STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	C 06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on June 4-11, 2019. The sample included sixteen (16) sampled residents and three (3) records of residents discharged from the facility for focused review.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		7/10/19

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

Electronically Signed | 07/04/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON 08/16/18. Based on information received from the complainants, observation, review of facility policy, and staff interview, the facility failed to provide care for 3 of 16 sampled residents (Resident #4, #13, and #15) and 2 supplemental residents (Resident #20 and #21) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors, announce themselves, and wait for permission prior to entering residents' rooms, identify/honor resident preferences, and provide dining assistance/feed residents in a dignified manner does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Information provided by the complainants indicated nursing staff failed to assist residents leaving them in soiled clothing and/or a dirty environment.	F 550	The wheelchair for #15 was cleaned on 6/28/19, Care plans for #20 and #21 were updated to include personalization for meal assistance and toileting preferences on 6/28/19, education on knocking before entering a room was provided to laundry staff on 6/28/19 in response to findings for #4. Resident #13 no longer resides in the facility. Residents who reside in the facility have the potential to be impacted by this practice. Education was provided by the DON or designee to licensed nurses, nursing assistants, and ancillary staff beginning on 06/17/19 on knocking prior to entering the room, wheelchair cleaning, providing assistance with meals when they are served, and providing privacy for cares or ensuring care plan clearly indicates patient preferences for cares if the patient□s preference is different than accepted norms.	

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F 550	Continued From page 2 Review of facility policy titled "Quality of Life - Dignity" occurred on 06/10/19. This policy, revised August 2009, stated, ". . . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. . . . Staff will knock and request permission before entering residents' rooms . . ." - Observations showed the following: * 06/04/19 at 10:37 a.m., Resident #21 utilized the bathroom with the bedroom and bathroom doors open, and unclothed/exposed to the hallway. Staff were not present in the room to assist her with transfer/toileting. * 06/04/19 at 2:51 p.m., Resident #21 utilized the bathroom with the bedroom and bathroom doors open, and unclothed/exposed to the hallway. An unidentified nurse attempted to close the bathroom door. The unidentified nurse left the room after Resident #21 refused to allow her to close the door. Review of Resident #21's medical record occurred on 06/04/19. The current care plan stated, ". . . self care deficit . . . Break . . . tasks into sub-task for easier patient performance . . . Cares in Pairs . . . Transfer with one assist with gait belt . . ." The care plan failed to identify Resident #21's preference for the bathroom and bedroom doors to be left open. - Observation on 06/04/19 at 11:20 a.m., showed Resident #4 sat in his room as an unidentified laundry staff member entered the room without knocking or identifying himself/herself. - Observation on 06/04/19 at 12:10 p.m., showed	F 550	The DON initiated audits on 06/24/19 on dignity and knocking before entering the room. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 550	Continued From page 3 Resident #20 held a bowl up to his mouth and ate spaghetti directly from the bowl. Wrapped silverware laid on the table beside the resident. An unidentified staff member walked passed Resident #20's table several times without offering assistance. After all thr trays had been passed, the unidentified staff member sat down to assist Resident #20. During an interview on 06/06/19 at 9:05 a.m., an administrative nurse (#5) stated he expected staff to set up trays for those residents who are able to feed themselves. The staff member then added residents who require assistance should be served when the staff member is able to sit down and assist them. - Observation on 06/04/19 at 3:21 p.m. showed Resident #15 sat in her wheelchair. Crumbs and stains covered Resident #15's T-shirt, pants, and wheelchair and debris covered the left foot pedal. - Observation on 06/05/19 at 12:12 p.m. showed a certified nursing assistant (CNA) (#3) standing next to Resident #13's wheelchair as she fed her. The CNA (#3) also scraped food residue from Resident #13's face with a glass. The CNA failed to sit next to the resident throughout the meal and failed to utilize a napkin to wipe residue from her face.	F 550		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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-	F 580		7/10/19

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F 580	Continued From page 4 (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). §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	F 580		

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F 580	Continued From page 5 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 information received from the complainants, record review and staff interview, the facility failed to notify the resident's physician and/or family member of a change in condition for 2 of 16 sampled residents (Resident #3 and #16) and 2 discharged residents (Resident #17 and #18) reviewed during the complaint survey. Failure to notify the physician of a resident's change in condition may result in complications to the resident and prevented the physician from evaluating the effectiveness of the current treatment plan. Findings include: Information provided by the complainants indicated facility staff failed to consistently notify them of changes in their family members' condition. Upon request, the facility failed to provide a copy of their policy addressing physician and/or family notification of a change in the resident's condition. - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, "Diagnosis . . . unspecified dementia without behavioral disturbance . . . muscle weakness . . . repeated falls . . . At risk for falls due to: history of falls . . . "	F 580	Falls from 2/28/19, 3/13/19, and 5/28/19 for resident #3 were reviewed with MD and family on 6/28/19. DON reviewed and validated falls that occurred after 5/28/19 included documentation of notifications to MD and family. Blood glucose results for resident # 16 from February through 6/28/19 were forwarded to the MD for review and recommendations on 6/28/19. Resident #17 and #18 no longer reside in the facility. Residents who experience changes in condition have the potential to be impacted by this practice. Education was provided by DON or designee to licensed nurses beginning on 06/17/19 on notification of MD and family of changes in condition. The DON initiated audits on the 06/24/19 regarding notification of MD and family of changes in condition. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. . Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if	

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F 580	Continued From page 6 Review of progress notes showed the following: * 02/28/19 at 2:20 p.m., "Resident found on floor . . . Family has been notified . . . Will update MD [medical doctor] at this time . . ." * 03/13/19 at 1:50 p.m., "Will update MD and family. Resident had a missed fall . . ." * 05/28/10 at 2:05 p.m., "Late entry. Will update MD and family. Resident had a witnessed fall . . ." - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included, type 2 diabetes. Medications included, "Levemir [insulin] 20 units two times a day and NovoLog [insulin] 10 units three times a day." A physician's order, stated "accuchecks four times a day . . . NovoLog . . . Inject as per sliding scale . . . 426+ = 7 units Call MD for blood glucose less than 50 and greater than 426 . . ." Review of the blood sugars showed a blood sugar reading of "426" on 02/08/19 and "430" on 02/09/19. The facility failed to notify Resident #16's physician of the blood sugar readings. During an interview on 06/05/19 at 3:54 p.m. an administrative nurse (#5) agreed the facility failed to notify the physician of a blood sugar readings that fell outside of ordered parameters. - Review of Resident #17's medical record occurred on all days of survey. The record identified diagnoses of Alzheimer's dementia, diabetes, hypertension requiring a diuretic, muscle weakness, and buttock/toe wounds. The progress notes, dated 10/02/18-05/05/18, identified the following:	F 580	indicated.	

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F 580	Continued From page 7 * 12/06/18 at 7:00 a.m. and 12/07/18 at 10:13 a.m., "Will update MD . . . her second rt [right] toe has a 2 cm [centimeter] wt [width] by 1.2 cm Lt [left] pressure area. Skin is intact and without drainage. Site is red, resident denies sensation or pain . . ." The facility failed to notify Resident #17's family of the pressure area to her toe. * 12/11/18 at 3:26 p.m., "This nurse paged [physician] regarding resident sore toe. He ordered Keflex [antibiotic] 500 mg [milligram] PO [by mouth] TID [three times per day] for 10 days. . . ." The facility failed to notify Resident #17's physician in a timely manner, paging him five days after they discovered the ulcer on her toe. * 01/12/19 at 9:19 p.m., "Resident is on follow up for: Un witnessed fall in her bathroom. . . . Resident is unable to transfer self back and fort [sic] [to] the bathroom. . . . Will update MD . . ." The facility failed to inform Resident #17's physician and family of her fall. * 03/22/19 at 2:42 p.m., "Resident returned from appointment with nephrologist . . . New orders to continue same medications, get a UA. . . ." A microbiology report, dated 03/24/19, identified "Escherichia coli [E-coli] and Proteus mirabilis [types of bacteria]" present in Resident #17's urine. The facility failed to notify the physician and family of Resident #17's positive urine culture. Resident #17's progress notes also identified the following: * 03/31/19, ". . . -7.5% change . . . Wt [weight] triggers for significant change. . . . She is eating < 30% average at meals. wt may not reflect a loss due to fluid. . . . Notify MD [medical doctor] and family of poor intakes. Offer supplement or other	F 580		

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F 580	Continued From page 8	F 580		

meal replacement when not eating. Follow on Nutrition risk." The facility failed to inform Resident #17's physician of her significant weight loss.

* 03/31/19 at 11:50 a.m., "Will update family and MD [physician]: Resident was hypoglycemic [low blood sugars] with a blood sugar of 52 mg/dl [Level 2 hypoglycemia]. She was non verbal, clammy and lethargic. Glucagon administered by this nurse, ambulance called. When ambulance crew arrived, resident sugar level was up to 60 mg/dl [Level 1 hypoglycemia]. Her vitals was [sic] stable, she verbally refused going to the hospital . . ." The facility failed to inform Resident #17's physician and family of her hypoglycemic episode.

* 04/09/19 at 6:03 p.m., "Resident's daughter . . . concerned that resident's right 2nd toe diabetic vascular ulcer is not improving. I note that right 2nd toe has a very thick necrotic black 0.8 cm circular scab dry [and] intact. No drainage. Surrounding toe is slightly red. Right foot is slightly cool to touch with pedal pulses palpable. Resident denies any pain or discomfort to the right foot. . . . Daughter . . . requests that a f/u [follow up] appointment be made ASAP [as soon as possible] with podiatrist . . ."

* 04/17/19 at 2:25 p.m., "Made an appointment with . . . podiatry to see if resident scabbed to her right second toe can be debride [sic]." The facility failed to schedule an appointment with Resident #17's podiatrist in a timely manner, contacting his office eight days after the family made their request.

* 05/02/19 at 5:45 p.m., "Resident is pale [and] diaphoretic. Blood glucose is 52 mg/dl [Level 2 hypoglycemia]. . . . No emisis or c/o [complained of] nausea. . . . [Physician] on call . . . paged

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F 580	Continued From page 9	F 580		

[and] gave new order to administer Glucagon 1 mg intramuscularly now [and] recheck blood glucose in 15 minutes. Order observed." The facility failed to inform Resident #17's primary physician of her hypoglycemic episode.
* 05/03/19 at 1:14 a.m., "Resident was found pale, diaphoretic and unresponsive [symptoms of Level 3 hypoglycemia]. Unresponsive to sternum rub. BS [blood sugar] was 35 [Level 2 hypoglycemia]. Glucagon 1 mg given. 15 mins later, resident continued to be unresponsive and pale. Her BS was 44. Another Glucagon 1 mg injected. 15 mins later her BS was 85. Nurse gave another sternum rub and resident pushed away hands. . . . [Physician] whom is taking call . . . gave order to administer the Glucagon 1 mg x [times] 2. Primary MD will be notified via fax." The facility failed to inform Resident #17's primary physician and family of her hypoglycemic episode.
* 05/05/19 at 5:00 p.m., "Resident was found unresponsive [symptom of Level 3 hypoglycemia] to sternum rub. BS was 67 mg/dL . . . Glucagon 1 mg given. Blood sugar rechecked 15 mins later was 106. Resident was responsive . . . Informed [Physician] on call . . . and he ordered to decrease dosage of Levemir . . . The Primary MD will be notified . . . " The facility failed to inform Resident #17's primary physician and family of her hypoglycemic episode.

- Review of Resident #18's medical record occurred on all days of survey, and identified diagnoses of carcinoma of skin and open wound to right lower leg.

Progress notes identified the following:
* 08/02/18 at 3:38 p.m., "Resident has a firm area

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F 580	Continued From page 10 to the left lower buttock, it is not raised, it has no discoloration, resident states it is very painful when palpated, [Physician] called . . ." The facility failed to inform Resident #18's family of her skin issue. * 09/12/18 at 4:35 a.m., "Nurse was sitting at the nursing station when she heard, 'help I'm slipping.' 'help.' 'help me.' This nurse and other nurse on duty went running into her room. This nurse saw resident slide out of her chair and onto the floor. . . . Faxed communication to MD regarding fall." The facility failed to inform Resident #18's family of her fall.	F 580		
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 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;	F 584		7/10/19

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F 584	Continued From page 11 §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 information received from the complainants, and observations, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior on 1 of 2 floors (first floor). Failure to maintain a clean and sanitary environment does not provide a comfortable living area for residents. Findings include: Information provided by the complainants indicated facility staff failed to provide a clean, comfortable environment for the residents to live in. Upon request, the facility failed to provide a copy of their policy addressing a clean, comfortable and homelike environment.	F 584	The wallpaper in room 168 and 178 was repaired. Room 174 was inspected for urine odor and the room, floor and bathroom were cleaned. Food items in room 170 were stored appropriately and in a manner that allows resident access to snack items as desired. Wheelchair in room 176 and foot pedals were washed and are scheduled for weekly washing. Residents who reside in the facility have the potential to be impacted by this practice. The DON provided education to licensed nurses, nursing assistants, and ancillary staff beginning 06/17/19 on keeping resident rooms and common areas clean and neat as part of routine cares. The	

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F 584	Continued From page 12 - Observations on the morning of 06/05/19 of the resident living area on first floor showed the following: * Room 168: torn wallpaper border near ceiling, glove laying on the sink, shirt laying on top of a dresser * Room 169: breakfast tray on bedside table at 11:00 a.m., clean brief laying on the bed, used towel on the sink, clothing on the floor (bra, socks, shirt), closet door open, shirt on the floor in closet * Room 170: cereal, popcorn, and soda can boxes on the floor, clothes and open popcorn bag on the bed, dirty plate on the bedside table, a used towel on the sink * Room 171: closet doors open, used towel on the sink, sink dripping * Room 172: unopened package of Procare wipes on the floor underneath the sink, opened package of Procare wipes on the floor behind the door, urinal tipped over behind the door * Room 174: pants and shirt draped over the back of a recliner, strong urine odor in the room * Room 176: dirty wheelchair foot pedals, uneaten breakfast tray on the sink at 11:20 a.m. * Room 178: torn wallpaper above the bed, tooth brush laying on a towel on the sink, sink dripping, paper towel on the floor by a wastebasket * Room 180: used washcloth laying in the sink	F 584	facility has assigned leadership staff as guardian angels who inspect rooms on a routine basis to ensure items are stored appropriately and rooms are neat and clean. The DON initiated audits of room cleanliness 06/24/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or	F 585		7/10/19

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F 585	Continued From page 13	F 585		

reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey

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F 585	Continued From page 14 Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility	F 585		

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F 585	Continued From page 15 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observations, review of Resident Council Meeting minutes, review of facility policy, and resident interviews, the facility failed to provide reasonable accommodation of needs regarding call lights for 6 of 16 confidential and/or sampled residents (Resident A, B, C, #5, #6, and #7). Failure to place call lights within the residents' reach and/or respond to the call lights in a timely manner does not allow residents to request/obtain assistance and may result in avoidable incontinence/falls, increased behaviors, and/or a decreased quality of life. Findings include: Information provided by the complainants indicated nursing staff failed to respond to call lights in a timely manner (waiting up to 55 minutes) resulting in residents and/or family members searching the halls for staff and indicated they found call lights that were not functioning properly. Review of the facility policy titled "Call Light, Use of" occurred on 06/10/19. This policy, dated June 2017, stated, ". . . Answer ALL call lights promptly	F 585	Residents A, B, and C are not identified in the report. Call light placement for #5 was validated on 6/28/19 and resident #6 was interviewed by Administrator on 6/28/19 regarding call light response time. Resident #7 no longer resides at the facility. Residents who reside in the facility have the potential to be impacted by this practice. The DON provided education to licensed nurses, nursing assistants, and ancillary staff beginning 06/17/19 on call light placement and call light response time. The Administrator or designee initiated call light audits on 06/24/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits	

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F 585	Continued From page 16 whether or not you are assigned to the resident . . . Never make the resident feel you are too busy to give assistance. Offer further assistance before you leave the room. . . . When providing care to resident, be sure to position the call light conveniently for the resident to use. . . . Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. . . ." Review of "Resident Council Meeting" minutes, dated March 22-May 23, 2019, occurred on 06/07/19. The meeting minutes identified the following concerns were discussed with the facility: * 03/22/19, ". . . Call lights taking long to be answered . . ." * 04/25/19, ". . . Call lights around meal times taking a long time . . ." * 05/23/19, ". . . Call light times in general . . ." Random interviews identified the following: * 06/05/19 at 12:05 p.m., resident (A) stated, "I've had to wait up to 45 minutes for someone to answer my light." * 06/05/19 at 1:30 p.m., resident (B) stated, "I've waited up to an hour for help." * 06/05/19 at 1:40 p.m., resident (C) said he/she has had to wait 15 minutes-to-one hour for someone to answer the light." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, muscle weakness, and difficulty in walking. The current care plan stated, ". . . Resident is at risk for falls r/t [related to] Decondition/weakness . . . Encourage the Resident to always call for assistance. . . ."	F 585	will be adjusted if indicated.	

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F 585	Continued From page 17 Observation on 06/04/19 at 11:00 a.m. and 06/05/19 at 11:15 a.m. showed Resident #6 asleep on his bed. Observation showed the call light clipped to the cord, hanging on the wall out of reach of the resident. - Review of Resident #5's medical record occurred on all days of survey. A progress note, dated 05/08/19 at 7:45 p.m., stated, "This nurse was alerted by CNA [certified nurse aide] at [7:30 p.m.] that resident was found lying on the floor near his bed. This nurse went to go assess the situation and found resident lying on the floor near the foot of his bed on his left side. Resident had shoes and socks on. The wheelchair was three feet away. Call light was on. This nurse asked resident what happened, resident said, "I'm tired of waiting, I've been waiting 30 minutes so I tried putting myself to bed." . . . ." - Review of Resident # 7's medical record occurred all days of survey. A progress note, dated 05/12/19 at 7:28 a.m., stated, "CNA found resident in bed at 640 AM when she screamed for help. Found blood all over her face and holding a baseball size blood clot in her hand. Resident stated to CNA that she had been screaming for help for a while during early morning. Found call-light clipped onto curtain out of reach from resident. Immediately called 911 and informed ER [emergency room]. . . . Resident is alert and slightly confused. . . ." Refer to F689 and F690.	F 585		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		7/10/19

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F 657	Continued From page 18 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEY COMPLETED ON 08/16/18. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 4 of 16 sampled residents (Resident #1, #5, #13, #14) and 1 discharged resident (Resident #17). Failure to revise the care plan limited the ability of	F 657	Resident #1 has orders to discontinue oxygen use. Resident #5 currently participates in PT □ with a request made to validate transfer status on 07/01/19 and care plan will be updated if needed when screening is complete. Care plan for #14 was revised to include current fall prevention measures. A skin assessment was completed by DON or designee on 6/14/19 and care plan updated, and	

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F 657	Continued From page 19 staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans - Comprehensive" occurred on 06/10/19. This undated policy stated, ". . . develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain . . . Incorporate identified problem areas . . . Incorporate risk factors associated with identified problems . . . Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident . . . care plans are revised as information about the resident and the resident's condition change . . ." - Review of Resident #1's medical record occurred on all days of survey. The current physician order stated, "Oxygen at 2 L/M [liters per minute] to maintain O2 [oxygen] saturations > [less than] 90%. Check each shift. . . ." Observations on 06/04/19 at 11:05 a.m. and 06/05/19 at 10:08 a.m., showed Resident #1 wearing a nasal cannula attached to an oxygen concentrator set at 1 liter per minute. The facility failed to review/revise the care plan to reflect Resident #1's respiratory status. During an interview on 06/06/19 at 9:05 a.m., an administrative nurse (#5) stated he/she would expect staff to address O2 use/interventions on the careplan.	F 657	toileting was added to care plan. Resident #13 no longer resides at the facility. Residents who reside in facility have the potential to be impacted if care plans are not updated. The DON provided education to licensed nurses beginning on 06/17/19 regarding accuracy of care plans and updating care plans to reflect current needs. Audits of care plans were initiated by DON 07/01/19 to validate accuracy. Audits of updates to care plan with changes in condition were initiated by DON 07/01/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 657	Continued From page 20 - Review of Resident #5's medical record occurred on all days of the survey. The current care plan stated, "ADL [activities of daily living] self care deficit as evidenced by unsteady gait related to lumbar L2 fracture. . . . Transfer with extensive assist of one with gait belt. . . ." Observation on 06/04/19 at 11:30 a.m. showed Resident #5 ambulated independently with a front wheeled walker into the bathroom. The facility failed to accurately identify Resident #5's level of assistance and toileting on the care plan. - Review of Resident #13's medical record occurred on all days of survey. The current physician order stated, "House supplement three times daily." The current care plan stated, "Nutritional status wt [weight] loss . . . Need for assistance at meals and altered textures . . . Refuses meals or takes poor . . . Provide diet as ordered - Pureed small portions per family request. Fortified cereal, pudding, cereal and magic cup . . ." Review of progress notes showed the following: * 02/28/19 at 2:02 p.m. - Doctor started resident on Zyprexa to help with weight gain * 02/28/19 at 3:56 p.m. - Resident declining and failing to thrive. Resident has been losing weight and does not have an appetite. * 04/02/19 at 12:05 p.m. - Family is aware of wt loss and does not want comfort measure or tube feeding support * 04/18/19 at 3:15 p.m. - Resident continue with failure to thrive and refusing to eat	F 657		

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F 657	Continued From page 21 Resident #13's current physician's order stated, ". . . Clean area to right clavicle . . . Clean large skin tear to RFA [right forearm] . . . Clean small skin tear to RFA . . . " The care plan stated, "At risk for alteration in skin integrity related to . . . impaired mobility . . . Encourage fluids . . . Float heels . . . Observe skin condition daily with ADL care daily: report abnormalities . . . Pressure redistributing device on bed/chair . . . Provide preventative skin care routinely and PRN [as needed] . . . Toileting program as indicated . . . Use pillows/positioning devices as needed . . ." Review of the nursing progress notes showed the following: * 05/20/19 at 10:00 p.m. - Abrasion on right clavicle is small and superficial * 05/23/19 at 3:30 p.m. - Alerted nurse to a large skin tear to right inner elbow area measuring 7 centimeters (cm) x 2 cm (open area bright red wound bed) and another skin tear to right forearm measuring 1 cm x 1 cm. Resident #13's care plan failed to identify current skin issues with treatment and the current weight loss approaches. - Review of Resident #14's medical record occurred on all days of survey. The current physician order stated, "Mepilex to open areas on bottom. Change every MWF [Monday, Wednesday, Friday] until healed . . . Mepilex type bandage change daily . . . Rt [right] foot wound . . .Wound to right lower extremity . . . Change daily. Wound nurse to follow . . ."	F 657		

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Review of Resident #14's medical record showed resident has fallen six times in the last six months. A progress note, dated 03/06/19 at 7:44 a.m., stated, ". . . Requesting to place floor mats at bedside . . ."

All observations during survey showed Resident #14 with no fall mats in place while in bed.

Observation on 06/04/19 at 10:59 a.m. showed two certified nursing assistants (CNAs) (#9 and #10) checked Resident #14's brief and provided incontinent cares for Resident #14 after a bowel movement (BM) while in bed.

The current care plan stated, "At risk for alteration in skin integrity related to: history of pressure ulcer . . . Transfer with two assist with gait belt . . .

Resident #14's care plan to failed to identify current skin issues, toileting method, and fall interventions.

- Review of Resident #17's medical record occurred on all days of survey, and identified a 37 pound weight loss between 12/03/18-05/05/19. Documentation failed to show staff identified Resident #17's food preferences and/or obtained orders for/implemented other interventions such as fortified foods/supplements.

Staff failed to individualize Resident #17's care plan identifying specific preferred foods/supplements.

During an interview on 06/04/19 at 3:30 p.m.,

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when asked how the facility addresses residents experiencing weight loss, a managerial dietary staff member (#12) reported monitoring residents for gradual/significant weight loss, and stated, "First, I would give the resident fortified foods, and then supplements. I try to do things like cookies, chocolate milk, whole milk, cheese and crackers, cereal, magic cup, sherbet, and peanut butter. If they need help, I ask them to be moved to an assisted table."

During an interview on 06/05/19 at 3:00 p.m., a managerial nurse (#5) confirmed the care plan failed to reflect Resident #17's food preferences and/or the fortified foods, supplements, and snacks recommended for her.

Resident #17's progress notes identified the following:
* 03/10/19 at 9:49 p.m., "Resident's daughter approached this recorder and stated, 'my Mom's toe is infected' . . . On exam 2nd toe on rt foot is light red, no swelling noted, has a dry callous type lesion of DP [sic] joint area, no drainage noted, residents [sic] states it does not hurt . . . Callous is dry measures 0.9 cm x 1 cm. . . ."
* 03/12/19 at 4:41 a.m., ". . . received first dose of Doxycycline . . . Toe is erythema and slightly warm to touch. Skin is intact. No drainage noted. . . . She stated only has pain when blanket is laying on the foot. Blanket was pulled back and she stated she had relief. . . ." and at 9:11 p.m., ". . . Right 2nd toe is red [and] swollen. Anterior distal tip of toe has a small circular open area with no drainage. Resident denies any pain or discomfort to toe. . . ."

The care plan failed to address removing

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MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 657	Continued From page 24 pressure from the top of Resident #17's feet.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON 08/16/18. MEDICATION ADMINISTRATION 1. Based on information received from the complainants, observation, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 2 of 2 sampled residents (Resident #1 and #2) on insulin and 1 supplemental resident (Resident #20) observed during medication administration. Failure to follow physician's orders for Resident #1 and #2 and failure to ensure Resident #20 consumed his/her medication may result in adverse health consequences. Findings include: Information provided by the complainants indicated family members questioned nursing staff regarding changes in the residents' medication/treatment regimen. Review of facility policy titled "Administering Medications" occurred on 06/10/19. This policy,	F 658	Parameters for holding insulin were requested from MD for Resident #2 on 07/02/19. Resident #1 had orders to discontinue insulin. Care plan was updated for Resident #20 on 06/28/19 to include medications are given in cocoa and to remain with resident until cocoa is consumed. An order was obtained from the attending physician authorizing staff to place medication in cocoa on 7/12/2019. Resident #5 and #8 blood sugars remained within parameters after insulin administration. Residents who receive insulin or who have medications given in food or drink items have the potential to be impacted by this practice. Education was provided by the DON to licensed nurses beginning on 06/17/19 on use of insulin pens, obtaining parameters and notifying MD if insulin is held, and remaining with residents until medication is taken. The DON initiated audits of competencies for medication pass for licensed nurse on 06/24/19. These audits will be continued until competencies are in place for each	7/10/19

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F 658	Continued From page 25 revised December 2012, stated, "Medications must be administered in accordance with the orders . . . If a dosage is believed to be inappropriate or excessive for a resident . . . contact the resident's Attending Physician . . . If a drug is withheld . . . update physician and family . . . Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. . . ." Review of facility policy titled "Administering Oral Medications" occurred on 06/10/19. This policy, revised October 2010, stated, ". . . Remain with the resident until all medication have been taken . . ." - Review of Resident #1 occurred on all days of survey. Review of Resident #1's medication administration record identified the following: * 04/14/19 at 7:36 a.m.: Novolog Flex Pen . . . Inject 3 units . . . BS [blood sugar] 90, held per nursing judgement. * 04/22/19 at 7:16 a.m.: Novolog Flex Pen . . . Inject 3 units . . . held BS 99, per nursing judgement. * 04/27/19 at 9:53 a.m.: Novolog Flex Pen . . . Inject 3 units . . . held per nursing judgment, BS 85. * 05/11/19 at 10:25 a.m.: Novolog Flex Pen . . . Inject 3 units . . . held per nursing judgement, BS 85. - Review of Resident #2 occurred on all days of survey. Review of Resident #2's medication administration documentation identified the following:	F 658	nurse. The DON or designee initiated random audits of medication pass including insulin administration on 07/02/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 658	Continued From page 26 * 03/10/19 at HS: [bedtime] Novolog Flex Pen Solution . . . Inject 14 units . . . Resident ate less than 50% of supper. HS bs 115. Lantus held. * 05/10/19 at 7:30 a.m.: Novolog Flex Pen Solution . . . Inject 5 units . . . held per nursing judgement. BS 87. - During observation of the noon meal on 06/05/19 at 12:20 a.m., an unidentified nurse reported he/she dissolved Resident #20's medication in hot chocolate because the resident usually refuses medications. The nurse then handed the cup of hot chocolate to Resident #20, watched the resident take a couple swallows and left. Staff failed to observe the resident consume all the medication, failed to obtain physician orders to disguise medications and/or orders for resident to self medicate. During an interview on 06/06/19 at 10:43 a.m., an administrative nurse (#5) stated that he/she would expect staff to notify the physician if insulin is held and to stay with residents until all medication is consumed. INSULIN PREPARATION AND ADMINISTRATION 2. Based on information received from the complainants, observation, policy review, and review of manufacturer's guidelines, the facility failed to follow professional standards of practice when preparing and administering insulin for 2 of 4 observations of insulin administration. (Resident #5 and #8). Failure to cleanse the rubber stopper before applying a new needle, cleanse the injection site prior to administration,	F 658		

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and failure to keep the needle inserted into the skin for at least 6 seconds may result in the resident receiving an infection and an inaccurate amount of insulin.

Findings include:

Information provided by the complainants indicated nursing staff failed to consistently cleanse the injection site prior to administering insulin.

Review of the facility policy titled "Insulin Administration" occurred on 06/05/19. This policy, revised January 2018, stated, ". . . Remove the cap from the pen and wipe the rubber stopper with an alcohol wipe. . . . Cleanse skin with an alcohol wipe using circular motion form (sic) the center of the chosen injection site until an area about three inches in diameter has been prepared. . . . Keep the needle in the skin for up to 10 seconds. . . ."

Review of manufacturer's guidelines for NovoLog insulin stated, ". . . Pull off the tamper resistant cap. Wipe the rubber stopper with an alcohol swab. . . . Choose your injection site and wipe the skin with an alcohol swab. . . . Insert the needle into your skin. Push down on the plunger to inject your dose. Needle should remain in the skin for at least 6 seconds to make sure you have injected all the insulin. . . ."

- Observation on 06/05/19 at 8:40 a.m. showed a licensed nurse (#1) removed the cap from the insulin pen and placed a new needle without cleansing the rubber stopper with an alcohol swab. The nurse primed the insulin pen, dialed

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F 658	Continued From page 28 the correct dose, then administered the insulin to Resident #5 without cleansing the injection site prior to the injection. The nurse pushed down the plunger to administer the insulin, then removed the needle from the skin after 3 seconds. - Observation on 06/05/19 at 8:48 a.m. showed a licensed nurse (#1) removed the cap from the insulin pen and placed a new needle without cleansing the rubber stopper with an alcohol swab. The nurse primed the pen, dialed the correct dose, then administered the insulin to Resident #8 without cleansing the injection site prior to the injection. The nurse pushed down the plunger to administer the insulin, then removed the needle from the skin after 3 seconds.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON 08/16/18. Based on information received from the complainants, observation, record review, and staff interview, the facility failed to provide dining assistance for 2 of 16 sampled residents (Resident #1 and #14) and 3 supplemental resident (Resident #22, #23, and #24) observed during meals. Failure to reposition, cue, and/or assist dependent residents may result in decreased intake and/or unwanted weight loss.	F 677	Care plan and Kardex for Resident #1 was updated to include assistance with placing dentures and washing face with routine a.m. cares on 06/28/19. Care plan and Kardex where updated on 7/12/19 for resident #14 regarding ensuring resident is alert and positioned appropriately for meals. Care plan was updated for Resident #22 regarding assistance with meal intake on 06/28/19. Care plan was updated to reflect positioning needs at meals for Resident # 23 on 07/01/19. An OT referral for screening for wheelchair	7/12/19

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F 677	Continued From page 29 Findings include: Information provided by the complainants indicated nursing staff failed to provide cues/assistance for residents with vision and/or mobility deficits. Upon request, the facility failed to provide a copy of their policy addressing dining assistance. Staff indicated they "provide standard of practice based on resident's individualized needs." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease, muscle weakness, and age-related physical debility. The current care plan stated, ". . . self care deficit . . . requires assistance related to: disease process, physical limitation, Parkinson's . . . Assist with daily . . . grooming . . . oral care . . . and eating as needed . . . Upper and lower dentures. . . ." Observation on 06/05/19 at 8:35 a.m., showed Resident #1 sitting in bed holding a piece of toast with a breakfast tray in front of her. Resident #1's eyes had yellowish crusty matter around the eye lids. The resident stated, "my eyes are blurry." Resident #1 asked for assistance obtaining her dentures. Resident #1's dentures were located on the sink. During an interview on 06/05/19 at 8:40 a.m., a certified nursing assistant [CNA] (#4) stated the CNA's try to do morning cares before the residents eat, but will try again after breakfast if they refuse. The CNA (#4) acknowledged she set-up Resident #1's breakfast tray. The CNA (#4) failed to give Resident #1 her dentures prior	F 677	positioning and care plan updated to include proper positioning for meals for Resident #24 on 07/02/19. Residents who require assistance with positioning, placement of dentures, grooming, and/or meal intake have the potential to be impacted by this practice. Education was provided by the DON to licensed nurses and nursing assistants beginning on 06/17/19, regarding positioning, ADL assist, level of alertness for meal intake, and assistance with meal intake. The DON initiated audits of ADL completion, positioning, and assistance with meal intake on 06/24/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 677	Continued From page 30 to providing tray set-up. - Review of Resident #14's medical record occurred on all days of survey. The current care plan identified, ". . . self care deficit as evidenced by requires assistance related to: disease process dementia, physical limitations. . . Assist with . . . eating as needed . . . Nutritional status as evidenced by mechanically altered diet and varying intakes that are overall poor. I need more assistance at meals . . . Encourage as needed to consume foods and/or supplements and fluids offered . . . . . ." Observation on 06/04/19 at 12:25 p.m. showed a CNA (#9) giving Resident #14 sips of cocoa from a cup. Resident #14's alertness level varied throughout the meal and she sat leaning heavily to her right side (with her head directly over the arm rest of her chair). The CNA (#9) failed to ensure Resident #14 was alert enough to safely eat/drink and failed to reposition her. - Review of Resident #22's medical record occurred on all days of survey. The current care plan identified, ". . . self care deficit as evidenced by: need for increased assistance with . . . tasks related to: disease process, Parkinson's disease with physical limitations . . . Assist with . . . eating as needed . . . At risk for nutritional status wt. [weight] change r/t [related to] variable oral intake . . . Encourage and assist as needed to consume foods and/or supplements and fluids offered . . . . . ." Observations showed the following: * 06/04/19 at 12:25 p.m., Resident #22 sat at an assisted table and stared straight ahead. She	F 677		

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made no effort to eat. Staff failed to cue and/or assist Resident #22 throughout the meal. Total intake consisted of a cup of cocoa.
* 06/05/19 at 12:12 p.m., Resident #22 sat at an assisted table and stared straight ahead. She made no effort to eat. An office staff member (#14) sat down to assist Resident #22 with her meal approximately fifteen minutes into the meal.

- Review of Resident #23's medical record occurred on all days of survey. The current care plan identified, ". . . self care deficit as evidenced by requires assistance related to: disease process, physical limitations . . . Assist with . . . eating as needed . . . Resident need to be positioned at 90 degree angle during . . . oral intake . . . Nutritional status increase need related to open areas Hospice care . . . Encourage and assist as needed to consume foods and/or supplements and fluids offered . . . . ."

Observation on 06/04/19 at 12:25 p.m. showed Resident #23 sat at an assisted table and leaned heavily to his right side (with his head directly over the arm rest of her chair) with his left hand wrapped with gauze. Resident #23 dropped food onto his clothing protector/pants while attempting to feed himself. The CNAs sitting at the table failed to reposition and/or assist the resident. An unidentified staff member repositioned Resident #23 and sat down to assist him approximately eleven minutes into the meal.

- Review of Resident #24's medical record occurred on all days of survey. The current care plan identified, ". . . self care deficit as evidenced by: need for staff performance of cares related to:

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F 677	Continued From page 32 disease process advanced dementia . . . Reposition at routine intervals before . . . meals . . . Requires total assist with . . . eating . . . Nutritional status as evidence by weight gain related to improved eating and inactivity. He . . . has a need for assistance or cueing at meals . . . Assist as needed to consume foods and/or supplements and fluids offered . . . . . ." Observation on 06/04/19 at 12:25 p.m. showed an unidentified CNA feeding Resident #24. Staff had raised the back of Resident #24's chair to an approximate 60 degree angle. The CNA (#9) failed to reposition the resident and left him in a reclined position throughout the meal. Staff failed to ensure alertness, reposition, cue, and/or assist dependent residents who were at risk for aspiration, decreased intake, and/or unwanted weight loss. Refer to F692.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON 08/16/18.	F 684	A skin assessment was completed on 06/14/19 for Resident #15 and skin was	7/10/19

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F 684	Continued From page 33 AREAS OF SKIN BREAKDOWN 1. Based on information received from the complainants, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to prevent the development and promote healing of skin breakdown for 2 of 4 sampled residents (Resident #13 and #15) and 1 discharged resident (Resident #18) at risk of developing or with known abrasions, skin tears, and burns. Failure to reassess and/or consistently utilize interventions contributed to Resident #13, #15, and #18 developing new wounds and/or healing of their various areas of skin breakdown. Findings include: Information provided by the complainants indicated nursing staff failed to consistently utilize physician ordered interventions to prevent and/or heal areas of skin breakdown. Review of the facility policy titled "Skin Management System" occurred on 06/10/19. This undated policy stated, ". . . Pressure Ulcers, Venous Ulcers, and Arterial Ulcers, and surgical sites will be documented on . . . form or EMR [electronic medical record]. Use one form per wound. Wound progress is to be documented each week with measurement and wound descriptions. Daily treatments are also documented on the same form. . . . Skin issues such as skin tears, bruises, rashes, abrasions, burns etc. will be documented . . ." - Review of Resident #13's medical record	F 684	found to be intact. Wound that was noted to be healed on 04/18/19 remains healed. Residents #13, #17, and #18 no longer reside at the facility. A skin assessments where completed by nursing leadership on 06/14/19 and 06/17/19 to identify any existing skin alterations and if indicated care plans updated, treatment orders obtained, and weekly skin assessments scheduled for residents.The weekly skin assessment dates were adjusted to allow closer monitoring by nurse managers. Completion of skin assessments is validated by nurse managers on a routine basis. This will be an ongoing process. The DON provided education to licensed nurses and nursing assistants beginning 06/17/19 on skin management program. Education included identification, documentation, and notification of skin alterations. Weekly wound rounds were implemented and are completed each Thursday. The DON initiated audits of skin management program compliance on 07/01/19. Areas audited include compliance with implementation of orders, documentation, and notification of progression of wound healing. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits	

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F 684	Continued From page 34 occurred on all days of survey. The current physicians order stated the following: * Started 05/21/19, ". . . Clean area to right clavicle with NS [normal saline], apply triple antibiotic cream and cover with mepilex every day shift . . ." * Started 05/25/19, ". . . Clean large skin tear to RFA [right forearm] with NS and applied antibiotic ointment and xeroform gauze, cover with boarder foam gauze. Clean small skin tear to RFA with NS and apply paper tape. Change Q [every] 3 days until healed . . . " A progress note, dated 05/23/19 at 3:30 p.m., stated ". . . CNA [certified nursing assistant] alerted nurse to a large skin tear to rt [right] inner elbow area . . . 7cm [centimeters] x 2cm wide skin tear unable to approximate, is open area bright red wound bed, no active bleeding noted, edges of wound dried looking. Also has a small 1 cm x 1cm skin tear on rt forearm . . ." Review of Resident #13's progress notes and skin/wound assessments identified the facility failed to document weekly on the progress of the skin including measurements and descriptions. Nurses' notes and wound assessments stated the following: * 05/18/19 - Abrasion measuring 1.0 cm x 1.5 cm on right clavicle area * 05/20/19 at 10:00 p.m. - Abrasion on right clavicle is small and superficial * 05/25/19 - Abrasion measuring 1.0 cm x 1.5 cm on right clavicle area Review of progress notes and skin/wound assessments identifies the facility failed to	F 684	will be adjusted if indicated.	

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document weekly on the progress of the skin including measurements and descriptions.

- Review of Resident #15's medical record occurred on all days of survey. The current physicians order stated, ". . . Skin evaluations weekly . . ."

Nurses' notes and wound assessments stated the following:
* 01/18/19 at 10:34 a.m. - ". . . Skin is intact. Potential for skin breakdown due to limited mobility . . ."
* 01/23/19 - Has 2 skin tears on her left leg, well approximated cleaned with NS, applied triple antibiotic and covered with appropriate dressing. Resident did not know what had happened
* 01/24/19 - Skin tears noted to the left lower leg, cover with tape, redness around the area
* 02/07/19 - Skin intact
* 02/14/19 - Skin intact
* 02/20/19 at 7:37 a.m. - ". . . notification of skin tear to left lateral calf of resident. Family is concerned that resident may have attempted independent transfer to the toilet as this is what has been observed in the past. Informed that resident will be monitored for safety and care staff will provide ADL assist."
* 02/21/19 - Skin tear on left lower leg measuring 10 cm x 2 cm x 0.1 cm with bordered gauze and non-adherent dressing applied. Change daily after cleaning with NS and PRN [as needed].
* 02/28/19 - Skin tear covered
* 03/08/19 10:38 a.m. - "Area to lower left extremity still not healed . . ."
* 03/13/19 at 10:34 a.m. - "Writer noted a new skin tear to left lower leg, above present one, measuring 1cm x 1.2cm. Writer asked resident

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what happened, she stated "well I don't know". Area was cleaned with normal saline, sterile boarder gauze dressing applied . . ."
* 03/28/29 - Skin tear
* 04/11/19 - Healing to pre-existing skin tear to left lower leg
* 04/18/19 - Skin intact
* 04/18/19 7:44 p.m. - ". . . left lower leg . . . Area is now healed . . ."

Review of progress notes and skin/wound assessments identifies the facility failed to document weekly on the progress of the skin including measurements, description, and identify the date the skin areas had healed.

- Review of Resident #18's medical record occurred on all days of survey, and identified diagnoses of carcinoma of skin and open wound to right lower leg.

RIGHT LOWER LEG

The Admission Evaluation, dated 07/07/18, identified, ". . . 6.5 x 6 cm radiation sore to the front of the right lower leg and 2 x 1 cm radiation sore to the front/2.2 x 2 cm radiation sore to the back of the left lower leg . . ."

Resident #18's care plan identified, ". . . Date Initiated: 07/07/18 . . . Scabbed areas at (bilateral lower extremeties) r/t [related to] recent radiation treatment . . . Encourage and assist as needed to turn and reposition, use assistive devices as needed, Follow up care with MD [medical doctor] as ordered, Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify MD PRN, Use pillows

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F 684	Continued From page 37 and/or positioning devices as needed . . ." The orders identified the following: * Start Date 07/14/18, ". . . Skin evaluation weekly on Saturday Days - complete weekly skin review under assessments one time a day every Sat [Saturday] . . ." The facility failed to perform this task on a weekly basis. * Start Date 07/27/18, ". . . Keep area to right lower extremity clean and dry. May use soap/water, enxymatic [sic] cleanser, or saline washes as needed. May use non-stick dressing/telfa if area oozes or bleeds temporarily. DO NOT routinely apply lotion or cream. as needed" Resident #18's progress notes identified the following: * 07/30/18 at 12:56 p.m., "Resident continues with dry area of carcinoma on her right shin . . ." * 08/28/18 at 4:39 p.m., "New order received to swab and culture wound to RLE [right lower extremity] to R/O [rule out] MRSA [antibiotic resistant organism] and Wound care Nurse to follow for possible debridement. . . ." The facility failed to reassess the wound since it was first identified on 07/07/18. * 08/30/18 at 5:00 p.m., ". . . call to [Physician] . . . due to preliminary report on wound culture and extensive bacteria present . . . resident's decreased tolerance with physical therapy over the past few days, and malodorous smell from wound bed . . . requests to send patient to ED [emergency department] for further workup due to concerns of systemic infection" . . . and at 7:38 p.m., ". . . returned back into facility . . . Received new orders saline wet to dry dressing daily . . . continue the Batruim [sic] DS . . . should	F 684		

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be effective in treating her infection to her open wound to lower right extremities . . ."
* 09/01/18 at 4:27 p.m., "Dressing to Right lower extremity changed using wet to dry with NS. Wound bed is tan with slough. A nickle [sic] sized scab came of [sic] with dressing, no bleeding present. . . ."
* 09/03/18 at 9:59 a.m., ". . . Dressing to Right lower leg . . . no drainage noted. . . ."

The only weekly skin review provided by the facility, dated 09/03/18, identified, ". . . left lower buttock . . . site with dressing. Right mid-lower leg wound with wet to dry dressing changed daily. . . ."

Resident #18's progress notes also identified:
* 09/05/18 at 10:31 a.m., "Wound to Right lower leg has wet to dry dressing. Wound looks to be healing and getting smaller in size, no drainage noted. . . ."
* 09/08/18 at 6:48 p.m., ". . . dressing to rt leg . . . no active drainage noted, no signs of infection noted. . . ."
* 09/09/18 at 12:42 p.m., ". . . dressing changed, wet to dry applied . . ."
* 09/14/18 at 10:58 a.m., "Wound to Right to lower anterior leg appears to be healing, it is getting smaller in size" . . . and at 3:59 p.m., "Dressing to Right lower leg changed . . . Wound is 7 x [times] 6 cm in diameter. . . . NO drainage noted. . . ." The facility failed to measure the wound since it was first identified on 07/07/18.
* 09/19/18 at 6:27 p.m., ". . . Dressing to Right lower leg changed using Aquacel and Kerlex. . . ."

The orders identified, Start Date 09/26/18, ". . .

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Cleanse RLE with NS, pat dry, apply Aquacel AG, wrap with kerlix, change daily, one time a day for Wound care . . ." The facility failed to perform this task on a daily basis.

Progress notes also identified:
* 10/03/18 at 7:09 p.m., "This nurse informed [Physician's] clinic that right lower leg does not improve with the current dressing management . . . stated we can do the Dakins Half Strength 0.25% topical solution, apply to right lower leg open wound BID [twice daily] wet to dry dressing x 1 week. . . ."
* 10/08/18 at 7:17 p.m., "Received orders . . . discontinue dakins, apply Santyl to right lower leg wound Q [every] 12 hrs [hours] until appointment with vascular surgeon . . . cover with gauze and Kerlix . . ."

The orders identified the following:
* Start Date 10/09/18, ". . . Apply santyl to right lower leg every 12 hours two times a day related to unspecified open wound, right lower leg . . . until 10/23/18 . . . Cover with gauze and kerlix . . . Follow up with vascular surgeon . . ." The facility failed to perform this task on a daily basis.

The Medication Administration Record identified the following:
* Start Date 10/08/18, ". . . Levaquin 500 mg [milligrams] PO [by mouth] every 24 hrs [hours] for 10 days. . ." The chart showed staff administered six doses of the antibiotic. (The tenth dose was due the day after she was discharged from the facility.)

The progress note, dated 10/09/18 at 10:30 p.m., identified, "Resident started first dose of

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Levaquin tonight. . . . Wound to right lower leg has yellow slough present in wound bed. Wound has purulent yellow drainage that is soaked onto the kerlix covering her legs. Wound has an odor to it. Dressing changed . . ." The physician placed Resident #18 on an antibiotic six days after staff first noted her leg was not improving under the current treatment program.

The care plan identified, ". . . Date Initiated: 10/10/18 . . . Infection of wound/skin . . . Administer meds as ordered, Record temperature as clinically indicated . . ."

The progress notes also identified the following:
* 10/12/18 at 10:00 p.m., ". . . taking Levaquin . . . Wound has a fishy smell to it. Wound has yellow sloth throughout it with purulent yellow drainage. Resident states it is painful when doing dressing changes. . . . Wound . . . dressed in santyl cream, guaze and kerlix . . . Will continue to monitor."
* 10/14/18 at 12:25 p.m., ". . . on Levaquin . . . Some yellow drainage noted. Drsg [dressing] changed . . ."
* 10/15/18 at 1:00 a.m., ". . . continues taking Levaquin . . . Dressing changed . . . Scant amount of yellow slough in middle of wound bed. Also had scant amount of yellow drainage noted on old dressing. . . ." The facility failed to measure the wound since it was first identified on 09/14/18.
* 10/16/18 at 9:10 p.m., ". . . transport to . . . [another facility out of state] . . ."

LEFT LOWER BUTTOCKS

Resident #18's care plan identified, ". . . Date Initiated: 07/07/18 . . . Administer treatment per

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F 684	Continued From page 41 MD orders, Encourage and assist as needed to turn and reposition, use assistive devices as needed, Follow up care with MD as ordered, Report evidence of infection such as purulent drainage, swelling. Localized heat, increased pain, etc. Notify MD PRN, Toileting program as indicated. . . ." The progress notes identified the following: * 08/02/18 at 3:38 p.m., "Resident has a firm area to the left lower buttock, it is not raised, it has no discoloration, resident states it is very painful when palpated, [Physician] called . . ." * 08/03/18 at 7:36 p.m., "Assessed area to left buttock. . . . Area not raised but more of a moveable nodule. Patient unable to differentiate pain from this side versus the other side at this time. This area is the same in color as the other side on examination. . . . We will continue to monitor and contact the MD if necessary. Patient does have an appointment scheduled on Tuesday . . ." * 08/06/18 at 2:39 p.m., ". . . continues with hardened area to her left buttock, she states it hurts only when palpated, it is with no change in color, resident has appointment tomorrow . . ." * 08/07/18 at 5:49 p.m., ". . . [Physician] findings were: Left buttocks mass, no cellulitis. New order was to get ultrasound. . . ." * 08/14/18 at 4:37 p.m., ". . . ultrasound done on Monday. . . . states that she [has] discomfort when she is seated. Left buttock has no discoloration/no redness, no swelling but has a palpable and movable mass, no warmth noted." * 08/27/18 at 4:00 p.m., "Patient had an Incision and Drainage done at [Hospital] by [Physician], with the following orders: Bactrim DS 800 mg-160 mg oral tab 1 tab PO BID x 7 days,	F 684		

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F 684	Continued From page 42 Norco 5 mg-325 mg [milligram] po tab 1 tab PO [by mouth] Q [every] 4 hr [hour] PRN for pain, Also, to change left buttock dressing daily, pack with ¼ iodoform, cover with gauze and tape. . . ." * 09/01/18 at 4:27 p.m., ". . . Incision to Left lower buttock packed with approximately 3 CM of Iodaform gauze, wet with NS and dry gauze. . . ." * 09/05/18 at 10:31 a.m., ". . . Incision to Left lower buttock packed with about 2 cm Iodaform and wet to dry using NS. NO drainage noted. . . ." * 10/03/18 at 7:09 p.m., "This nurse . . . asked for an order to D/C [discontinue] the current dressing on resident's left buttock area. . . . stated we can do the Dakins Half Strength 0.25% topical solution, apply to right lower leg open wound BID wet to dry dressing x 1 week. . . ." The chart lacked assessment of the wound since it was first identified on 09/05/18. * 10/16/18 at 9:10 p.m., ". . . transport to . . . [another facility out of state] . . ." During an interview on 06/06/19 at 8:00 a.m., when asked questions pertaining to the facility's care expectations, the managerial nurse (#5) stated, "What [staff] were supposed to do was complete a weekly wound tracker. The weekly skin assessment would catch any other type of skin issue, non-pressure sore. . . . so we know it's there." The facility failed to: * Accurately identify/document observations of Resident #18's radiation sore on her leg and mass on her buttocks, * Administer medications as per physician's order, * Treat Resident #18's infected leg sore and buttock mass in a timely manner,	F 684		

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F 684	Continued From page 43 * Treat Resident #18's infected leg sore and buttock mass as per physician's order, and * Measure Resident #18's the radiation sore and mass in a timely manner/weekly per facility policy. BLOOD SUGAR PARAMETERS 2. Based on information received from the complainants, record review, and review of professional reference, the facility failed to establish individualized blood glucose parameters for 1 of 1 resident discharged from the facility (Resident #17) who experienced repeated hypoglycemic (low blood sugar) episodes. Failure to establish high/low blood glucose parameters has the potential to place all diabetic residents at risk for serious adverse events. Findings include: Information provided by the complainants indicated nursing staff failed to provide care/services to a resident who experienced a hypoglycemic episode and failed to communicate information regarding the resident's condition to other staff members. Review of the "American Diabetes Association" website occurred on 06/10/19. The article entitled, "Glycemic targets: Standards of Medical Care in Diabetes - 2019" stated, ". . . Glucose monitoring allows patients to evaluate their individual response to therapy and assess whether glycemic targets are being safely achieved. Integrating results into diabetes management can be a useful tool for . . .	F 684		

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preventing hypoglycemia, and adjusting medications . . . Level 1 hypoglycemia is defined as a measurable glucose concentration < 70 mg/dL[milligrams per deciliter] . . . a measured glucose level < 70 mg/dL . . . is considered clinically important . . . Level 2 hypoglycemia (defined as a blood glucose concentration < 54 mg/dL) . . . is the threshold at which neuroglycopenic symptoms begin to occur and requires immediate action to resolve the hypoglycemic event. Lastly, level 3 hypoglycemia is defined as a severe event characterized by altered mental and/or physical functioning that requires assistance from another person for recovery. . . . Symptoms of hypoglycemia include . . . shakiness, irritability, confusion, tachycardia, and hunger. . . . Level 3 hypoglycemia . . . can progress to loss of consciousness, seizures, coma, or death. . . ."

- Review of Resident #17's medical record occurred on all days of survey and identified diagnoses of Alzheimer's dementia and diabetes.

The physician's orders identified Resident #17 received the following:
* Novolog injections three times daily per sliding scale with meals
* 100 mg Januvia daily
* 100 unit/ml Levemir twice daily, and
* 1000 mg Metformin twice daily.

The care plan identified, "Endocrine system r/t [related to] insulin dependent diabetes . . . Obtain glucometer readings and report abnormalities as ordered . . . Report symptoms of hypoglycemia: weakness, pallor, diaphoresis, vision changes, change in consciousness. . . ."

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F 684	Continued From page 45 The progress notes identified the following: * 03/31/19 at 11:50 a.m., "Will update family and MD [physician]: Resident was hypoglycemic with a blood sugar of 52 mg/dl [Level 2 hypoglycemia]. She was non verbal, clammy and lethargic. Glucagon administered by this nurse, ambulance called. When ambulance crew arrived, resident sugar level was up to 60 mg/dl [Level 1 hypoglycemia]. Her vitals was [sic] stable, she verbally refused going to the hospital . . ." It's unclear who ordered the Glucagon. The chart lacked evidence staff informed Resident #17's primary physician of her hypoglycemic episode. * 05/02/19 at 5:45 p.m., "Resident is pale [and] diaphoretic. Blood glucose is 52 mg/dl [Level 2 hypoglycemia]. . . . No emisis or c/o [complained of] nausea. . . . [Physician] on call . . . paged [and] gave new order to administer Glucagon 1 mg intramuscularly now [and] recheck blood glucose in 15 minutes. Order observed." The chart lacked evidence staff informed Resident #17's primary physician of her hypoglycemic episode. * 05/03/19 at 1:14 a.m., "Resident was found pale, diaphoretic and unresponsive [symptoms of Level 3 hypoglycemia]. Unresponsive to sternum rub. BS [blood sugar] was 35 [Level 2 hypoglycemia]. Glucagon 1 mg given. 15 mins later, resident continued to be unresponsive and pale. Her BS was 44. Another Glucagon 1 mg injected. 15 mins later her BS was 85. Nurse gave another sternum rub and resident pushed away hands. . . . [Physician] whom is taking call . . . gave order to administer the Glucagon 1 mg x [times] 2. Primary MD will be notified via fax." The chart lacked evidence staff informed Resident	F 684		

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F 684	Continued From page 46 #17's primary physician of her hypoglycemic episode. * 05/03/19 at 2:34 p.m., "Resident had a blood sugar of 32 mg/dl [Level 2 hypoglycemia with symptoms of Level 3 hypoglycemia] this morning. Called the on-call Doctor . . . Emergency glucagon was administered on Right deltoid. Check glucose level 15 min [minutes] later and went up to 78 mg/dl. He gave an order to put and [sic] IV [intravenously] and give fluids . . . This nurse tried to insert . . . IV twice but was not able to get it. Called ambulance and they came an [sic] inserted a 22 gauge [IV] on her right arm. Immediately started fluids. Resident became alert and responsive. . . . Called [Primary Physician] and informed him of residents current status. . . ." * 05/05/19 at 5:00 p.m., "Resident was found unresponsive [symptom of Level 3 hypoglycemia] to sternum rub. BS was 67 mg/dL . . . Glucagon 1 mg given. Blood sugar rechecked 15 mins later was 106. Resident was responsive . . . Informed [Physician] on call . . . and he ordered to decrease dosage of Levemir . . . The Primary MD will be notified . . . " It's unclear who ordered the Glucagon. The chart lacked evidence staff informed Resident #17's primary physician of her hypoglycemic episode. During an interview on 06/05/19 at 3:00 p.m., a managerial nurse (#5) confirmed the facility failed to consistently notify Resident #17's primary physician of her hypoglycemic episodes and failed to obtain blood glucose parameters from her physician identifying when he should be notified of her condition. Failure to establish individualized parameters to treat low blood glucose levels for unresponsive	F 684		

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F 684	Continued From page 47 residents has the potential to place residents at risk of developing a life-threatening hypoglycemic reaction.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on information received from the complainants, observation, record review, and staff interview, the facility failed to provide the necessary care and services to prevent the development and promote healing of pressure ulcers for 2 of 2 sampled residents (Resident #3 and #14) and 1 discharged resident (Resident #17) at risk of developing and/or with known ulcers. Failure to implement, monitor, and modify interventions to reduce risk factors and consistently provide treatment to prevent the development of new pressure ulcers and/or heal current pressure ulcers resulted in Resident #14 and #17 developing avoidable facility-acquired pressure ulcers and had the potential to result in other residents (Resident #3) developing skin	F 686	Resident #3 air mattress was replaced on 06/12/19. Resident #14 had a skin assessment completed on 06/14/19. Skin sheets and care plan were updated for Resident #14. Resident #17 no longer resides at the facility. Residents who require the use of air mattresses and those that have skin alterations have the potential to be impacted by this practice. Air mattresses were inspected and replaced if indicated. Residents who had skin alterations identified during skin assessments that were completed on 06/14/19 & 06/17/19 had care plans updated, treatment orders obtained, and weekly skin assessments	7/10/19

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F 686	Continued From page 48 breakdown. Findings include: Information provided by the complainants indicated nursing staff failed to consistently utilize physician ordered interventions in a timely manner to prevent and/or heal ulcers. Review of the facility policy titled "Skin Management System" occurred on 06/10/19. This undated policy stated, ". . . Pressure Ulcers, Venous Ulcers, and Arterial Ulcers, and surgical sites will be documented on . . . form or EMR [electronic medical record]. Use one form per wound. Wound progress is to be documented each week with measurement and wound descriptions. Daily treatments are also documented on the same form. . . . Skin issues such as skin tears, bruises, rashes, abrasions, burns etc. will be documented . . ." - Review of Resident #14's medical record occurred on all days of survey. The Significant Change Minimum Data Set (MDS), dated 05/31/19, identified extensive assistance from two or more people for bed mobility, one Stage II pressure ulcer, and one venous and arterial ulcer. Right Lower Leg Resident #14's current physician order stated, ". . .Wound to right lower extremity: Apply santyl ointment to dark eschar tissue. Apply hydrogel gauze over santyl [not on good tissue]. Cover with non-adherent dressing. Wrap with gauze and with tape. Apply protective ointment to	F 686	scheduled. The DON provided education to licensed nurses and nursing assistants beginning on 06/17/19. Education included validating air mattresses are turned on and weekly skin assessments are completed and documented. Education also included completing treatments as assigned and documenting the completion of treatments and updating MD and family on progression or lack of progression of wound healing. The DON initiated audits on 07/01/19 of skin management compliance. Areas audited include compliance with implementation of orders, documentation of skin alterations and of completion of treatments, and notification of progression or lack of progression of wound healing. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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peri-wound area. Change daily. Wound nurse to follow [started 05/17/19] . . ."

Resident #14's progress notes showed the following:
* 03/06/19 at 7:44 a.m. - "Resident has a wound on lower right calf. cleansed with NS. Patted dry. TAO [triple antibiotic ointment] applied and covered . . . MD [physician] notified."
* 03/06/19 at 12:43 p.m. - "New orders for wound to lower right leg. Apply steri strips to wound, apply gauze and kerlex. Change gauze and kerlex BID [twice per day]."
* 03/08/19 skin assessments shows open area to right lower leg (RLL) 11 centimeters (cm) x 4 cm

No further documentation regarding right lower leg until 05/04/19

*05/04/19 at 11:41 a.m. - "Writer was dressing RLL and noted open areas that were weeping and swelling from ankle to mid-leg. Area is red, no warmth noted. MD notified via phone, ordered mepilex over open areas, change MWF [Monday, Wednesday, Friday]. Ace wraps to be put on from foot to mid leg and taken off at HS [night] . . ."
* 05/06/19 at 10:05 a.m. - "Resident RLL [right lower extremity] continues to be weeping and writer noted bleeding. CNA [certified nursing assistant] reported foul odor when removing dressing for shower. Area is red, warm and tender to touch, no swelling noted . . . MD has been updated via fax."
* 05/07/19 at 6:13 p.m. - ". . . Dressing change to right lower lateral leg. Area is red, cool to touch et draining clear fluid . . ."
* 05/08/19 at 3:32 a.m. - "Resident has a treatment to RLE [right lower extremity] for

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swelling and weeping . . . some redness present which may be related to dressing changes and ACE wrap. at [sic] this time RLE is not wrapped with bandage. Will continue to monitor and notify md of any changes or worsening."
* 05/09/19 at 5:47 a.m. - ". . . discoloration to area scattered. some redness and purplish skin present which may be related to dressing changes and ACE wrap. at [sic] this time RLE is not wrapped with bandage . . . Will continue to monitor and notify md of any changes or worsening."

Review of record showed the doctor responded to fax on 05/09/19. The physician stated he/she would see the resident tomorrow (4 days after symptoms reported).

* 05/10/19 at 12:37 p.m. - ". . . Ulcer on right leg is red, with darken area small amount of clear fluids was seen draining at left lateral aspect of wound . . ."
* 05/10/19 at 7:21 p.m. - ". . . rt lower leg wound-dakens wet to dry BID until healed . . . wound nurse to follow, doxycycline 100mg [milligrams] po [oral intakes] BID X 7 days."
* 05/11/19 at 2:29 p.m. - "Resident's ulcer on right leg is blackish in color . . . minimal serosanguineous drainage . . ."
* 05/12/19 at 11:07 a.m. - ". . . Eschar/scabbing is resolving. Yellow purulent drainage . . ."
* 05/13/19 at 9:50 p.m. - ". . . area has some debrided areas and some dark colored tissue . . ."
* 05/15/19 at 10:49 p.m. - "Continues on an antibiotic for RLE wound. wound [sic] area is around lower ankle, dark tissue, with some small areas of debridement . . ."

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F 686	Continued From page 51 * 05/16/19 at 2:43 p.m. - "Order received from [doctor name] . . . apply santyl to dark eschar tissue, apply hydrogel gauze over eschar, cover with non-adherent telfa dressing, wrap with gauze and secure with tape . . . Wound nurse to follow." * 05/19/19 at 1:01 p.m. - ". . . Wound on her right lower extremity drains has a serosanguinuous drainage, black skin tissue softens and easily removed. . . ." * 05/20/19 at 2:47 p.m. - ". . . [doctor name] recommended resident be seen in the emergency department due to possible sepsis . . ." * 05/20/19 at 6:17 p.m. - "Resident admitted to . . . Trinity Health hospital . . ." * 05/24/19 at 11:28 a.m. - "Resident returned to facility . . . New orders for levaquin 250mg PO every other day x3 days . . . Right lower leg has minimal eschar and slough present, wound bed is pink . . ." Review of Resident #14's Admission/Readmission Evaluation on 05/24/19 identified a Stage III vascular ulcer to right lower leg (front). The record showed no further documentation after 05/24/19 regarding the progress of the wound. Review of progress notes and skin/wound assessments identified the facility failed to document weekly measurements. Coccyx Resident #14's current physician order stated, ". . . Mepilex to open areas on bottom. Change every MWF until healed [started 05/01/19] . . ."	F 686		

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Resident #14's progress notes showed the following:
* 04/27/19 at 1:50 p.m. - "Writer noted three open areas to resident's bottom. the [sic] first one measures 0.8cm x 1cm on the left buttock and the second one measures 0.5cm x 0.8cm on the left buttock, and the third one measures 0.4 cm x 0.5cm on the right buttock. Foam dressings applied. Writer also noted redness around anal area, calmo applied. Will update MD at this time and continue to monitor."
* 04/29/19 at 9:31 a.m. - "MD would like areas on bottom to be treated with mepilex, change every MWF . . ."

Physician's order to start Mepilex on 04/29/19 to the open area on bottom. Review of May 2019 Treatment Administration Record (TAR) showed Resident #14's treatment failed to be started until 05/01/19.

Review of progress notes and skin/wound assessments showed the facility failed to document weekly on the progress of the wounds including measurements and descriptions.

Right Toe

The current physician order stated, ". . . Paint wound on RT 1st MTPJ [metatarsophalangeal joint] wound, with Betadine and cover with a Mepilex type bandage change daily [started 02/28/19] . . ."

Resident #14's progress notes showed the following:
* 02/19/19 9:17 p.m. - "[Doctor name] here to

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round on resident, order rec'd [received] to continue hydrocolloid dressing to rt MTP joint ulcer until healed. Change every 3 days and prn. Appt with podiatry for evaluation. . . ."
* 02/27/19 7:33 p.m. - "Resident went out to a podiatry appt. [appointment] today, recommends paint wound with betadine and cover with mepilex type dressing daily. No soaking."
* 05/11/19 6:39 p.m. - ". . .Ulcer on right phalangeal region . . ."
* 05/28/19 3:01 p.m. - "Has vascular wound on her toe."

Review of progress notes and skin/wound assessments identified the facility failed to document weekly on the progress of the wound including measurements and descriptions.

- Review of Resident #17's medical record occurred on all days of survey and identified diagnoses of Alzheimer's dementia, diabetes, and toe wounds.

Right Second Toe

The progress notes identified the following:
* 12/06/18 at 7:00 a.m. and 12/07/18 at 10:13 a.m., "Will update MD Resident rt [right] great toe [nail] came off during showers . . . her second rt toe has a 2 cm [centimeter] wt [width] by 1.2 cm Lt [left] pressure area. Skin is intact and without drainage. Site is red, resident denies sensation or pain . . ."
* 12/11/18 at 3:26 p.m., "This nurse paged [physician] regarding resident sore toe. He ordered Keflex 500 mg [milligram] PO [by mouth] TID [three times per day] for 10 days. First dose given by this nurse." The facility notified Resident

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F 686	Continued From page 54 #17's physician five days after discovering the pressure area on her right second toe." The facility failed to notify Resident #17's physician in a timely manner, paging him five days after they discovered the ulcer on her toe. * 12/12/18 at 10:39 a.m., ". . . Pharmacy called and reported a different dosage, Author contacted [Physician], and confirmed dosage with [Physician] and pharmacy" . . . and at 8:48 p.m., "Resident continues with Keflex abt [antibiotic] 250 mg po Tid x 10 days for infection prophylaxis to right great toe nail bed where toenail came off . . . Right great toe nail bed is dark pink [and] without any drainage. Right 2nd toe distal joint has a 2 cm (W) [width] x 1/2 cm (L) [length] red area that blanches. Resident denies any pain to the toes . . ." * 12/13/18 at 3:58 a.m., "Resident great toe and distal middle toe assessed. No drainage, swelling or signs of infection observed. Resident denied pain. . . ." * 12/14/18 at 9:33 p.m., "Resident continues with alert charting for infection to right second toe distal joint. Right 2nd toe is red with a small yellow hardened area to anterior aspect. No drainage. Site blanches. Resident denies having any pain. Right great toe nail bed . . . has no redness or drainage. . . ." * 12/17/18 at 9:18 p.m., ". . . continues on Keflex . . . 2nd toe right foot distal joint has a red area with a firm yellow center that has a scab forming. No drainage. Area left OTA [open to air]. Resident denies any pain or discomfort to the right foot [and] toes. . . ." * 12/18/18 at 9:07 p.m., ". . . remains on Keflex . . . Right 2nd toe distal joint is slightly red [and] blanches with palpation. Center of red area has a small circular hard white area with scab forming.	F 686		

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No drainage [and] OTA. Resident denies any pain or discomfort to her toes. . . ."
* 12/19/18 at 9:00 p.m., ". . . continues with Keflex . . . Right second toe distal joint has a slightly red area with small circular yellow center with scab formed. No drainage. . . ."

The care plan identified, ". . . Date Initiated: 12/17/2018 . . . Infection of wound/skin (Right great toe) . . . Administer meds as ordered, Diagnostic tests as ordered, Maintain precautions as indicated, Obtain labs as ordered and notify MD of results, Record temperature as clinically indicated. . . . Date Initiated: 12/19/2018 . . . Scab at right 2nd toe r/t [related to] friction, impaired mobility, diabetes . . . Administer treatment per MD orders, Diet and supplements per MD orders, Encourage and assist as needed to turn and reposition, use assistive devices as needed, Float heels as able, Follow up care with MD as ordered, Report evidence of infection such as purulent drainage, swelling. Localized heat, increased pain, etc. Notify MD PRN [as needed]. . . ."

Progress notes also identified the following:
* 12/20/18 at 8:00 p.m., ". . . continues with Keflex . . . Right 2nd toe is slightly red with small white center forming a scab. No drainage. no c/o pain to toe. . . ."
* 12/21/18 at 4:16 p.m., "Wound nurse assessed the open area to resident's right foot 2nd toe. The wound measures 1.1 cm x 0.9 cm. The wound bed contains 100% hard slough. No drainage. No odor. No c/o pain. The wound nurse recommends that the area be cleansed with normal saline. Apply Antisept, and wrap in gauze. Change daily. . . ." The facility failed to measure

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the wound for nine days.
* 12/22/18 at 1:06 p.m., ". . . continues with Keflex . . . Right 2nd toe is slightly red with small white center forming a scab. No drainage. . . ."
* 12/25/18 at 8:00 p.m., ". . . completed . . . Keflex . . . right 2nd toe distal joint has a small scab dry [and] intact [and] base of toe is slightly red [and] warm to touch. This note faxed to Dr. . . ."
* 12/26/18 at 10:05 p.m., ". . . Right 2nd toe distal joint has a small brown scab dry [and] intact. Base of right 2nd toe is slightly red [and] warm to touch. . . . denies any pain or discomfort." The chart lacked evidence that the ulcer resolved, as staff failed to document further observations of the toe.

The quarterly MDS, dated 01/08/19, identified the resident was at risk of developing pressure ulcers and had moisture associated skin damage.

The physician's orders identified, Start Date 03/07/19 ". . . Skin evaluation every Thursday AM, every day shift every Thu [Thursday] . . ."

The next set of progress notes addressing Resident #17's toe identified the following:
* 03/10/19 at 9:49 p.m., "Resident's daughter approached this recorder and stated, "my Mom's toe is infected" . . . On exam 2nd toe on rt foot is light red, no swelling noted, has a dry callous type lesion of DP [sic] joint area, no drainage noted, residents [sic] states it does not hurt . . . Callous is dry measures 0.9 cm x 1 cm. . . ." The facility failed to identify the observable changes to Resident #17's toe prior to family voicing their observations/concerns.
* 03/11/19 at 2:54 p.m., ". . . Resident has Dx

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[diagnosis] of cellulitis to right 2nd toe. New orders for . . . Doxycycline hyclate 100 mg tab po Bid x 7 days . . . Apply betadine daily to right 2nd toe. . . ."

The significant change MDS, dated 03/11/19, identified the resident was at risk of developing pressure ulcers and infection of the foot (e.g., cellulitis, purulent drainage).

A progress noted, dated 03/12/19 at 4:41 a.m., identified, ". . . received first dose of Doxycycline . . . Toe is erythema and slightly warm to touch. Skin is intact. No drainage noted. . . . She stated only has pain when blanket is laying on the foot. Blanket was pulled back and she stated she had relief. . . ." and at 9:11 p.m., ". . . Right 2nd toe is red [and] swollen. Anterior distal tip of toe has a small circular open area with no drainage. Resident denies any pain or discomfort to toe. . . ." The facility failed to measure the open area on the tip of Resident #17's toe.

The care plan identified, ". . . Date Initiated: 03/12/2019 . . . Infection of wound/skin (right 2nd toe) . . . Administer meds as ordered, Maintain precautions as indicated, Record temperature as clinically indicated. . . ." The care plan failed to address removing pressure from the top of Resident #17's feet.

Progress notes also identified the following:
* 03/17/19 at 2:52 a.m., ". . . continues taking Doxycycline . . . No drainage. Denies of [sic] any pain. . . . Foot elevated while in bed. . . ."
* 03/18/19 at 9:05 p.m., ". . . took last dose of Doxycycine . . . Right 2nd toe is dark pink with small circular scab to the anterior tip of toe. No

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F 686	Continued From page 58 drainage. Resident denies any pain or discomfort. . . ." * 03/29/19 at 1:27 p.m., "Received new order from podiatry . . . Continue Betadine treatment to right second toe for 7 days then discontinue." * 04/03/19 at 11:19 a.m., "Note received from [Physician] with addendum made to specify "painful calluses and ulceration to right 2nd toe, left foot hammer toe deformity and callus the left big toe." * 04/09/19 at 6:03 p.m., "Resident's daughter . . . concerned that resident's right 2nd toe diabetic vascular ulcer is not improving. I note that right 2nd toe has a very thick necrotic black 0.8 cm circular scab dry [and] intact. No drainage. Surrounding toe is slightly red. Right foot is slightly cool to touch with pedal pulses palpable. Resident denies any pain or discomfort to the right foot. ROM [range of motion] [and] sensation is intact to right foot [and] toes when palpated [sic]. . . . Daughter . . . requests that a f/u [follow up] appointment be made ASAP [as soon as possible] with podiatrist . . ." Staff failed to identify the observable necrosis to Resident #17's toe prior to family voicing their observations/concerns. The facility failed to measure/assess the ulcer since it was first identified on 03/12/19. * 04/17/19 at 2:25 p.m., "Made an appointment with . . . podiatry to see if resident scabbed to her right second toe can be debride [sic]." Staff failed to schedule an appointment with Resident #17's podiatrist in a timely manner, contacting his office eight days after the family made their request. * 04/22/19 at 2:00 p.m., "Resident returned from appointment with podiatrist . . . No new orders. Dr. report states improving cellulitis right 2nd toe. Continue observation . . ."	F 686		

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F 686	Continued From page 59 The only weekly skin review provided by the facility, dated 05/02/19, identified, "Skin intact, dry." Four days later, a progress note, dated 05/06/19 at 1:41 a.m., identified, "Medial right great toe is not blanchable, black in color, redness present at ankle to black area at base of the toe. redness measures 22 cm in length from above the ankle to base of toe. blackened area on toe is 5 cm x 2 cm. Areas between the toes are flesh colored. 2nd toe has 1 cm x 1 cm area previously noted to be discolored and is in notes from podiatry. 3rd toe has reddened area 1 cm x 1 cm right lowere extremity is warm and dry, no edema present, dorsal part of foot is cool to touch as are the toes, reflexes in expremity and foot present. . . . telephone order OK to transfer resident to ER and treat per family request. . . . Family in facility requesting resident be transferred to hospital for eval and treatment related to recent hypoglycemia and discolored toe." On 04/09/19, staff described "a very thick necrotic black 0.8 cm circular scab." The chart lacked documentation regarding the toe until 05/06/19, at which time staff described a "blackened area on toe, is 5 cm x 2 cm." During an interview on 06/06/19 at 8:00 a.m., when asked questions pertaining to Resident #17's ulcer, a managerial nurse (#5) stated, "Originally, it was due to pressure, then they decided it was a diabetic ulcer, and then it became necrotic. She was put on antibiotics when she went to the hospital." When asked questions pertaining to the facility's care expectations, the managerial nurse (#5) stated,	F 686		

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F 686	Continued From page 60	F 686		

"What they were supposed to do was complete a weekly wound tracker. Every week the Nurse Manager measures pressure sores. I would assume they started a wound tracker as soon as they found the sore. They would document the size, color, drainage, and stuff. I couldn't find a weekly skin assessment either. The weekly skin assessment would catch any other type of skin issue, non-pressure sore. . . . so we know it's there."

The facility failed to:
* Notify physician in a timely manner after discovering the ulcer on Resident #17's toe,
* Accurately identify/document observations of the infected area,
* Measure Resident #17's toe ulcer in a timely manner/weekly per facility policy,
* Document if/when Resident #17's ulcer resolved,
* Assess/identify observable color changes/necrosis on Resident #17's toe,
* Care plan the need to remove pressure from the top of Resident #17's feet, and
* Schedule an appointment with the podiatrist in a timely manner after discovering the necrosis on Resident #17's toe.

- Review of Resident #3's medical record occurred on all days of survey. A Significant Change MDS, dated 04/13/19, identified a risk for pressure ulcer, no pressure ulcer present, pressure reducing device for chair, and pressure reducing device for bed.

The current care plan, dated 04/10/19, stated, ". . . resident has suspected deep tissue injury to buttock, coccyx area r/t [related to] immobility

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F 686	Continued From page 61 during recent hospital stay . . . The resident requires an APM [air pressure mattress]for her bed . . ." Observation on 06/05/19, at 9:55 a.m., showed two CNAs (#3 and #4) assisted Resident #3 from the wheelchair to the bed, performed ADL's [activities of daily living] and exited Resident #3's room. Resident #3's air mattress pump was unplugged from the electrical outlet. The CNAs failed to assure the air mattress was on and fully inflated. During an interview on 06/06/19 at 9:05 a.m., an administrative nurse stated he/she would expect staff to make sure the air mattress was on and lying on the bed frame would create a problem because there is nothing soft to prevent the resident from lying on the steel frame.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON 07/26/17 and 08/16/18. GAIT BELT USE	F 689	Resident #14 is currently attending PT, with validation of transfer status. Resident #15 was referred to PT for screening regarding transfer status. Toileting documentation schedules and care plans were updated for Resident #11	7/10/19

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F 689	Continued From page 62 1. Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 4 (Resident #3, #14, and #15) observed during a gait belt transfer. Failure to properly use a gait belt during transfers placed the resident at risk of accidents and injury. Findings include: Review of the facility "Gait Belt Skill Checklist" occurred on 06/10/19. This list stated, ". . . properly position gait belt low on resident waist . . . Properly grasp belt for effective use . . . Assist resident from a sit to stand position grasping gait belt properly. . . ." - Observation on 06/04/19 at 10:59 a.m. showed two certified nursing assistant (CNAs) (#9 and #10) placed a gait belt around Resident #14's waist and assisted her to transfer from her chair to bed. The CNAs (#9 and #10) held the gait belt with one hand and lifted under the resident's arm axilla with the other hand. The resident did not fully bear weight, and her knees bent to an almost 90 degree angle. - Observation on 06/05/19 at 9:55 a.m. showed two CNAs (#3 and #4) transferred Resident #3 from the wheelchair to bed with assist of two and a gait belt. CNA (#4) failed to properly use the gait belt during transfer and lifted Resident #3 under her right arm pit. - Observation on 06/05/19 at 1:55 p.m. showed a CNA (#6) transferred Resident #15 from the	F 689	and #14. Resident #3 had a skin assessment completed on 6/12/19 to determine if any injury had occurred related to transfer, skin was intact. Resident #17 no longer resides at the facility. Residents who require assistance with transfers with gait belts and those that have experienced falls when attempting to self transfer to toilet have the potential to be impacted by this practice. Falls for current residents were reviewed on 06/17/19. The DON provided education on transferring with gait belts and documentation of toileting times to licensed nurses and nursing assistants beginning on 06/17/19. Gait belt competencies for licensed nurses and nursing assistants were completed by the DON or designee beginning on 06/24/19. The DON initiated audits on 07/01/19 to include direct observation of the use of gait belts with transfers. The DON initiated audits on 07/01/19 of compliance with documentation of toileting. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 689	Continued From page 63 wheelchair to the toilet with assist of one with a gait belt. Review of Resident #15's medical record occurred on all days of survey. The current care plan stated, ". . Transfer with two staff assist with gait belt . . ." During an interview on 06/06/19 at 9:05 a.m., a managerial nurse (#5) stated, if the resident requires assistance from two staff members, he expected one staff member to stand on each side of the resident with one hand on the back of the gait belt and one hand on the front of the gait belt. TOILETING ASSISTANCE 2. Based on information received from the complainants, record review, review of a professional reference, the facility failed to provide adequate supervision/assistance for 2 of 2 sampled residents (Resident #11 and #14) and 1 discharged resident (Resident #17) who fell while attempting to self-transfer to the bathroom. Failure to provide adequate supervision/assistance resulted in residents experiencing preventable falls with/without injury. Findings include: Information provided by the complainants indicated nursing staff failed to provide adequate supervision/assistance resulted in residents' attempts to self-tranfer to the bathroom. Berman, Snyder, and Frandsen's, "Kozier & Erb's	F 689		

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Fundamentals of Nursing: Concepts, Process, and Practice, "10th edition, Pearson Education, Inc., New Jersey, page 651, stated, ". . . Risk Factor and Preventative Measures for Falls: Urinary frequency or receiving diuretics, Weakness from disease process or therapy, Current medication regimen that includes sedatives, hypnotics, tranquilizers, narcotic analgesics, diuretics. . . . Assist with voiding on a frequent and scheduled basis. . . ."

Findings include:

- Review of Resident #11's medical record occurred on all days of survey. The current care plan identified, ". . . Urinary incontinence r/t [related to] Disease process (dementia), functional incontinence, BPH [benign prostatic hyperplasia] . . . Provide assistance with toileting every two hours at minimum. . . . At risk for falls due to: history of falls, impaired balance/poor coordination. Interventions: Increased toileting during nighttime hours (every 2-3 hours). . . ."

Progress notes identified the following:
* 05/02/19 at 6:30 p.m., ". . . Light sounding . . . Lying on back next to foot of his bed . . .Was sitting in recliner prior . . . Incontinent of urine . . ."
* 05/04/19 at 6:41 a.m., ". . . Kneeling on floor by bed . . . Incontinent of urine . . ."
* 05/30/19 at 9:57 a.m., ". . . Lying on floor in front of recliner . . . Large loose incontinent BM [bowel movement] . . ."
* 05/31/19 at 12:46 p.m., ". . . Found on floor next to bathroom . . . Had incontinent BM . . ."

Toileting documentation identified staff assisted

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F 689	Continued From page 65 Resident #11 as follows: * 05/02/19 at 2:42 a.m. and 9:56 p.m. * 05/04/19 at 4:05 a.m., 7:51 a.m., and 8:45 a.m. * 05/30/19 at 2:11 a.m., 10:26 a.m., and 9:47 p.m. * 05/31/19 at 2:13 a.m., 10:24 a.m., and 9:02 p.m. - Review of Resident #14's medical record occurred on all days of survey. The current care plan identified, ". . . Urinary incontinence r/t: disease process dementia, impaired mobility . . . provide incontinent care as needed . . . At risk for falls due to: impaired balance/poor coordination . . . anticipate resident needs; assess comfortable for positioning in bed; reposition and provide incontinent cares at routine times . . ." Progress notes identified the following: * 03/17/19 12:34 a.m., ". . . found on the floor . . . lying on her back with her lower extremities under the bed . . . call light . . . sounding when staff arrived . . . found incontinent of bladder and incontinent of a small BM . . ." * 04/07/19 at 10:34 p.m., ". . . resident was sitting on the floor by her bed . . . incontinent of bowel . . ." Toileting documentation identified staff assisted Resident #11 as follows: * 04/07/19 at 9:27 a.m. * 03/17/19 at 12:48 a.m., 9:53 a.m., and 8:57 p.m. - Review of Resident #17's medical record occurred on all days of survey. The record identified diagnoses of Alzheimer's dementia, osteoarthritis, muscle weakness, hypertension	F 689		

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F 689	Continued From page 66 requiring a diuretic, and repeated falls. The care plan identified, ". . . requires assistance related to physical limitations, visual impairment . . . CNA [certified nursing assistant] to assist to toilet prior to and following meals. Offer toileting on last rounds for night shift. . . ." Progress notes identified the following: * 01/12/19 at 9:19 p.m., "Resident is on follow up for: Un witnessed fall in her bathroom. . . . Resident is unable to transfer self back and fort [sic] [to] the bathroom. Resident educated to wait for assistance after activating call light, can't transfer self." Failure to offer residents supervision/assistance with toileting on a more frequent basis may have resulted in Resident #11, #14, and #17 experiencing preventable falls. Refer to F585 and F690.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		7/10/19

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F 690	Continued From page 67 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: INCONTINENCE 1. Based on information received from the complainants, record review, and review of the facility policy, the facility failed to assess the residents' bowel and bladder patterns to maintain continence for 2 of 16 sampled residents reviewed (Resident #11 and #14) and 2 discharged residents (Resident #17 and #19). Failure to assess bowel and bladder patterns and implement routine toileting consistent with these patterns may result in avoidable incontinence, urinary tract infections (UTIs), and/or falls and does not allow residents to attain/maintain their highest practicable physical and psychosocial well-being.	F 690	Resident #11 and #14 care plan and task lists were updated to include toileting at routine times on 06/10/19. Resident #17 and #19 no longer reside at the facility. Residents who require toileting schedules and those who have abnormal UA results have the potential to be impacted by this practice. Residents who require toileting schedules were reviewed and care plans updated beginning 06/10/19. The DON provided education to licensed nurses and nursing assistants on toileting schedules beginning on 06/17/19 and to licensed nurses on appropriate clinical follow up on UA results and initiation of new orders for antibiotics on 06/17/19.	

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F 690	Continued From page 68 Findings include: Information provided by the complainants indicated nursing staff failed to toilet residents on a frequent basis resulting in residents' observed in soiled clothing/bedding. Review of the facility policy titled "Incontinence Prevention Program" occurred on 06/11/19. This undated policy stated, ". . . Based upon the results of the Evaluation of Continence . . . Prompted voiding is a scheduled toileting program . . . Residents are offered toileting assistance at regular intervals while awake and as needed at night. . . . Habit training is a scheduled bladder management program designed according to the patient's/resident's individual voiding pattern. . . . Routine Toileting . . . A scheduled bladder management program will be designed to toilet an incontinent patient/resident when a voiding pattern cannot be established or for a patient/resident who is unable to communicate the need to void . . . " - Review of Resident #11's medical record occurred on all days of survey. The current care plan identified, ". . . Urinary incontinence r/t [related to] Disease process (dementia), functional incontinence, BPH [benign prostatic hyperplasia] . . . Provide assistance with toileting every two hours at minimum. . . . At risk for falls due to: history of falls, impaired balance/poor coordination. Increased toileting during nighttime hours (every 2-3 hours) . . ." Review of toileting documentation, dated 05/01/19-06/03/19, showed staff toileted	F 690	The DON initiated audits on 07/01/19 for compliance with toileting schedules and documentation of toileting. The DON initiated audits on 07/01/19 of follow up on UA results and initiation of new orders for antibiotics. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 690	Continued From page 69	F 690		

Resident #11 one-to-four times per day. The progress notes further identified staff found Resident #11 on the floor incontinent of urine and/or stool on four occasions.

- Review of Resident #14 medical record occurred on all days of survey. The current care plan identified, ". . . Urinary incontinence r/t: disease process dementia, impaired mobility . . . provide incontinent care as needed . . . At risk for falls due to: impaired balance/poor coordination . . . anticipate resident needs; assess comfortable for positioning in bed; reposition and provide incontinent cares at routine times . . ."

Review of toileting documentation, dated 03/01/19-04/30/19, showed staff toileted Resident #14 one-to-four times per day. The progress notes further identified staff found Resident #14 on the floor incontinent of urine and/or stool on two occasions.

- Review of Resident #17's medical record occurred on all days of survey. Diagnoses included history of UTIs and repeated falls. The care plan identified, ". . . requires assistance related to physical limitations, visual impairment . . . CNA [certified nursing assistant] to assist to toilet prior to and following meals. Offer toileting on last rounds for night shift. . . ."

Review of toileting documentation, dated 04/10/19-05/15/19, showed staff toileted Resident #17 zero-to-seven times per day at random times throughout the day. The facility failed to consistently toilet Resident #17 prior to/following meals as care-planned. The progress notes further identified staff found Resident #17

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F 690	Continued From page 70 on the floor of her bathroom on one occasion. - Review of Resident #19's medical record occurred on all days of survey. The care plan identified, ". . . At risk of urinary incontinence r/t Disease process BPH, urinary retention . . . Remind and assist as needed with toileting at routine times such as upon arising in AM, before/after meals, activities, therapy and at bedtime . . ." Review of toileting documentation, dated 10/01/18-11/19/18, showed staff assisted/toileted Resident #19 two-to-six times per day at random times throughout the day. The facility failed to consistently toilet Resident #19 prior to/following meals as care-planned. Facility staffs' failure to assist/toilet Resident #11, #17, and #19 in a timely manner may have resulted in their experiencing incontinence/avoidable falls. Refer to F585 and F689. URINE CULTURES 2. Based on record review and staff interview, the facility failed to provide services to treat urinary tract infections (UTIs) for 1 of 1 resident discharged from the facility (Resident #17) with a history of UTIs. Failure to contact the physician immediately after being notified of a positive urine culture resulted in Resident #17 receiving delayed treatment for a confirmed UTI. Findings include:	F 690		

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F 690	Continued From page 71 Upon request, the facility failed to provide a copy of their policy addressing urinary tract infections. Staff indicated they "use the McGeers Criteria." - Review of Resident #17 medical record occurred on all days of survey. Diagnoses included history of UTIs and repeated falls. The care plan identified, ". . . requires assistance related to physical limitations, visual impairment . . . CNA [certified nursing assistant] to assist to toilet prior to and following meals. Offer toileting on last rounds for night shift. . . ." The progress notes identified the following: * 03/22/19 at 5:43 a.m., ". . . Resident lowered to her knees after resident stated her right knee became weak . . ." * 03/22/19 at 2:42 p.m., "Resident returned from appointment with nephrologist . . . New orders to continue same medications, get a UA. . . ." A microbiology report, dated 03/24/19, identified "Escherichia coli [E-coli] and Proteus mirabilis [types of bacteria]" present in Resident #17's urine. The report further indicated the bacteria as susceptible to Nitrofurantoin, Piperacillin/Tazobactam, and Trimethoprim/Sulfa [antibiotics]. The chart lacked evidence that staff notified the physician of Resident #17's positive urine culture. The progress notes identified the following: * 03/26/19 at 7:00 p.m., "CNA reports that when he was transferring resident from w/c [wheelchair] to toilet with gait belt, resident's legs buckled [and] she had to be lowered to the floor . . ."	F 690		

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F 690	Continued From page 72 * 04/01/19 at 5:00 p.m., "Resident's hands [and] arms are shaking. Her cheeks are red [and] flushed . . . Resident had a large food filled emesis . . . [Physician] paged. New orders to get UA/UC [urinalysis/urine culture]. Start resident on Cephalexin [antibiotic] . . ." During an interview on the morning of 06/06/19 at 8:00 a.m., the managerial nurse (#5) confirmed staff should have immediately contacted the physician after being notified of her positive urine culture. Facility staff failed to contact Resident #17's physician for eight days after being notified of her positive urine culture, delaying her antibiotic treatment.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		7/10/19

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F 692	Continued From page 73 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: HYDRATION 1. Based on information provided by the complainants, observation, review of facility policy, record review, and staff interviews, the facility failed to offer fluids 3 of 16 sampled residents (Resident #6, #15 and #16) who required staff assistance for fluid intake and were at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Information provided by the complainants indicated nursing staff failed to provide dependent residents assistance with fluid intake. Review of facility policy titled, "Hydration Policy" occured on 06/11/19. This policy, dated 01/2017, stated, ". . . each resident receives adequate fluids to maintain proper hydration . . ." - Review of Resident #6's medical record occurred on all days of the survey. Diagnoses included unspecified dementia and difficulty in walking. The current care plan stated, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered . . ." Observation on 06/04/19 at 11:15 a.m., showed a CNA (#13) provided cares for Resident #6 and	F 692	Care plans were updated on 07/02/19 for residents #6, #15, and #16 to offer fluids with cares. Resident #17 no longer resides at the facility. Residents who require assistance with fluid intake and those that experience weight loss have the potential to be impacted by this practice. Care plans were updated for like patients on 07/02/19. The DON provided education to licensed nurses and nursing assistants on offering fluids with cares on 06/17/19. The DON provided education on weight loss interventions to licensed nurses, nursing assistants, and dietary staff on beginning on 07/02/19. The DON initiated audits/observation of offering fluids with cares on 06/24/19. The DON initiated audits of compliance with offering identified nutritional interventions to residents experiencing weight loss on 07/02/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 692	Continued From page 74	F 692		

exited the room. The CNA failed to offer the resident fluids.

- Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbance. The current care plan stated, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered . . ."

Observation on 06/05/19 at 1:55 p.m. showed a certified nursing assistant (CNA) (#6) provided cares for Resident #15 and exited the room. The CNA failed to offer the resident fluids.

- Review of Resident #16's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and dehydration. The care plan stated, ". . . Encourage as needed to consume foods and/or supplements and fluids offered . . ."

Observation on 06/04/19 at 3:42 p.m. showed two CNA (#7 and #8) provided cares for Resident #16 and exited the room. The CNAs failed to offer the resident fluids.

During an interview on 06/06/19 at 10:00 a.m., an administrative nurse (#5) stated he/she expected facility staff to provide fluids during cares.

NUTRITION

2. Based on information provided by the complainants, record review, and staff interview, the facility failed to address the nutritional needs for 1 of 1 resident discharged from the facility (Resident #17) who experienced significant

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F 692	Continued From page 75	F 692		

weight loss. Failure to identify Resident #17's food preferences and obtain orders for/implement other interventions (i.e.: fotrified foods/supplements) in a timely manner contributed to Resident #17 experiencing significant unplanned weight loss.

Findings include:

Information provided by the complainants indicated nursing staff failed to put interventions in place to prevent residents from experiencing significant weight loss.

Upon request, the facility failed to provide a copy of their policy addressing weight loss.

During an interview on 06/04/19 at 3:30 p.m., when asked how the facility addresses residents experiencing weight loss, a managerial dietary staff member (#12) reported monitoring residents for gradual/significant weight loss, and stated, "First, I would give the resident fortified foods, and then supplements. I try to do things like cookies, chocolate milk, whole milk, cheese and crackers, cereal, magic cup, sherbet, and peanut butter. If they need help, I ask them to be moved to an assisted table."

Review of Resident #17's medical record occurred on all days of survey, and identified diagnoses of Alzheimer's dementia, diabetes, hypertension, and buttock/toe wounds.

The weight record identified:
* 12/03/18, 210 pounds
* 01/08/19, 208 pounds (2 pound weight loss)
* 02/12/19, 200 pounds (10 pound weight loss)

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F 692	Continued From page 76 * 04/04/19, 190 pounds (20 pound weight loss) * 05/05/19, 173 pounds (37 pound weight loss) The physician's orders identified the following: * 03/05/19, "Consistent Carbohydrate (CCD) diet Ground Meat texture, Regular/Thin consistency, Low Sodium < 1.5 mg [milligram] in 24 hours for Nutritoon [sic]." * 03/06/19, "Lasix Tablet 40 mg." * 03/22/19, "Fluid restriction as directed by cardiologist . . . Not > [greater than] 1750 ml in 24 hours." * 04/11/19, "Speech evaluation - weight loss." The progress notes, dated 10/02/18-05/05/19, identified the following: * 01/08/19, "Quarterly Assessment - [Resident #17] is on a carbohydrate controlled diet with ground meats. Her intakes vary averaging < [less than] 30% [percent]. She receives food in bowls to assist with eating. She can make her needs and wants known. Staff assists with meal set up due to blindness. Her weight is 208# [pounds]. Has refused several meals this past 2 weeks. Is being evaluated for UTI [urinary tract infection]. Offer alternatives when not eating or supplement when refuses meals. Monitor on Nutrition risk." * 01/18/19, "Care Plan Progress Note . . . Dietary was not present. [Resident #17] weighs 208 pounds and usually eats 0-25% of meals. . . ." * 03/08/19, ". . . Eats less than 50% of meals Weight Stable . . ." * 03/11/19, ". . . Eats 50% to 75% of meals Weight Stable . . ." * 03/21/19, "Care Plan Progress Note . . . Dietary was not present. [Resident #17] weighs 191 pounds [down 17 pounds since 01/18/19] and usually eats 51-25% of meals. . . ."	F 692		

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F 692	Continued From page 77 * 03/22/19, ". . . Eats 75%-100% of meals Weight Stable . . ." It is unclear how staff determined Resident #17's weight was stable, when the record showed a 17 pound weight loss the day before. * 03/26/19, ". . . Eats 50% to 75% of meals Weight Stable . . ." * 03/29/19, ". . . [Resident #17] is on a carbohydrate controlled diet/1.5 gm [gram] sodium with ground meats and 1750 ml fluid restriction. Her intakes vary averaging < 40%. Yesterday intakes were poor. She receives food in bowls to assist with eating. She can make her needs and wants known. Staff assists with meal set up due to blindness. Her weight is 190# [down 18 pounds since 01/18/19] Triggers for significant wt [weight] change. Maybe partly water and decrease in intakes prior to past month. Monitor on Nutrition risk." * 03/31/19, ". . . -7.5% change . . . Wt triggers for significant change. Has been stable for past 2 weeks. Continues on low sodium carbohydrate controlled diet with ground meat and 1750 ml fluid restriction. She is eating < 30% average at meals. wt may not reflect a loss due to fluid. . . . Notify MD [medical doctor] and family of poor intakes. Offer supplement or other meal replacement when not eating. Follow on Nutrition risk." The facility failed to notify Resident #17's physician of her significant weight loss. Documentation also failed to show staff identified Resident #17's food preferences and/or obtained orders for/implemented other interventions such as fotrified foods/supplements. * 04/01/19, ". . . Eats 50% to 75% of meals Weight Stable . . ." * 04/23/19, ". . . -10.0% change . . . [Resident #17] continues to have a wt loss. She averages	F 692		

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F 692	Continued From page 78 less than 50% of meals. She takes fluids well. She is on a fluid restricted diet carbohydrate controlled with ground meats. Some of loss maybe r/t [related to] fluid losses. Offer alternates when not eating her meals. She is taking her snacks well. Has cellulitis at this time. Continue to monitor." * 05/05/19, ". . . Eats 50% to 75% of meals Weight Stable . . ." The care plan identified, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered, Honor food preferences, Provide diet as ordered carbohydrate controlled low sodium ground meat, Review weights and notify MD and responsible party of significant weight loss. . . ." The facility failed to individualize Resident #17's care plan identifying specific preferred foods/supplements. During an interview on 06/05/19 at 3:00 p.m., a managerial nurse (#5) confirmed the care plan failed to reflect Resident #17's food preferences and/or the fortified foods, supplements, and snacks recommended for her. After identifying Resident #17 as at risk for significant weight loss, the facility failed to: * notify the physician of Resident #17's significant weight loss, * identify, care plan, and provide preferred foods, fortified foods, supplements, and/or snacks, and * monitor/document Resident #17's intake in an effort to identify which interventions were beneficial and her remaining caloric needs. Refer to F677.	F 692		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		7/10/19

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F 695 SS=D	Continued From page 79 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainants, observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 2 of 3 residents (Resident #1 and #13) receiving oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Information provided by the complainants indicated nursing staff failed to ensure oxygen was administered per physician's order. Review of the facility policy titled "Oxygen Administration" occurred on 06/10/19. This policy, revised August 2017, stated, ". . . Validate physician orders for oxygen and set liter flow according to physician order. . . ." Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice, "9th ed., Pearson Education, Inc.,	F 695	Orders for oxygen for Resident #1 were discontinued. Resident #13 no longer resides in the facility. Residents who require supplemental oxygen have the potential to be impacted by this practice. Orders were reviewed and care plans updated for these residents on 07/02/19. The DON provided education to licensed nurses on oxygen administration and following orders as written beginning on 06/17/19. The DON implemented audits for compliance with MD orders and oxygen use on 06/24/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months. Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ."

- Review of Residents #1's medical record occurred on all days of survey. A physician's order stated, ". . . Oxygen at 2 L/M [liters per minute] to maintain O2 [oxygen] sats [saturations] >90%. Check each shift. . . ."

Observation on 06/04/19 at 11:05 a.m., and 06/05/19 at 10:08 a.m., showed Resident #1 wearing a nasal cannula attached to an oxygen concentrator set at 1 liter per minute.

The facility failed to consistently provide Resident #1 oxygen at the ordered concentration per nasal cannula.

- Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dependence on supplemental oxygen and hypoxemia (low levels of oxygen). A current physician's order stated, "Oxygen at 2L [liters] to keep sats greater than 90% prn as needed . . ." Review of Resident #13's oxygen sats since January 2019 showed resident oxygen sat levels remained above 90% daily with oxygen applied.

The current care plan stated, ". . . Has/At risk for respiratory impairment related to: history of recurrent pneumonia . . . Oxygen per MD orders . . ."

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F 695	Continued From page 81 All observations during survey showed Resident #13 with oxygen on continuously at 2L. During an interview on 06/06/19 at 10:00 a.m., an administrative nurse (#5) stated Resident #13's family requests oxygen on continuously and confirmed the facility should obtain a continuous oxygen order.	F 695		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the physician visits the resident at least once every 30 days for the first 90 days after admision, and at least once every 60 thereafter	F 712	Date of compliance is July 10, 2019 Resident #15 record was reviewed and MD visit was completed 05/31/19. Residents who reside at the facility have	7/10/19

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F 712	Continued From page 82 for 1 of 1 sampled resident (Resident #15). Failure to ensure residents receive the required phsyician visits may result in negative outcome and delay treatment. Findings include: Review of Resident #15's medical record occurred on all days of survey. Resident was admitted on January 2019 and the medical record lacked evidence the resident received the required physician visits per the regulations.	F 712	the potential to be impacted by this practice. An audit of MD visits was completed by the Medical Records Clerk on 07/02/19 The DON provided education to the Medical Records Clerk on 07/01/19 on required MD visits and notifications to MD when visits are due. The DON or designee will complete audits of compliance with required MD visits and notifications that visits are due beginning 07/01/19. These audits will be completed weekly for three months and then monthly as an ongoing change in practice. Results of audits will be submitted to the QAPI team for review and recommendations. Date of compliance is July 10, 2019.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 resident discharged from the facility (Resident #17) with a significant medication error. Failure to administer an antibiotic as stated in the physician's orders may result in a negative outcome for the resident. Findings include: Review of the facility policy titled "Administering	F 760	Resident #18 no longer resides in the facility. Residents who require initiation of antibiotic therapy have the potential to be impacted by this practice. The DON or designee provided education to licensed nurses on initiation of antibiotic therapy timely beginning on 07/01/19. Education included the use of the EKIT to initiate antibiotics timely. The DON initiated audits on 07/01/19. These audits will be completed weekly for	7/10/19

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F 760	Continued From page 83 Medication" occurred on 06/10/19. This policy, revised December 2012, stated, ". . . Medications must be administered in accordance with the orders, including any required time frames. . . ." - Review of Resident #18's medical record occurred on all days of survey, and identified diagnoses of carcinoma of skin and open wound to right lower leg. The Medication Administration Record identified "[Start Date 10/08/18] . . . Levaquin 500 mg [milligrams] PO [by mouth] every 24 hrs [hours] for 10 days. . ." The progress notes identified the following: * 10/09/18 at 10:30 p.m., "Resident started first dose of Levaquin tonight. . . . Wound to right lower leg has yellow slough present in wound bed. Wound has purulent yellow drainage that is soaked onto the kerlix covering her legs. Wound has an odor to it. . . ." * 10/16/18 at 9:10 p.m., ". . . transport to . . . [another facility out of state] . . ." The facility failed to administer the medication for the first time twenty-four hours after receiving the order and only administered six of nine recommended doses of the antibiotic. (The tenth dose was due the day after she was discharged from the facility.) The facility failed to administer Resident #18's antibiotic per the physician's order.	F 760	three months and then monthly as an ongoing change in practice. Results of audits will be submitted to the QAPI team for review and recommendations. Date of compliance is July 10, 2019.	
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing	F 801		7/10/19

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F 801	Continued From page 84 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 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	F 801		

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F 801	Continued From page 85 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 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 staff interview, the facility failed to ensure the dietary manager received the necessary education to obtain the required qualifications to hold the director of food and nutrition for 1 of 1 dietary manager (#2). Failure	F 801	CDM or registered dietitian will be in the facility full time beginning the week of July 22, 2019. This practice will continue until the current dietary manager completes the courses for CDM.	

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F 801	Continued From page 86 to ensure qualified staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services has the potential to result in adverse consequences for resident. During an interview on 06/05/19 at 4:25 p.m., a dietary manager (#2) stated, "I have started the process of getting my CDM [certified dietary manager]." Upon request, on 06/05/19, the facility failed to provide evidence of staff member (#2) completing the required education of CDM, certified food service manager, or a national certification for food service management and safety from a national certifying body. The facility failed to provide the necessary training in food and nutrition services to carry out daily operation duties.	F 801	Residents have the potential to be impacted by this practice. The current dietary manager was enrolled in course work for her CDM on June 6, 2019. She is currently completing courses as assigned. The Administrator or designee will monitor course completion on a weekly basis to ensure the current food service manager meets the CDM requirements as expediently as possible. Until that is achieved a CDM or registered dietitian will be on duty in house no less than 32 hours per week. Date of compliance July 24, 2019	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/10/19

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F 880	Continued From page 87 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 88 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON 08/16/18. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 6 of 16 sampled residents (Resident #1, #3, #4, #13, #14, and #16) observed during personal cares. Failure to follow infection control practices of hand hygiene during toileting/personal cares has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 06/10/19. This undated policy stated, ". . . Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . . . Before and after assisting a resident with toileting (hand washing with soap and water) . . . The use of gloves does not replace	F 880	Residents #1, #3, #4, #14, and #16 have been free of ill effects related to non-compliance with infection control standards. Resident #7 no longer at facility. Residents who reside in the facility have the potential to be impacted by this practice. Education was provided on handwashing and observations of proper hand washing during cares and between tasks were initiated following survey. The DON provided education to licensed nurses and nursing assistants on hand hygiene and completed competencies on hand hygiene with nursing staff beginning on 06/17/19. The DON initiated audits/observations of hand hygiene on 06/24/19. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Audits will then continue monthly for eight months.	

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F 880	Continued From page 89 handwashing/hand hygiene . . ." Review of the facility policy titled "Infection Prevention and Control Manual Standard Precautions" occurred on 06/10/19. This undated policy stated, ". . . Sterile gloves and examinations gloves are removed . . . As soon as practical when contaminated . . . Between resident contacts . . . Before touching uncontaminated surfaces or other areas of the same resident's body that may be contaminated . . ." Observations showed the following: * 06/04/19 at 10:59 a.m., two certified nursing assistants (CNAs) (#9 and #10) applied gloves and provided incontinent cares for Resident #14 after a bowel movement (BM). The CNA (#10) changed gloves and, without performing hand hygiene, placed a clean brief, removed his/her gloves, and then both CNAs positioned the resident into his/her wheelchair. The CNA (#10) failed to remove gloves and perform hand hygiene after incontinent cares. * 06/04/19 at 3:42 p.m., two CNAs (#7 and #8) applied gloves and provided incontinent cares for Resident #16 after a BM. The CNA (#8) failed to remove gloves or perform hand hygiene before placing a clean brief, and then both CNAs positioned the resident into his/her wheelchair. * 06/05/19 at 9:55 a.m., two CNAs (#3 and #4) gloved and assisted Resident #3 from wheelchair to bed. One of the CNAs (#3) removed her gloves, failed to perform hand hygiene and exited the room. While wearing gloves, CNA (#4) checked the resident's brief and stated, "it's not wet." The CNA (#4) removed her gloves, lowered the bed, adjusted the bedspread and attached	F 880	Results of audits will be forwarded to the QAPI team for review and recommendations and frequency of audits will be adjusted if indicated.	

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F 880	Continued From page 90 the call light to the bed. Without performing hand hygiene the CNA (#4) assisted Resident #1 in the same room. The CNA raised Resident #1's bed, closed the window blinds and donned gloves. The CNA (#4) performed perineal care after a bowel movement [bm] for Resident #1. Without performing hand hygiene or changing gloves, the CNA picked up a spray bottle [Peri fresh] and sprayed the Resident's perineal area. The CNA removed her soiled gloves, and applied clean gloves. The CNA (#4) failed to complete hand hygiene between glove changes, prior to other tasks, and after perineal cares. * 06/05/19 at 11:50 a.m., two CNAs (#3 and #4) assisted Resident #4 from bed to wheelchair. The Resident #4's feeding tube became lodged and disconnected underneath him. Contents of the feeding tube [gastric secretions] leaked onto the floor and onto CNA's (#3) ungloved hands. The CNA (#3) failed to don gloves prior to performing cares. * 06/05/19 at 3:20 p.m., two CNAs (#7 and #11) applied gloves and provided incontinent cares for Resident #16 after a BM. The CNA (#7) failed to remove gloves or perform hand hygiene before placing a clean brief, and then both CNAs positioned the resident into his/her wheelchair. * 06/05/19 at 3:33 p.m., two CNAs (#7 and #11) applied gloves and provided incontinent cares for Resident #13. Without removing his/her gloves CNA (#7) removed the resident's oxygen, positioned the resident into his/her wheelchair and replaced the resident's oxygen. The CNA (#7) failed to remove gloves and perform hand hygiene after incontinent cares. During an interview on 06/06/19 at 9:05 a.m., an administrative nurse (#5) stated he/she expected	F 880		

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F 880	Continued From page 91 staff to perform hand hygiene/change gloves before, after, and in between cares.	F 880		