weekly skin assessments documented in Resident #54's medical record from 3/21/19 to 4/25/19. This was confirmed with the Licensed Practical Nurse/Wound Nurse and the Director Of Nursing (DON) in an interview on 5/23/19 at 8:32 AM, with the Administrator present. An entry identified in the nursing "Progress Notes" dated 4/19/19, identified Resident #54 had an unstageable pressure ulcer on her right heel. There were no measurements or description of the wound as directed in the care plan. Review of the April 2019 Treatment Record revealed no treatments to Resident #54's right heel from 4/5/19, until 4/19/19. An interview was conducted with the Director of Nursing (DON) on 5/22/19 at 4:19 PM. The DON stated it would be her expectation that staff should follow the care plan. Resident #74 Review of Resident #74's care plan revised 5/16/17, identified the resident was visually impaired but he still enjoyed involvement in singing and spiritual programs. Continued review of the care plan specifically identified Resident #74 as blind and there was a need for in room visits. The identified intervention included Resident #74 enjoyed music, specifically the blues. Review of the "Admission Record" revealed Resident #74 was admitted to the facility on	F 656	care plans weekly for four weeks, then monthly for two months. Minimum Data Set Nurses and Medical Record Nurse will audit all medication focused care plan. The auditors will bring the results of their audits to the monthly Quality Assurance Committee to review, revise, and/or resolution.		

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F 656	Continued From page 20 12/26/15, with a diagnosis of Cerebral Infarction (stroke). Review of Resident #74's most recent quarterly "Minimum Data Set (MDS)" assessment, dated 4/24/19, revealed the resident was severely cognitively impaired and unable to participate in the Brief Interview for Mental Status (BIMS) cognitive evaluation. The assessment documented the resident was "highly impaired" visually; was "rarely/never understood"; required extensive staff assistance with all activities of daily living (ADLs); and was unable to be interviewed about his preferences related to routines/activities due to his cognitive impairment and communication deficits. Observations were made of Resident #74, while he was in his room on 5/20/19 at 1:41 PM, 5/20/19 at 4:04 PM, and on 5/21/19 at 9:32 AM. At each observation there was no radio present. There was a television in the room and it was off. There was no music playing. The resident could not be reliably interviewed to determine if sitting in his room quietly was his choice, due to his cognitive and communication deficits. An interview was conducted with CNA #109 on 5/21/19 at 12:30 PM. The CNA stated she had worked at the facility for the past year and had never been directed to turn a radio on or to turn the television on for Resident #74 to listen to music. A review was conducted of three (3) documents completed by the Activities Coordinator, titled "In Room/1:1 Activities." The forms were dated 2/19, 3/19, and 4/19. The form dated 2/19, identified Resident #74 received in room music for 10	F 656			

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F 656	Continued From page 21 minutes on 2/6/19, and on 2/26/19. The form dated 3/19 identified Resident #74 listened to music for 10 minutes on 3/5/19. The form dated 4/19 identified Resident #74 listened to music for 10 minutes on 4/8/19. The forms were completed by the Activities Coordinator, who was not in the facility during the survey, and was not available for an interview regarding the resident having been provided only 10 minutes of his care planned, and preferred activity for March 2019, and April 2019, and for 20 minutes during the month of February 2019. An interview was conducted with MDS Coordinator #2 on 5/22/19 at 4:15 PM. MDS Coordinator #2 stated the Activities Coordinator creates an activity care plan for the residents. She said if an issue was care planned and not done, it means someone needed training and the staff members needed to follow the care plans. Resident #3 The "Care Plan" for Resident #3, most recently reviewed/revised on 5/2/19, documented the resident had altered respiratory status related to chronic respiratory failure with hypercapnia and COPD. Interventions included to "administer respiratory treatments as ordered." Review of a "Physician's Order," dated 2/20/19, revealed the Resident #3 was to be administered an Atrovent Inhaler (an anticholinergic medication), two (2) puffs orally four (4) times daily, for COPD with acute exacerbation. On 5/20/19 at 11:39 AM, interview with Resident #3 revealed she had not received her Atrovent inhaler for three (3) days because the facility did not have the medication in stock. She stated she	F 656			

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F 656	Continued From page 22 needed the medication. She stated she depended upon staff to have her medications. The "Medication Administration Record (MAR)," dated 5/2019, documented the resident's Atrovent Inhaler was not administered as follows: 5/17/19 - not administered at 12:00 PM or 8:00 PM. 5/18/19 - not administered at 8:00 AM or 12:00 PM. 5/19/19 - not administered at 8:00 AM, 12:00 PM, 4:00 PM (resident absent from facility) or 8:00 PM. 5/20/19 - not administered at 8:00 AM. On 5/21/19 at 4:15 PM, Licensed Practical Nurse (LPN) #102 confirmed there were doses documented as not having been administered between 5/17/19 and 5/20/19. She stated the resident reported to her that her Atrovent inhaler had been unavailable last week. On 5/22/19 at 8:44 AM, Resident #3 stated she was in no additional respiratory distress as a result of not receiving her Atrovent inhaler last week. On 5/22/19 at 10:09 AM, LPN #24, stated that the resident had no Atrovent inhaler in the medication cart. She stated the off-going medication nurse, 5/17/19 at 3:00 PM, had informed her there was no Atrovent inhaler for the resident, but the medication had been ordered. On 5/22/19 at 10:18 AM, LPN #33 was asked why the facility had not acquired an Atrovent inhaler for three (3) days for Resident #3. She stated she called the pharmacy provider and stated authorization to purchase the Atrovent inhaler	F 656			

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F 656	Continued From page 23 was required, from either the DON or herself, and the provider had not received that authorization. LPN #33 stated she had been told the morning of 5/20/19, the resident still did not have an Atrovent inhaler and at that time she went to the "backup pharmacy" to purchase the medication. She stated the resident should not have gone three (3) days without her Atrovent inhaler. On 5/22/19 at 05:17 PM, Registered Nurse #90 confirmed on 5/18/19 at 4:00 PM and 8:00 PM, there was no Atrovent inhaler in the medication cart and that she had mischarted some of the administration times of the medication. An interview was conducted with the Director of Nursing (DON) on 5/22/19 at 4:19 PM. The DON stated staff should follow the care plan.	F 656			
F 679 SS=D	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, observation, staff interviews, and record review, the facility failed to provide an ongoing program of activities based on the identified preferences/interests of two (2)	F 679	F 679 483.24 (c) Activity Care Plans		7/15/19

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F 679	Continued From page 24 residents, Residents #74 and #46, out of a sample of 19 residents. Findings include: Review of the facility's policy titled, "Activity Program," dated 10/26/09, revealed: It is the policy of this facility than [sic] an ongoing program of activities be designed to meet the needs of each resident. . .Activity Programs consist of individual, small and large group activities that are deigned [sic] to meet the needs and interests of each resident and include, as a minimum. Resident #74 On 5/20/19 at 1:41 PM, Resident #74 was observed in his room and in bed. There was no radio observed in his room with music playing and the resident's television was powered off. On 5/20/19 at 4:04 PM, Resident #74 was observed in his room, in bed, and again, there was no radio with music playing and the resident's television was off. An annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 8/17/18, identified Resident #74 enjoyed listening to music. The quarterly "MDS" with an ARD of 4/24/19, revealed a Brief Interview for Mental Status (BIMS) was not able to be completed; however, the facility assessed Resident #74 as being severely cognitively impaired. Review of Resident #74's care plan, revised 5/16/17, revealed the resident was visually impaired; however, he still enjoyed involvement in singing and spiritual programs. Continued review of the care plan specifically identified Resident #74 as blind and a need for in room visits. The	F 679	1) A radio was provided for resident #74 5/22/19 by the Life Connections Coordinator. A radio was provided for Resident # 46 on 5/22/19 by the Life Connections Coordinator. The Life Connections Coordinator was educated to document all one on one activities by the administrator on 6/19/19. The care task were updated for Resident #74 and Resident #46 on 6/25/19 by the Life Connections Coordinator to include turning on the radio and/or television. The Activity Coordinator was in-serviced by the Administrator on June 19, 2019 regarding the facility policies for care plans. 2) Residents who require in room activities have the potential to be affected. The Life Connections Coordinator reviewed all residents for the need of in room activities to develop and implement weekly in room activity program on 6/28/19. 3) All resident care plans and care task were audited and/or updated by the Life Connections Coordinator completed by 6/28/19 to ensure they reflect information to meet resident's activity needs. The Life Connections Coordinator will update the care plan for new residents and with changes to reflect residents activity needs. All facility nursing staff were in serviced beginning on June 19,2019 and completed on June 20, 2019 by the Administrator regarding reviewing the care plan and/or care task and providing activities. Life Connections Coordinator will document all activities on activity logs.		

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F 679	Continued From page 25 intervention documented on the resident's care plan included Resident #74 enjoyed music, specifically the blues. Review of progress notes titled, "Life Connections," dated 11/9/18, 2/12/19, and 4/26/19, revealed Resident #74 enjoyed listening to music. Continued review of the progress notes revealed the Activities Coordinator completed the progress notes; however, she was not available for interview during the survey process. A review was conducted of documents titled, "In Room/1:1 Activities," dated February 2019, March 2019, and April 2019. The form dated February 2019 revealed Resident #74 received in room music for 10 minutes on 2/6/19 and on 2/26/19. The form dated March 2019 revealed Resident #74 listened to music for 10 minutes on 3/5/19. The form dated April 2019 revealed Resident #74 listened to music for 10 minutes on 4/8/19. Certified Nursing Assistant (CNA) #84 was interviewed on 5/20/19 at 4:04 PM. CNA #84 stated she had worked at the facility since February 2019. The CNA further stated there was no radio in Resident #74's room and the television was turned on periodically, but not on any specific channel. On 5/21/19 at 9:32 AM, Resident #74 was observed in his room and in bed, with no radio observed in his room playing music and the television was off. An interview was conducted with CNA #109 on 5/21/19 at 12:30 PM. The CNA stated she had worked at the facility for the past year and had never been directed to turn a radio on or to turn	F 679	In room activities will be provided to resident's who are unable to or chose not to participate in group activities. 4) Beginning July 15, 2019, the Activity logs will be reviewed weekly for 6 weeks by the Administrator to ensure that all residents have routine activities documented. The Medical Records Nurse and the Minimum Data Set Nurse will review residents care plans and care task with each comprehensive assessment to ensure it reflects current activity information. Beginning July 15, 2019, Activities observations will be conducted 2 x weekly x 4 weeks then weekly for 6 weeks by the Administrator to ensure resident activities meet residents needs. Findings will be brought to the Quality Assurance and Improvement Committee monthly by the Activities Director for review, revision, and/ or resolution of the plan.		

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F 679	Continued From page 26 the television on for Resident #74 to listen to music. The Administrator was interviewed on 5/21/19 at 2:54 PM. The Administrator stated his expectation was staff would provide a resident with in room activities. The Director of Nursing (DON) was interviewed on 5/22/19 at 4:15 PM. The DON stated it was her expectation that residents were provided activities that they were interested in. The DON further stated the facility was going to provide the resident with a radio today. Resident #46 Review of Resident #46's admission MDS assessment, dated 8/17/18, revealed the resident had severely impaired cognition, and communications deficits described as "rarely/never understood." The assessment documented the resident was dependent on staff for all activities of daily living (ADLs). The MDS documented that the resident indicated it was "very important" for him to keep up with the daily news and listen to music in the activity/routine preferences section of the assessment. Review of Resident #46's undated "Face Sheet" (a document with demographic and diagnoses information) revealed a readmission date of 5/8/19, with diagnoses including Pressure Ulcers and Quadriplegia. Interview with the Medical Records Nurse on 05/21/19 at 3:38 PM, revealed Resident #46 does not have a page in the activity participation book, and there is no documentation that activities of any kind had been provided since Resident #46's	F 679			

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F 686	Continued From page 28 pressure ulcer that went unmonitored from 3/27/19 until 4/19/19, and no documented treatment from 4/6/19 through 4/18/19. The pressure ulcer deteriorated from a Stage 2 to an unstageable pressure ulcer that required debridement (surgical removal of dead tissue). Findings include: A facility policy titled, "Skin Care Process", dated 1/17/18, indicated, ". . . It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet professional standards to treat the loss of skin integrity should it occur. . . Staff Roles. . . The following is recommended as a minimum, other responsibilities may be assigned as allowed by regulatory or licensing agencies. . . Registered Nurse. . . Conducts or supervises the Admit/Readmit Physical Evaluation, and the completion of the Braden scale [skin assessment] as well as other evaluations at determined times. . . Stages pressure wounds. . . Observes wounds weekly. . . Oversees the licensed practical nurse and nursing assistant in the implementation of the plan of care. . . Licensed Practical Nurse. . . May measure and document progress of wounds if trained and competent in wound evaluation ... Notifies the registered nurse or Medical Professional of any lack of healing or new issues related to a wound. . . Documentation should include, but is not limited to, regular skin inspections, pressure wound measurements and progress. . . When documenting, it is important to include the location of the wound, presence of exudate, pain, signs of infection, and the wound bed characteristics. . ."	F 686	2. This deficient practice has the potential to affect all facility residents with a pressure ulcer or identified as high risk for development of pressure ulcers. A 100% audit of all residents with pressure ulcers was conducted by the Medical Records Clerk and the Director of Nursing to ensure treatments were provided in accordance with the physician's orders the week of June 23, 2019. A 100 % Audit was conducted as of July 2, 2019 of all in-house residents Braden Scale by the Minimum Data Set Nurse, residents identified to be at risk for pressure areas body audits and skin assessments had been conducted and there were reviewed to ensure appropriate interventions were implemented. The facility Administrator and the Regional Nurse Consultant observed a sample of treatments administered to residents in the facility with pressure areas to ensure treatments were being provided as ordered. 3. Nursing staff were in serviced on June 4, 2019 and June 5, 2019 regarding the facilities policies and procedures on Skin Care and Treatment & Services for Pressure Ulcers by the Director of Nursing. The facility has placed a Registered Nurse in the treatment nurse position full-time as of the week of July 8, 2019. The facility nurse management staff attended a pressure ulcer training session at Sunplex Subacute Center on Wednesday, July 10, 2019. Starting June 27, 2019, the Nurse Management Staff are reviewing nurses' notes, physician		

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F 686	Continued From page 29 According to the National Pressure Ulcer Advisory Panel (NPUAP), "... Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister ...Granulation tissue, slough and eschar are not present ...Stage 3 Pressure Injury: Full-thickness skin loss in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar [dead tissue] may be visible. The depth of tissue damage varies by anatomical location; Undermining and tunneling may occur. If slough or eschar [dead tissue] obscures the extent of tissue loss this is an Unstageable Pressure Injury. . .Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. . ." Review of the admission Minimum Data Set (MDS) assessment, dated 3/12/19, revealed Resident #54 was re-admitted to the facility on 3/5/19, with diagnoses including End Stage Renal Disease, Malnutrition, and Dementia. The MDS indicated the resident had severe cognitive impairments, scoring a 2 of 15 on the Brief Interview for Mental Status (BIMS). The assessment also documented the resident was readmitted with two (2) Stage 2 pressure ulcers. No measurements, wound location or description were included on the MDS. Review of the nursing "Progress Notes", dated 3/5/19, revealed the resident had a right inner and	F 686	orders and daily shift reports in the morning standup meeting to discuss new pressure injuries and ensuring proper treatment is in place and documented. The Weekly Wound Reports will be reviewed in the Patients at Risk Meetings weekly by the Nurse Management Staff. 4. Beginning July 15, 2019, the Director of Nursing will audit all weekly pressure ulcer reports and all new admissions weekly for four weeks and monthly for two months to ensure that interventions are in place for residents at risk and that treatments are being administered per physician orders for any resident with pressure ulcers in the facility. The Director of Nursing will complete treatment observations 3 times a week for three weeks then weekly for three weeks to ensure treatments are being completed per physicians orders and preventative measures are in place. The Director of Nursing will bring the results of her audit to the monthly Quality Assurance Committee for review, revision, and/or resolution.		

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F 686	Continued From page 30 outer suspected deep tissue injury. No location was documented. The progress notes identified the resident with no edema. Review of the "Admission & Readmission Evaluation", dated 3/5/19, noted under "Skin Integrity", revealed Resident #54's skin was normal, warm, normal turgor, and dusky. There was an area that directed the clinical staff to document any skin concerns and it noted ". . .bilateral heels. . ." There was no additional and/or descriptive information documented regarding the resident's heels. A "Braden Scale for Predicting Pressure Sore Risk" dated 3/5/19, indicated Resident #54 was at low risk for the development of a pressure ulcer. Review of a "Physician Order" dated 3/5/19, directed staff to treat a fluid filled blister to the right inner heel with wound cleanser, to pat dry, and to apply a dry dressing daily. Review of a "Weekly Pressure Injury Record", dated 3/7/19, indicated Resident #54's right heel Stage 2 pressure ulcer was first identified on 3/7/19. The length of the pressure ulcer was two (2) centimeters (cm) x 2 cm. The form noted there was no depth, tunneling, undermining, no exudate, and no odor present. The section titled "Additional Notes/Comments" revealed the wound was described as an intact fluid filled blister. The physician and the family were notified of the changes in the resident's skin. Review of a physician's (MD) "Progress Note", dated 3/7/19, indicated Resident #54 had a history of bilateral deep vein thrombosis (DVT) and was being treated with Eliquis (a medication	F 686			

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F 686	Continued From page 31 to reduce the likelihood of a DVT). The MD's note indicated the resident had left leg edema, and the MD ordered a repeat ultrasound of the left leg. On 3/8/19, the ultrasound came back positive for a non-occlusive DVT to the left lower extremity. Continued review of the MD's "Progress Notes" revealed Resident #54 was seen by the MD on 3/19/19, and that visit note indicated the resident's skin was warm, intact, and dry. The resident was seen again on 3/21/19, 3/28/19, 4/4/19, 4/9/19, 4/11/19, and on 4/23/19, by the MD. Her skin was noted to be warm, dry, and intact on those visits. These assessments were follow-up to the presence of the DVT in the left leg. The existing Stage 2 pressure ulcer to the left heel resolved, but no evidence was found in the MD's progress notes that addressed the status of the resident's pressure ulcer on the right heel during the MD visits listed above. Review of the nursing "Weekly Body Audits", dated 3/20/19, 4/3/19, 4/10/19, 4/17/19, 4/24/19, and 5/1/19 revealed ". . .No new skin alterations. . ." There was no documentation on the body audits listed above that indicated Resident #54 had a Stage 2 pressure ulcer on the right heel, or that the wound was being monitored or treated. Review of a "Weekly Pressure Injury Record" dated 3/21/19, indicated Resident 54's right heel Stage 2 pressure ulcer was first identified on 3/7/19. The length of the pressure ulcer was 2 cm x 2 cm. The form noted there was no depth, tunneling, undermining, no exudate, and no odor present. There were no comments under a section entitled "Additional Notes/Comments." The next "Weekly Pressure Injury Record" was	F 686			

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F 686	Continued From page 32 not completed until 4/25/19, and noted Resident 54's pressure ulcer was a Stage 3. The length of the pressure ulcer was 1.8 cm x 1.4 cm. The form now noted the depth of the pressure ulcer was 0.4 cm. There was no tunneling, no undermining, there was a small amount of exudate, and the wound bed now had slough. It was noted the physician and the family were notified of the change in the resident's pressure ulcer. Under the section entitled "Additional Notes/Comments" it stated that the wound had slough and a new order was obtained for Santyl for gentle debridement. Review of the March 2019, "Treatment Administration Record (TAR), revealed Resident #54 had an order to clean the fluid filled blister to the resident's right heel, with wound cleanser, pat dry, and to apply a dry dressing, daily. The treatment start date was 3/6/19, and the end date was 3/23/19. There was no evidence that treatments were provided on 3/8/19, 3/11/19, 3/18/19, or on 3/21/19. Continued review of the March 2019 TAR revealed an order change, on 3/23/19, that directed staff to clean the fluid filled blister with wound cleanser, to apply betadine, and apply a dry dressing daily. A low air loss mattress was ordered on this same date as an intervention. Review of a Registered Dietician's (RD) "Progress Note", dated 4/3/19, revealed the resident triggered for significant weight loss. The note documented the resident was consuming 50 to 75 percent of her meals, nutritional supplements were added, and the note indicated the resident had Stage 2 pressure ulcers to bilateral heels. Additional fortified cereal was	F 686			

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F 686	Continued From page 33 added to her breakfast and fortified mashed potatoes were added to her lunch and dinner meals. Review of a "Patient at Risk (PAR)" note found in the electronic health record, and dated 4/5/19, identified the significant weight loss that Resident #54 sustained. There was no mention of the status of the resident's pressure ulcers Review of a 4/5/19 "Physician's Order" revealed instructions for staff to treat the fluid filled blister on the resident's right heel with wound cleanser, to apply betadine, and apply a dry dressing once daily. There was no documented evidence that the treatments were completed from 4/6/19 through 4/18/19. Review of the nursing "Progress Notes" dated 4/12/19, indicated a PAR meeting was held. The PAR note indicated Resident #54 had a Stage 2 pressure ulcer on her ". . .left heel. . ." and the ". . .right heel has resolved. . ." The PAR note was reviewed with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/22/19, and the LPN/WN confirmed the information in the PAR note was incorrect. The left heel wound had resolved, and the right heel wound had deteriorated. Review of the nursing "Progress Notes" dated 4/19/19, revealed a PAR meeting was held. The "PAR" note stated Resident #54 had a right unstageable pressure injury. It specifically stated, ". . .The wound is stable. . .Patient denies pain with this wound. Patient removes bandage [sic] and requires redirection [sic] to elevate her feet r/t (related to) dementia. . .Action: Betadine and dry dressing and prn (as needed). Continue with	F 686			

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F 686	Continued From page 34 current [sic] plan of care. . ." Review of a "Care Plan" dated 3/25/19, revealed Resident #54 had a Stage 2 pressure ulcer to the right inner heel. The care plan noted the focus was resolved on 4/12/19. One of the care plan goals was for the wound to show signs of healing and remain free from infection. The goal was documented as "resolved on 4/12/19." Another care plan intervention dated 3/25/19, directed staff to observe, document, and report as needed any changes to the skin status. The intervention specifically directed staff to document ". . . appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size (length X (by) width X depth, stage. . .". The intervention was documented as "resolved on 4/12/19." Review of the April 2019 TAR documented Resident #54 received daily treatments of betadine and dry dressing to the right heel from 4/1/19, through 4/5/19. Continued review of the April TAR revealed from 4/6/19 through 4/18/19, the resident did not receive wound care treatments. This was evidenced by entry areas marked with an "X" and no staff initials. Wound care treatments were resumed on 4/19/19, with new treatment orders, which included: "cleanse the wound, apply betadine, and apply a dry dressing daily." This treatment continued until 4/27/19, when the wound had deteriorated significantly, and was an unstageable pressure ulcer on the right heel. The wound care orders were updated on 4/27/19, to include: "apply wound cleanser, apply nickel thick Santyl Ointment 250 unit/gram (a debriding ointment to help remove dead tissue from wounds), and cover with a dry dressing daily." The TAR indicated the resident received these treatments	F 686			

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F 686	Continued From page 35 daily from 4/27/19, through 4/30/19. Review of a "Physician's Order" dated 4/26/19, revealed: "Santyl ointment 250 unit/gram (Collagenase), apply once daily and cover with a dry dressing for an unstageable pressure ulcer." On 4/29/19, a "Physician's Order" was obtained for the Physical Therapist (PT) to evaluate and to treat once by sharp debridement, to ". . .decrease devitalized tissue, and improve circulation to patient's wound as referred by wound care nursing staff. . ." Review of "Physical Therapy PT Evaluation & Plan of Treatment" dated 4/30/19, noted the condition of Resident 54's right heel pressure ulcer as follows: length of the pressure ulcer was 2.0 centimeters (cm); width was 2.5 cm; depth/exposure, subcutaneous tissue, fascia depth measure 0.4 cm; edge was distinct, rolled and thickened; undermining was absent; no tunneling; necrotic (dead) tissue type was loosely adherent yellow slough; necrotic tissue amount was greater than 50 percent but less than 75 percent of the bed covered; the skin surrounding wound was normal; peri-tissue description was shiny; peripheral tissue induration was less than two (2) cm around the wound; granulation amount was less than 25 percent of wound filled; mild odor; and, minimal amount of drainage. There was no infection noted. Under a section entitled "Assessment Summary" the physical therapist (PT) documented Resident #54 had an unstageable pressure ulcer to the right heel that measured 2.5 cm by 2.0 cm with 0.4 depth with the presence of necrotic tissue over 50 percent of wound bed with rolled edges.	F 686			

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F 686	Continued From page 36 Interview was conducted with the LPN/WN on 5/22/19 at 2:40 PM, in the LPN/WN office space, so the LPN/WN could reference the EHR during this interview. The wound nurse stated she had been on vacation and was not responsible for the wound care during that time. When asked specifically, she confirmed she had worked during the time frame of 3/21/19, through 4/25/19. The LPN/WN referenced an Excel spreadsheet on her computer where she documented her wound care notes. The LPN/WN stated this spreadsheet was not included in the residents' EHRs. She stated that she emails the spreadsheet information to the Director of Nursing (DON), the Administrator, the Medical Director, and the MDS Coordinator weekly, but it is not included in the residents' medical record. An interview was conducted with the Medical Records (MR) staff member on 5/22/19 at 3:39 PM. The MR staff stated the LPN/WN collected information on the Excel sheet and this sheet was then used to discuss concerns in the weekly PAR meeting. She stated the weekly body audits were used by nursing to identify any new skin issues on the resident's body. A subsequent interview with the MR staff member was conducted on 5/22/19 at 5:17 PM. The MR staff member confirmed there were no weekly skin records for Resident #54 from the 3/21/19 weekly assessment until the 4/25/19 skin assessment, which identified any changes in the resident's skin condition. The DON was interviewed on 05/22/19 at 4:19 PM, and she stated staff participated in weekly PAR meetings. She said her expectations were for the staff to clinically assess the wounds, keep up with the weekly pressure ulcer forms, and to	F 686			

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F 686	Continued From page 37 identify if the wound was healing or not. She said she expected staff to measure the wounds and describe the wounds. The DON once again stated the Excel document kept by the LPN/WN was not considered part of the clinical record. The DON confirmed Resident #54's pressure ulcer had deteriorated and that treatments and assessments had not been provided as ordered. An interview was conducted with the LPN/WN, DON, and the Administrator on 5/23/19 at 8:32 AM. During the interview, the care plans were discussed and the LPN/WN stated that when "staff" resolved the left heel wound, the treatments to the right heel wound were inadvertently discontinued in the electronic health record (EHR) too. This action discontinued any electronic notifications to the LPN/WN regarding Resident #54's right heel pressure ulcer. The LPN/WN also stated the electronic record to address the weekly skin assessments were discontinued in error. The LPN/WN stated the entry in the progress note dated 4/12/19, was an error and the entry should have noted the left heel pressure ulcer was resolved and not the right heel. The DON stated the Excel document was a Quality Assurance (QA) document and the measurements should be on this document. At 9:28 AM, the DON was interviewed and stated the LPN/WN was not wound certified. On 5/23/19 at 9:45 AM, the MR staff presented the Excel documents and stated these were the personal notes of the LPN/WN and could not be copied. The following information was documented from the Excel documents: on 3/27/19, the document identified the resident had a suspected deep tissue injury and it was a current Stage 2 pressure ulcer, describe as an	F 686			

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F 686	Continued From page 38 intact blister and was noted as improved with treatment of betadine and a dry dressing. On this same date the Excel document identifies the Resident #54 had an intervention of a low air loss mattress, heel protector, and nutritional supplements. There were no measurements identified. Further review of the Excel documents revealed for 4/2/19, there was no documentation related to the resident's right heel wound. An observation of Resident #54's wound was conducted on 5/23/19 at 11:25 AM. The LPN/WN was observed to attempt to provide the resident wound care. The resident's right heel had purulent drainage over most of the wound bed. The resident refused wound care at this time. The resident refused to have the LPN/WN replace the dressing to her right heel during this observation. The DON was interviewed on 5/23/19 at 4:09 PM. She once again confirmed the information collected in the Excel document by the LPN/WN was not in or a part of the medical record. The DON again confirmed her expectation was for staff to follow the MD orders and care plans.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688			7/15/19

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F 688	Continued From page 39 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, record reviews, and interviews, the facility failed to ensure a resident received restorative services and a splint as recommended by therapy. This failure affected one (1) resident, Resident #8, of 19 sampled residents. This had the potential for a decline in function for Resident #8. Findings include: A request was made for a copy of the facility's policy regarding restorative nursing services and the use of splints to prevent/minimize contractures (the condition of shortening and hardening of muscles, tendons, other tissue leading to deformity and rigidity of joints). An interview with the Administrator on 5/23/19 at 10:00 AM, confirmed there was no facility policy on referring residents for restorative services. The Administrator submitted a signed statement indicating there was no facility policy to address these issues. On 5/20/19 at 1:40 PM, Resident #8 was observed in her wheelchair. Her right hand and arm were contracted and there were no splints or devices in place. The resident was interviewed at the time of the observation and stated that staff do not apply splints to her right arm.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility 1. Resident #8 was assessed for decrease in range of motion from baseline in right arm contracture with no negative findings by the Director of Nursing on 5/23/2019. The Director of Nursing sent a communication form to therapy to screen for a right arm splint for resident #8 on 6/4/2019. 2. This deficient practice has the potential to affect all residents in the building with adaptive equipment. A 100% audit of all residents with physician orders for adaptive equipment was completed by the Medical Records Nurse on 6/21/2019. A 100% audit for all resident tasks with adaptive equipment was completed by the Medical Records Nurse on or before 6/20/19. 3. The Director of Nursing initiated an in-service for all licensed nurses that there was a new communication form to therapy and about the screening process on 6/5/2019 and completed on 6/13/2019. Physician orders will be reviewed for		

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F 688	Continued From page 40 Review of Resident #8's undated "Face Sheet" (a document with demographic and diagnoses information) revealed the resident had diagnoses that included Hemiplegia and Hemiparesis affecting the right side, Cerebrovascular Disease, Aphasia, and Pain. Review of Resident #8's significant change "Minimum Data Set (MDS)" assessment, dated 8/31/18, revealed the resident was cognitively intact and required extensive staff assistance for all activities of daily living (ADLs). The assessment further documented the resident had received Occupational Therapy, five (5) times a week, from 11/29/17 to 8/31/18. Review of Resident #8's most recent quarterly MDS assessment, dated 2/14/19, revealed the resident was cognitively intact; and required extensive assistance with activities of daily living (ADL). The assessment indicated the resident was not currently receiving any therapies. Review of the "Care Plan" dated 9/14/18, for Resident #8, revealed the resident had an activities of daily living (ADL) self-care deficit related to physical debility, and impaired physical mobility. There were no care plans related to restorative programs or the use of a splint to reduce/prevent contractures Review of a "Restorative Referral Form" dated 9/26/18, revealed the resident was recommended to receive passive range of motion and a splint to the right arm. The purpose/goal of the restorative program was to prevent further contractures of the right elbow and maintain the skin integrity. Passive range of motion to the right elbow and	F 688	adaptive equipment Monday through Friday in standup meetings by the Nurse Management Staff. 4. Beginning July 15, 2019, the Director of Nursing will observe two residents that require adaptive equipment once a week for three weeks then one resident that requires adaptive equipment once a week for three weeks to ensure that physician orders for adaptive equipment are being followed. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing for review and recommendations by the committee revisions, updates, or resolutions.		

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F 688	Continued From page 41 fingers were to be completed, and an elbow splint was to be applied daily. On 5/22/19 at 10:45 AM, an interview with Certified Occupational Therapy Assistant (COTA) #152 confirmed the "Restorative Referral" dated 9/26/18, recommended splints and a restorative nursing program for Resident #8. An interview on 5/22/19 at 3:40 PM, with the Rehab Director verified Resident #8 had a referral for restorative nursing services and a splint that she was not receiving. An interview with the Director of Nursing (DON) on 5/23/19 at 9:30 AM, confirmed there was no documentation that indicated the resident was placed on a restorative nursing program or that the resident was wearing a splint to reduce or prevent contractures as recommended. A review of Resident #8's medical record did not include documented evidence of a functional decline for the right upper extremity. The medical record review revealed no evidence the resident had received restorative services or that a splint was being applied to Resident #8's right elbow, since 8/31/18.	F 688			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690			7/15/19

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F 690	Continued From page 42 not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, observations and interviews the facility failed to maintain a urinary catheter in a manner that reduced the risk of recurrent Urinary Tract Infections for one (1) resident, Resident #8, of eight (8) residents in the facility with urinary catheters. Findings Include:	F 690	F690 Bowel and Bladder Incontinence 1. The charge nurse on the south unit on 5/23/2019 immediately secured the catheter tubing for resident #8. The charge nurse on the south unit on 5/23/2019 provided suprapubic catheter care for Resident #8. The charge nurse on the south unit on 5/23/2019 assessed		

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F 690	Continued From page 43 The policy "Catheter Care, Suprapubic" dated August 25, 2014, did not include the positioning of the catheter tubing off the floor to prevent stagnant flow of urinary output and increased risk of infection. An interview with the Director of Nursing (DON) on 5/23/19 at 9:30 AM, confirmed the policy lacked this standard of practice directive. On 5/20/19 at 1:40 PM, the resident was observed in her wheelchair with her suprapubic catheter tubing on the floor. At 2:30 PM, on the same date, the resident was observed in the dayroom of the South Unit, in the electric wheelchair, with the suprapubic catheter tubing on the floor. On 5/21/19 at 3:05 PM, the resident was observed in her room, in the wheelchair, with the catheter tubing on the floor. Licensed Practical Nurse (LPN) #33 was present at the time of the observation and confirmed the catheter tubing was on the floor and the resident had a history of UTIs. On 5/23/19 at 9:00 AM, the resident was observed in her wheelchair, in the dining room, with the suprapubic catheter tubing on the floor. Review of Resident #8's undated "Face Sheet" (a document with demographic and diagnoses information) revealed the resident was initially admitted to the facility on 12/13/05, and readmitted on 10/4/11, with diagnoses that included Hemiplegia and Hemiparesis affecting the right side, Aphasia, History of Urinary Tract Infections (UTIs) and Pain.	F 690	Resident #8 for signs and symptoms of infection without negative findings. 2. Residents with indwelling catheters have the potential to be affected. A 100% audit was conducted on 6/7/2019 by the Transitional Care Unit Manager and Director of Nursing on all residents with an indwelling catheter, totaling six, to ensure that the catheter tubing was secure and off the floor. Physician orders were obtained by the Director of Nursing and Transitional Care Unit Manager and entered into the medical record for all residents requiring an indwelling catheter to ensure the catheter tubing doesn't touch the floor completed by June 28, 2019. 3. The Director of Nursing initiated an in-service for all nursing staff on the Suprapubic Catheter Care Policy and Infection Control including the securing tubing, and keeping tubing off of the floor on 6/5/2019 and completed on 6/13/2019. Urinary catheter tubing will be secured and off the floor. 4. Beginning July 15, 2019, the Director of Nursing will observe catheter tubing on three residents a week for three weeks then one resident a week for two weeks. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for review and recommendations by the committee revisions, updates, or resolutions.		

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F 690	Continued From page 44 Review of the quarterly "Minimum Data Set (MDS)" assessment dated 2/14/19, revealed the resident was cognitively intact, and required extensive assistance with activities of daily living (ADLs). The assessment also documented the resident had an indwelling urinary catheter. Review of the "Physician Orders" dated 10/1/15, revealed the resident had a suprapubic catheter due to Urinary Retention. Review of Resident #8's "Care Plan" dated 9/14/18, revealed the resident had an activities of daily living (ADL) self-care deficit related to physical debility and impaired physical mobility. The care plan also revealed the resident had a suprapubic catheter related to neuromuscular dysfunction and urinary retention. Review of the nursing "Progress Notes" dated 2/2/19, revealed the resident had a urinalysis (lab test) on that date and the lab results prompted new orders for an antibiotic to treat a UTI. Interviews with staff members that routinely care for Resident #8, were conducted on 5/22/19, including: Certified Nurse Aide (CNA) #100 at 9:30 AM, Licensed Practical Nurse (LPN) #65 at 9:45 AM, and CNA #84 at 9:50 AM. The interviews revealed an understanding of the need to maintain suprapubic catheter tubing and drainage bag off the floor to maximize urinary output and reduce the risk of recurrent UTIs.	F 690			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755			7/15/19

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F 755	Continued From page 45 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interview, the facility failed to ensure medication was acquired in a timely manner for one (1) resident, Resident #3, of 19 sampled residents whose medications were reviewed. Findings include:	F 755	F755 Pharmacy services/procedures/pharmacist/Records 1. Physician was notified that Resident #3 prescription inhaler was not administered as ordered. The prescription inhaler was obtained from back up pharmacy by licensed practical nurse on		

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F 755	Continued From page 46 The facility's "Medication Administration - General Guidelines" policy and procedure, dated 11/1/08, documented: "Medications are administered as prescribed in accordance with good nursing principles and practices. . ." Review of a "Physician's Order," dated 2/20/19, revealed Resident #3 was to be administered an Atrovent Inhaler (an anticholinergic medication), two (2) puffs orally four (4) times daily, for COPD with acute exacerbation. On 5/20/19 at 11:39 AM, interview with Resident #3 revealed she had not received her Atrovent inhaler for three (3) days because the facility was "out of my inhaler." She stated she had been told "the staff needed to order it." She stated she needed the medication, that she was not a "responsible person" and that was the reason she was at the nursing home. She stated, "I depend on the staff to have my medications." Review of Resident #3's "Face Sheet," undated, located in the Electronic Health Record (EHR), revealed the resident was admitted to the facility on 2/9/19, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation and Acute and Chronic Respiratory Failure with Hypercapnia. Review of Resident #3's admission "Minimum Data Set," assessment dated 2/16/19, revealed the resident had a "Brief Interview for Mental Status" score of 15, which indicated she was cognitively intact. The assessment documented she required supervision to extensive assistance with activities of daily living (ADLs) and had shortness of breath or trouble breathing with exertion.	F 755	5/20/19. Resident #3 medication regimen resumed at next scheduled dose. Resident #3 was assessed by Registered nurse and no acute respiratory findings were noted. 2. The Facility recognizes that all residents receiving an inhaler has the potential to be affected by this deficient practice. A 100% audit of all residents receiving inhalers was completed on 6/25/19 by the Transitional Care Manager and the Director of Nursing with no negative findings. 3. One on one in-service with Registered Nurse #90 and LPN #24 for inaccurate documentation in Resident #3 medication administration record. An in-service for all nursing staff was on initiated on 6/5/19 and completed on 6/13/19 on ordering/receiving medication and documentation. Medications not available immediately will be obtained from the back up pharmacy, if unavailable, the practitioner will be notified for additional orders. 4. Beginning July 15, 2019, the Director of Nursing will audit medication carts twice a week for four weeks and then weekly for two months to ensure that any residents with an order for an inhaler has the medication available. Negative findings will be brought to the Quality Assurance and Improvement Committee by the Director of Nursing monthly for review, revision, and resolution of the plan.		

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F 755	Continued From page 47 The "Care Plan" for Resident #3, most recently reviewed/revised on 5/2/19, documented the resident had altered respiratory status related to chronic respiratory failure with hypercapnia and COPD. Interventions included to "administer respiratory treatments as ordered." The "Medication Administration Record (MAR)," dated 5/2019, documented the resident's Atrovent Inhaler was administered/not administered as follows: 5/17/19 - not administered at 12:00 PM or 8:00 PM. Administered at 8:00 AM and 4:00 PM. 5/18/19 - not administered at 8:00 AM or 12:00 PM. Administered at 4:00 PM and 8:00 PM. 5/19/19 - not administered at 8:00 AM, 12:00 PM, 4:00 PM (resident absent from facility) or 8:00 PM. 5/20/19 - not administered at 8:00 AM. Administered remainder of doses. On 5/21/19 at 4:15 PM, Licensed Practical Nurse (LPN) #102 was asked about Resident #3's Atrovent inhaler administration documentation. She reviewed the MAR and confirmed there were doses documented as not having been administered between 5/17/19 and 5/20/19. She stated the resident reported to her that her Atrovent inhaler had been unavailable last week. On 5/22/19 at 8:44 AM, Resident #3 was interviewed about the missed doses and stated she was in no additional respiratory distress as a result of not receiving her Atrovent inhaler last week. Review of the "Nursing Progress Notes," dated 5/17/19, through 05/20/19, revealed no	F 755			

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F 755	Continued From page 48 documentation the resident had experienced respiratory distress as a result of not receiving her Atrovent inhaler. On 5/22/19 at 10:09 AM, LPN #24, who had documented the dose of Atrovent inhaler as having been administered on 5/17/19 at 4:00 PM, was asked if the Atrovent had been administered. She stated she had "charted wrong" and had told the resident there was no Atrovent inhaler in the medication cart. She stated the off-going medication nurse, 5/17/19 at 3:00 PM, had informed her there was no Atrovent inhaler for the resident, but the medication had been ordered. On 5/22/19 at 10:18 AM, LPN #33 was asked why the facility had not acquired an Atrovent inhaler for three (3) days for Resident #3. She stated she called the pharmacy provider and stated authorization to purchase the Atrovent inhaler was required, from either the DON or herself, and the provider had not received that authorization. LPN #33 stated she had been told the morning of 5/20/19, the resident still did not have an Atrovent inhaler and at that time she went to the "backup pharmacy" to purchase the medication. When asked if the resident should have had to go three (3) days without her Atrovent inhaler doses, she stated, "No." On 5/22/19 at 05:17 PM, Registered Nurse #90, who had documented the doses of Atrovent inhaler had been administered on 5/18/19 at 4:00 PM and 8:00 PM, was asked if the Atrovent had been administered. She stated she had made an error in charting. She stated there was no Atrovent inhaler in the medication cart and the resident had informed her there was no Atrovent inhaler to administer.	F 755			

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758			7/15/19

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F 758	Continued From page 50 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interviews, the facility failed to ensure that one (1) resident Resident #12, out of a sample of five (5) residents reviewed for unnecessary medications, was administered an as needed (PRN) antianxiety (Xanax) beyond 14 days without a clinical justification. Findings include: Review of the facility's policy titled, "Psychotropic Medications" undated, revealed, ". . .When any psychotropic medication is ordered the following will occur. . .PRN psychotropic medications will have a 14 day [sic] period of administration time. If prescribing MD/NP orders to continue the medication beyond 14 days, the MD/NP will document rationale and the duration for the medication in the clinical record. . .PRN antipsychotics medications-are limited to a 14 day [sic] period unless. . .The MD /NP evaluates the patient for the appropriateness of the medication, and documents the evaluation and rationale in the clinical record. . ." Review of Resident #12's "Admission Record" indicated the resident was admitted to the facility on 10/30/17, with a diagnosis of Generalized	F 758	F 758 Psychotropic Medications 1. Psychiatric Mental Health Nurse Practitioner evaluated Resident #12 for anxiety and depression on 05/23/19 with no order changes. Psychiatric Nurse Practitioner stated in progress note on 05/23/19 that she will adjust medication if symptoms increase or become bothersome. Xanax was discontinued on 05/27/19 due to non-use of medication for greater than 14 days by Medical Nurse Practitioner. Resident #12 transferred to a local hospital on 06/17/19 for an unrelated medical condition prior to an additional follow-up visit with Psychiatric Mental Health Nurse Practitioner. 2. Residents receiving an anti-anxiety medication ordered as needed have the potential to be affected by the same deficient practice. The Medical Nurse Practitioner reviewed all residents receiving anti-anxiety medications ordered as needed on 05/30/19 and adjusted medication regimen according to the individual needs of each resident. A 100%		

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F 758	Continued From page 51 Anxiety Disorder. Review of physician's "Order Recap Report" dated 6/12/18, revealed Resident #12 was ordered to be administer Xanax 0.25 milligrams (mg) one (1) tablet by mouth every 12 hours as needed (PRN) for generalized anxiety. The Medication Administration Record (MAR) for January 2019, identified Xanax 0.25 mg was to be administered every 12 hours PRN for Generalized Anxiety. The January MAR indicated Resident #12 was administered the antianxiety medication on the following dates: 1/1/19 at 8:02 AM and 11:00 PM, 1/10/19 at 7:53 AM, 1/12/19 at 8:38 AM, 1/18/19 at 11:30 AM, and on 1/29/19 at 12:45 PM. The MAR showed staff monitored R#12's behavior and side effects. Review of the "Consultant Pharmacist Communication to Physician" dated 1/23/19, indicated Resident #12 was on Xanax, and ". . .continued use is appropriate for no more than 14 days from the original order date and if continued, a duration is required to be added in order to meet the rule. . . Please evaluate and if continued, please add a duration. . ." The physician marked to continue the PRN Xanax for the next three (3) months and signed it 2/21/19. There was no justification documented. The MAR for February 2019 identified the Xanax 0.25 mg was to be administered every 12 hours PRN. The February MAR indicated the resident received the antianxiety medication on the following dates: 2/1/19 at 11:35 AM, 2/12/19 at 11:29 AM, 2/13/19 at 9:00 AM, 2/16/19 at 9:35 AM, 2/17/19 at 10:00 AM, 2/18/19 at 9:04 AM, and on 2/21/19 at 9:30 AM. The MAR noted this	F 758	audit was completed by the Director of Nursing on 06/28/19 to ensure that residents receiving antianxiety medication ordered as needed have documentation regarding usage timeframe and rationale for use of medication. 3. An individual in-service with Psychiatric Mental Health Nurse Practitioner and Medical Nurse Practitioner was conducted on 06/18/19 by the Director of Nursing regarding use of psychotropic medication ordered as needed requirements for duration, documentation, and rationale of usage. All Nurses were in-serviced by the Director of Nursing initiated on 06/05/19 and completed on 06/13/19 regarding documentation of non-pharmacological interventions utilized prior to use of psychotropic medication ordered as needed and proper documentation and timeframe regarding use of psychotropic medication ordered as needed. 4. Beginning July 12,2019, the Medical Records Nurse will review new orders five (5) times a week for four (4) weeks for any new psychotropic medications ordered as needed to ensure that limited duration and rationale for use are indicated. Beginning July 15, 2019, the Director of Nursing will perform a weekly audit for two (2) months of psychotropic medication ordered as needed for usage and notify Medical and/or Psychiatric NP of findings for medication review by Nurse		

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F 758	Continued From page 52 order was discontinued on 2/27/19. The MAR showed staff monitored Resident #12's behavior and side effects. The MAR for March 2019, identified the Xanax 0.25 mg was to be administered every 12 hours PRN. The March MAR indicated the resident received the antianxiety medication on the following dates: 3/5/19 at 7:05 PM, 3/10/19 at 3:59 PM, 3/11/19 at 2:00 PM, 3/12/19 at 1:09 PM, 3/13/19 at 6:50 PM, 3/18/19 at 4:00 PM, 3/19/19 5:01 PM, 3/20/19 at 6:00 PM, and on 3/30/19 at 7:00 PM. The MAR noted this order was discontinued on 2/27/19. The MAR showed staff monitored Resident #12's behavior and side effects. The MAR for April 2019, identified the Xanax 0.25 mg to be administered every 12 hours PRN. The April MAR indicted the resident received the psychotropic medication on the following dates: 4/1/19 at 10:45 AM, 4/3/19 at 10:05 AM, 4/6/19 at 11:28 AM, 4/7/19 at 1:35 PM, 4/9/19 at 7:40 PM, 4/11/19 at 7:14 PM, 4/12/19 at 6:54 PM, 4/13/19 at 1:40 PM, 4/14/19 at 7:35 PM, 4/15/19 at 2:04 PM, 4/17/19 at 2:32 AM and again at 4:07 PM, 4/19/19 at 6:00 PM, 4/21/19 at 1:03 AM, 4/22/19 at 7:08 PM, 4/23/19 at 8:02 PM, 4/27/19 at 8:10 PM, and on 4/29/19 at 7:30 PM. The MAR showed staff monitored Resident #12's behavior and side effects. The MAR for May 2019, identified the Xanax 0.25 mg was to be administered every 12 hours PRN. The May MAR indicated the resident received the psychotropic medication on the following dates: 5/1/19 at 5:47 M, 5/5/19 at 9:28 AM, and on 5/11/19 at 8:15 PM. The MAR showed staff monitored Resident #12's behavior and side	F 758	Practitioner. Findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for review, revision, and/or resolution of the plan.		

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F 758	Continued From page 53 effects. An interview was conducted with Registered Nurse (RN) #41 on 5/21/19 at 1:59 PM. RN #41 stated the resident was extremely hard of hearing and had very bad anxiety. Telephone interview, on 5/23/19 at 12:11 PM, with Resident #12's attending physician, who was also the facility's Medical Director, revealed the use of psychotropic medications was discussed during the Quality Assurance meetings; however, he was unaware there needed to be a clinical justification to continue the PRN antianxiety medication.	F 758			
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by	F 801		7/15/19	

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F 801	Continued From page 54 an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the	F 801			

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F 801	Continued From page 55 course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and interview, the facility failed to ensure the Dietary Manager (DM) had an active certification. This failure affected 89 residents who received their meals from the kitchen, of the 90 residents residing in the facility. Findings include: Review of the facility policy entitled "Professional Staffing" dated May 2014, revealed a "qualified food services director" was employed by the facility and was responsible for insuring all dietary practices were in full compliance with applicable regulatory requirements. The certified DM was qualified based on educational requirements and/or experience as defined by the state requirements. During an interview with the DM on 5/21/19 at 9:40 AM, during the kitchen tour, she confirmed her certification had expired 4/14/19, and was not current. An interview on 5/23/19 at 10:00 AM, with the DON and the Administrator, confirmed staff certifications and licenses must be kept current.	F 801	F801/Qualified Dietary Staff 1. The District Manager, a Certified Dietary Manager, started serving as the Interim Certified Dietary Manager as of June 20, 2019. 2. All residents have the potential to be affected by this deficient practice. The Nursing Home Administrator ensured that the facility had a Certified Dietary Manager as of 6/20/19 and has audited the Dietary manager and Registered Dietician personnel files as of 6/20/19 to ensure they have current and appropriate credentials. Copies of Certified Dietary manager and Registered Dietician respective certifications are on file in the facility. 3. The Nursing Home Administrator in-serviced the Dietary manager and the District Dietary Manager regarding the certification requirements for the Dietary Manager on June 20, 2019. A permanent Certified Dietary Manager started on June 26, 2019. The Nursing Home		

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F 801	Continued From page 56	F 801	Administrator will ensure that the Dietary Department has a qualified Dietary Manager at all times.		
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 facility policy review, observations, and group interviews, the facility failed to ensure food was served at palatable temperatures. This affected the 36 residents on the North Unit who ate in their rooms of 89 residents who received	F 804	4. Beginning July 1, 2019, the facility Nursing Home Administrator will audit monthly to ensure that the facility has a qualified Dietary Manager, at all times, and upon changes in personnel. District Dietary Manager will report to the facility Administrator quarterly confirmation that Dietary Manager qualification remains active and any upcoming expirations prior to occurring. This audit will be conducted monthly for 3 months and the results brought to the monthly Quality Assurance Committee by the Nursing Home Administrator for review, revisions, and/or resolution. F 804 483.60(d)(2) 1) Meal trays had been delivered and were consumed before the results of the test trays were known.		7/15/19

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F 804	Continued From page 57 their meals from dietary services in the facility. Findings include: Review of the facility's undated policy entitled "Food: Preparation", included direction for the cook to insure all foods were held at appropriate temperatures. During the resident group meeting on 5/21/19 at 9:30 AM, the residents revealed the room meal trays served on the North Unit had cold food. On 5/22/19 at 11:50 AM, the food on the tray line was observed, and temperature checks were conducted by Cook #1. The corn was 160 degrees Fahrenheit (F), mixed vegetables were 165 degrees F, the fish was 150 degrees, the fortified mashed potatoes were 170 degrees F, the pureed pinto beans were 165 degrees F, pureed chicken was 165 degrees F, the pureed chili was 165 degrees F, the chicken breasts were 170 degrees F, the pinto beans were 180 degrees F, the chili was 185 degrees F and the corn bread was 160 degrees. A test tray audit was conducted on 5/22/19. The test tray was placed on the second, and last, food cart that went to the North Unit. The cart left the kitchen at 12:40 PM, and arrived on the North Unit at 12:42 PM. At 12:50 PM, all the lunch trays had been delivered to the residents on the North Unit. The temperatures and tasting were completed with the Dietary Manager (DM) present when the last resident's tray had been delivered. The pureed chicken was 109.5 degrees F and was not hot. The pureed chili was 116.8 degrees F and was not hot. The pureed	F 804	2) Residents who receive meals from the kitchen have the potential to be affected by this deficient practice. 3) All dietary staff members were inserviced by the acting Dietary Manager on or before June 20, 2019 and will be re-inserviced by the Regional Dietary Manager on or before June 21, 2019 regarding meal serving temperatures and to notify the nursing staff of when trays are taken to the halls. 4) The Dietary manager or Regional Dietary Manager will sample one tray 5x week for 4 weeks then weekly for 4 weeks, beginning the week of July 11, 2019, to test food temperatures on hall trays to ensure warm foods are at or above 120 degrees. Findings will be brought to the Quality Assurance and Improvement Team for review, revision and/or resolution of the plan.		

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F 804	Continued From page 58 pinto beans were 108.7 degrees F and were not hot. The food taste was palatable. The DM confirmed the food was not hot enough when it was served on the North Unit.	F 804			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, record review, and interview, the facility failed to ensure the dishwasher was functioning with sanitizer, and the kitchen remained clean and sanitary. This affected 89 of 90 residents residing in the facility, who received dietary services. Findings include: The facility's policy titled "Warewashing" revised	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. The chemical containers for the dish machine were immediately replaced on 5/20/2019 with new containers by the acting Dietary Manager. Chemical levels were verified to ensure proper sanitization on 5/20/2019 by the acting Dietary Manager. The oven doors and the vent		7/15/19

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F 812	Continued From page 59 9/2017, indicated all dishware, service-ware and utensils would be cleaned and sanitized after each use. The facility's policy titled "Environment" revised 9/2017, indicated all food preparation areas, food service areas, and dining areas would be maintained in a clean and sanitary condition. During the initial kitchen tour that began on 5/20/19 at 9:45 AM, the dishwasher was operated by Dietary Aide (DA) #6 and assisted by DA #11. There were six (6) racks of dishes, trays and glasses that had been run through the dishwasher. DA #6 was requested to test the sanitizer in the dishwasher. She stated the dishwasher was a low temperature machine that used sanitizer. When DA #6 used a test strip in the dishwasher it indicated there was no sanitizer present. At 10:00 AM, the Dietary Manager (DM) joined the conversation and confirmed the test strips indicated no sanitizer present in the dishwasher. She instructed dietary staff to stop using the dishwasher until it could be checked. The kitchen tour continued with the DM present, and revealed the following: 1. The inside of the oven doors and the vent under the oven doors had a large amount of sediment and spillage build-up. 2. The grease in the fryer had a large amount of sediment. 3. The top of the fryer and the bottom shelf of a table next to the fryer, had a large amount of grease spillage and sediment. There were three (3) clean, steel bowls and a colander being stored on the bottom shelf with the grease spillage. 4. The bottom shelf of the prep table had a large	F 812	under the doors were cleaned on 6/21/2019 by the acting Dietary Manager. The grease was changed out on 6/21/2019 by the acting Dietary Manager. The top of the fryer and the bottom shelf of the table next to the fryer were cleaned by the acting Dietary Manager on 6/21/2019. The three- steel bowls and the colander on the bottom shelf of the table were cleaned by the acting Dietary Manager on 6/21/2019. The bottom shelf of the prep table was cleaned by the acting Dietary Manager on 6/21/2019. Two loaf pans, five full pans, three 1/2 pans and three 1/3 pans were cleaned by the acting Dietary Manager on 6/21/2019. The floor fan was cleaned on 6/21/2019 by the acting Dietary Manager. Two freezers were cleaned on 6/21/2019 by the acting Dietary Manager. The bins with the serving pieces and the thirty- nine serving pieces in the bins were cleaned on 6/21/2019 by the acting Dietary Manager. 2. This deficient practice has the potential to affect all facility residents. The Registered Dietician conducted a sanitation check in the kitchen on 6/27/2019 to ensure that proper sanitation techniques are being utilized in the kitchen at the pot sink and in the dish room. 3. The acting Dietary Manager in-serviced all dietary staff as of June 20,2019 on the cleaning policy and procedures including the cleaning schedule, and the sanitation system. The kitchen staff were in-serviced		

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F 812	Continued From page 60 amount of sediment. 5. Stored pans were wet and dirty, including: two (2) 1/4 loaf pans, five full pans, three (3) 1/2 pans, and three (3) 1/3 pans. 6. The floor fan in the kitchen had a large amount of dirt build up. 7. Two (2) of the freezers had spillage and garbage on the bottom. 8. The bins with the serving pieces had sediment and spillage. There were 39 dirty serving pieces in the bins and available for resident use. All of the above findings were confirmed by the DM, at the time of the observations, during the kitchen tour with the Dietary Manager.	F 812	by the Dish Washer Service Company on June 21st, 2019 regarding the food contract service policies and procedures for utilization of the dish machine. Kitchen staff members not completing the required education were not allowed to be scheduled to work until the education has been complete. The facility began a cleaning schedule as of 6/21/19 and will be monitored Monday through Friday by the Dietary Manager. The staff members responsible for following the cleaning schedule assigned by the acting dietary manager received additional education as of 6/28/19 to complete assignments outlined in the cleaning schedule. 4. The Registered Dietician will conduct monthly sanitation checks in the kitchen to ensure compliance with the requirements. The Dietary Manager will ensure the monthly Registered Dietician sanitation audit is completed on a monthly basis for 3 months. The Dietary Manager will audit weekly to ensure the cleaning schedule log is complete and the chemical sanitation logs are complete and of proper levels for 12 weeks. These audits will begin as of July 11, 2019. The Dietary Manager will bring the results of these audits to the monthly Quality Assurance Committee for review, revisions, and/or resolution.		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		7/15/19	

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F 842	Continued From page 61 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842			

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F 842	Continued From page 62 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on facility policy reviews, record reviews, and staff interviews, the facility failed to ensure medical records were complete and accurate for two (2) residents of 19 residents sampled, whose records were reviewed, Residents #54, and #3. Specifically, the facility failed to accurately assess and document the status of a pressure ulcer for Resident #54 and failed to accurately document medication administration in the medical record for Resident #3. Findings include:	F 842	F842 Resident Records 1. Resident #54 Medical record was updated to include missing Weekly Pressure Injury Record dated 3/28/19, 4/4/19, 4/11/19 and 4/18/19 by the Wound Care Nurse on 6/26/19. The Director of Nursing, a Registered Nurse, assessed Resident # 54 pressure injury to the right heel on 5/23/19 and ensured that treatment was current and wound staging current. Resident #3 medication was obtained from back up pharmacy on		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
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F 842	Continued From page 63 The facility Administrator submitted a written statement on facility letterhead dated 05/23/19, which stated, "...we do not have a policy on what goes into the medical records by which a staff member...we follow normal standards of practice, who does the care, documents the care..." The Administrator signed the document. Resident #54 Review of the "Admission Record," revealed Resident #54 was admitted to the facility on 3/5/19. Review of the resident's "Progress Notes," dated, 3/5/19, the date of the resident's admission, revealed the resident had a right inner and outer suspected deep tissue injury. There was no description of the wound, or where it was located. Review of the "Admission & Readmission Evaluation" dated, 3/5/19, revealed under "Skin Integrity," Resident #54's skin was evaluated as normal, warm, normal turgor, and dusky. Continued review of the evaluation revealed a section that directed clinical staff to document any skin concerns with "...bilateral heels ..." being documented in the section. Review of Resident #54's clinical record revealed there were missing "Weekly Pressure Injury Records" dated 3/28/19, 4/4/19, 4/11/19, and 4/18/19. The missing notes were confirmed in an interview with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/22/19 at 2:40 PM. The LPN/WN said she had been off work (personal time) during March but was working 3/21/19 through 4/25/19. The LPN/WN stated aloud, "why are there no notes?" The DON was interviewed on 5/23/19 at 8:32 AM, and stated she had two (2) Registered Nurses (RNs) who assist with wounds. The DON was unable to provide evidence the weekly skin assessments	F 842	5/20/19 and available to the resident medical record was updated by licensed nursing staff to include accurate information. 2. All residents have the potential to be affected by this deficient practice. A 100% audit was conducted by the Transitional Care Manager and the Director of nursing on Electronic Health Record of all residents with Inhalers to ensure that the medication was available and administered as ordered beginning on 6/20/19 and completed 6/25/19. A 100% audit of all residents with pressure injuries was completed on 6/17/19 by the Medical Record Nurse. The Medical Records were audited to ensure that appropriate documentation including the sizing and staging of pressure areas was included in the medical record. 3. All licensed nursing staff members in-serviced by Director of Nursing beginning on 6/5/19, and completed 6/26/19. A Registered Nurse will completed weekly wound rounds, staging and documentation. Medication Administration Records will be completed to reflect medication administration by the nursing staff. 4. The Director of nursing will audit wound documentation weekly for four weeks, monthly for two months beginning June 20, 2019. The Director Of Nursing will audit all physician orders for inhalers weekly for four weeks and monthly for two months beginning June 20, 2019 to		

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F 842	Continued From page 64 were completed as care planned by any of the nurses. During an interview on 5/22/19 at 2:40 PM, at the desk of the wound nurse, the LPN/WN attempted to retrieve an Excel document kept on her computer. The LPN/WN stated she completes a weekly wound assessment, and that she had an Excel document in which she collected data that was then shared with the Patient at Risk (PAR) team each week. She stated the PAR team included the Director of Nursing (DON). The LPN/WN said that the Excel document was emailed to the Administrator, the DON, Medical Director, and the Minimum Data Set (MDS) Coordinator each week. The LPN/WN stated the Excel document was not part of the electronic medical records. She said she used this document for her wound care notes. On 05/23/19 at 09:45 AM, the Medical Records Supervisor presented the Excel documents, and stated and per their attorney, this cannot be copied. She stated that these documents were the personal notes of the wound nurse and not part of the clinical record. She stated, "this would have been done in a weekly injury pressure form." The Treatment Administration Record (TAR) for March 2019 and April 2019 had missing entries. For March 2019 the missing entries were identified as 3/8/19, 3/11/19, 3/18/19, and 3/21/19. The missing entries on the April 2019 TAR were from 4/6/19 through 4/18/19, which indicated the resident did not receive physician ordered treatment to the pressure ulcer on Resident #54's right heel. In an interview on 5/23/19 at 8:32 AM the DON reviewed the	F 842	ensure that medication is being administered as ordered. Findings will be brought to the Quality Assurance and Improvement Committee monthly for review, revision, and resolution of the plan.		

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F 842	Continued From page 65 documents and said she would look into it. The DON failed to provide any additional information or evidence the treatments had been provided for Resident #54. Review of the nursing "Progress Notes" dated 4/12/19, indicated a "Patient at Risk (PAR) meeting was held. The PAR note indicated Resident #54 had a Stage 2 pressure ulcer on her ". . .left heel. . ." and the ". . .right heel has resolved. . ." The PAR note was reviewed with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/22/19, and the LPN/WN confirmed the information in the PAR note was incorrect. The left heel wound had resolved, and the right heel wound had declined. The DON was interviewed on 5/22/19 at 4:19 PM. The DON confirmed the excel document, which contained additional details of Resident 54's wound was not considered part of Resident #54's clinical record. The DON was asked about the missed treatments for Resident #54 and said she would "look into it." The DON failed to provide any additional information or evidence that the treatments had been provided as ordered for Resident #54. The DON, LPN/WN, and the Administrator were interviewed on 5/23/19 at 9:45 AM. The LPN/WN confirmed the "Progress Note" dated 4/12/19, was inaccurate. It was during this interview the LPN/WN stated the medical record computer program (PCC) had discontinued wound care to the right heel in error on 4/12/19, and failed to generate the weekly skin assessments for Resident #54. The DON stated, "We need to make some changes, the nurses have a lot to do."			F 842			

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F 842	Continued From page 66 The facility's "Medication Administration - General Guidelines" policy and procedure, dated 11/01/08, documented: ". . .The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record] after the medication is given. . .If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time, . . .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. . ." Resident #3 Review of the electronic health record (EHR) for Resident #3 revealed she had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation and Acute and Chronic Respiratory Failure with Hypercapnia. The admission "Minimum Data Set," dated 02/16/19, documented Resident #3 had a "Brief Interview for Mental Status" score of 15, which indicated she was cognitively intact. It documented she required supervision to extensive assistance with activities of daily living and had shortness of breath or trouble breathing with exertion. A "Physician's Order," originally dated 2/20/19, documented the resident was to be administered Atrovent Inhaler two (2) puffs orally four (4) times daily for COPD with acute exacerbation. On 5/20/19 at 11:39 AM, Resident #3 reported she had not received her Atrovent inhaler for three (3) days because the facility was "out of my inhaler."	F 842			

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F 842	Continued From page 67 The "Medication Administration Record (MAR)," dated 5/2019, documented the resident's Atrovent Inhaler was administered/not administered as follows: 5/17/19 - not administered at 12:00 PM or 8:00 PM. Administered at 8:00 AM and 4:00 PM. 5/18/19 - not administered at 8:00 AM or 12:00 PM. Administered at 4:00 PM and 8:00 PM. 5/19/19 - not administered at 8:00 AM, 12:00 PM, 4:00 PM (resident absent from facility) or 8:00 PM. 5/20/19 - not administered at 8:00 AM. Administered remainder of doses. On 5/22/19 at 10:09 AM, LPN #24, who had documented the dose of Atrovent inhaler as having been administered on 5/17/19 at 4:00 PM, was asked if the Atrovent had been administered. She stated she had "charted wrong" and had not documented the error in the nurses' progress notes. On 5/22/19 at 05:17 PM, Registered Nurse #90, who had documented the doses of Atrovent inhaler had been administered on 5/18/19 at 4:00 PM and 8:00 PM, was asked if the Atrovent had been administered. She stated she had made an error in charting and had not documented the error in the nurses' progress notes.	F 842			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		7/15/19	

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F 883	Continued From page 68 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 883			

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F 883	Continued From page 69 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interviews, the facility failed to follow Centers for Disease Control (CDC) guidelines for the administration of the pneumococcal vaccine for three (3) of five (5) sampled residents, Residents #60, #62 and #79, whose clinical records were reviewed for vaccine status. Findings include: The facility's "Standing Orders for Administering Pneumococcal Vaccine to Adults" policy and procedure, dated 7/17/18, directed: "Adults should receive PPSV23 (pneumococcal polysaccharide vaccine) no sooner than one year after receiving PV13 [pneumococcal conjugate vaccine]." The CDC guidelines for the administration of the pneumococcal vaccines, dated 11/30/15, documented: "Pneumococcal vaccine timing for adults 65 years and older. For those who have not received any pneumococcal vaccines, or those with unknown vaccination history. . Administer one (1) dose of PCV13. Administer one (1) dose of PPSV23 at least one (1) year later for most immunocompetent adults. . For those who have previously received one (1) dose	F 883	F883 Influenza and Pneumococcal Immunizations 1) Resident #60 was assessed for the pneumococcal immunization by the Director of Nursing and received consent from resident #60 s responsible party to give the Plevnar13 vaccination. The Plevnar13 vaccination was administered to resident #60 on 6/26/2019, education provided to the Responsible party from the CDC website by the Assistant Director of Nursing. Resident #62 was assessed for the pneumococcal immunization by the Assistant Director of Nursing and received consent from resident #62 s responsible party to give the Plevnar13 vaccination. The Plevnar13 vaccination was administered on 6/28/2019, education provided from the CDC website to Responsible party by the Assistant Director of Nursing. Resident #79 was assessed for the pneumococcal immunization by the MDS/Care Plan Coordinator and received consent from Resident #79 to administer the Plevnar13 vaccination. The Plevnar13 vaccination was administered to resident #79 on		

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F 883	Continued From page 70 of PPSV23 at [or greater than] 65 years and no doses of PCV13. . .Administer one (1) dose of PCV13 at least one (1) year after the dose of PPSV23 for all adults, regardless of medical conditions. . ." Resident #60 Review of the Electronic Health Record (EHR) for Resident #60 revealed the resident was admitted to the facility on 1/7/10, with diagnoses which included Congenital Hydrocephalus and Unspecified Dementia with Behavioral Disturbance. Continued review revealed the resident was 75 years old. Review of Resident #60's immunization record, located in the EHR, revealed the resident had received a "Pneumovax Dose 1" on 11/10/08; however, there was no documented evidence the recommended second dose was offered or given to the resident; and the documentation did not indicate which vaccine the resident had received. Resident #62 Review of the EHR for Resident #62 revealed the resident was admitted to the facility on 5/11/12, with diagnoses which included Diabetes Mellitus Type II. Continued review revealed the resident was 88 years old. Review of Resident #62's immunization record, located in the EHR, revealed the resident had received a "Pneumovax Dose 1" on 7/3/17; however, there was no documented evidence the recommended second dose was offered or given to the resident; and the documentation did not indicate which vaccine the resident had received. Resident #79	F 883	6/28/2019, education provided to resident #79 from the CDC website by the Assistant Director of Nursing. 2) This deficient practice has the potential to affect all facility residents requesting a pneumococcal vaccination. A 100 % audit of residents for vaccinations was conducted on 6/20/2019 by the Director of Nursing to ensure vaccinations given per resident request with physician orders in place and appropriate declinations/ consent forms signed. 3) All licensed nursing staff were in-serviced June 5th,6th,7th and 13th, 2019 by the Director of Nursing regarding the facility policies and procedures for the Pneumococcal Vaccination. Any staff members not having completed the required education will not be allowed to return to the schedule until their education has been completed. Pneumococcal consent forms will be completed upon admission by admitting nurse. The facility Nurse Management staff will review all new admissions Monday through Friday to ensure that the consent/declination form is in the medical record. 4) Beginning on July 1, 2019, the Director of Nursing will audit all new admission records weekly for four weeks, then monthly for two months to ensure consents/declinations have been signed and are in the medical record. Findings will be brought to the Quality Assurance and Improvement Committee monthly for review, revision, and/or resolution of the		

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F 883	Continued From page 71 Review of the EHR for Resident #79 revealed the resident was admitted to the facility on 10/10/17, with diagnoses which included Chronic Respiratory Failure with Hypercapnia, Chronic Obstructive Pulmonary Disease, and Chronic Congestive Heart Failure. Continued review revealed the resident was 71 years old. Review of Resident #79's immunization record, located in the EHR, revealed the resident had received a "Pneumovax Dose 1" on 10/19/17; however, there was no documented evidence the recommended second dose was ever offered or given to the resident; and the documentation did not indicate which vaccine the resident had received. On 5/23/19 at 11:50 AM, the Director of Nursing (DON) was asked if she knew the name of the pneumococcal vaccine the facility used for Residents #60, #62 and #79. She stated she did not know. She stated she would look. No additional information was received from the DON. On 5/23/19 at 12:00 PM, during a telephone interview, the facility's Medical Director was asked if he expected the facility to follow the CDC guidelines for the use of Prevnar 13 and PPSV23. He stated, "Yes. Absolutely." On 5/23/19 at 3:36 PM, the DON provided documentation from their pharmacy provider a vial of "Pneumovax 23" had been purchased by the facility on 07/06/16. The documentation of the pneumococcal vaccinations administered to Residents #60, #62 and #79 was reviewed with the DON. When asked if she knew if the pneumococcal vaccinations which had been	F 883	plan.		

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F 883	Continued From page 72 administered to the residents were the PCV13 or the PPSV23, she stated she did not know. When asked if the facility had followed the CDC guidelines for the administration of the pneumococcal vaccines, she stated, "all you see is what's there," as she pointed to the pneumococcal immunization documentation for Residents #60, #62 and #79.	F 883			

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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

06/21/2019

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* The Survey conducted on 5/22/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000			

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

TITLE

(X6) DATE

Electronically Signed

06/21/2019

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.