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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6O8Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00394

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245369**

2.STATE VENDOR OR MEDICAID NO.
(L2) **055842700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MARKS LIVING**
(L4) **400 - 15TH AVENUE SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

4. TYPE OF ACTION: **7** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/15/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **61** (L18)
13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Angela Hatch, HFE NE II 1/23/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/23/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2020

CMS Certification Number (CCN): 245369

Administrator
St. Marks Living
400 - 15 th Avenue Southwest
Austin, MN 55912

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 7, 2020 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

January 22, 2020

Administrator
St. Marks Living
400 - 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: October 7, 2019

Dear Administrator:

On January 10, 2020, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On January 15, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 7, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 26, 2019 did not go into effect. (42 CFR 488.417 (b))

- Civil money penalties. (42 CFR 488.430 through 488.444).

In our letter of October 28, 2019, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 13, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 7, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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ID: 6O8Y

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8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/5/2019** (L34)

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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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13.Total Certified Beds **61** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Stephanie Powers HFE NE II 1/15/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/22/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 27, 2019

Administrator
St Marks Living
400 - 15th Avenue Southwest
Austin, MN 55912

RE: CCN 245369
Cycle Start Date: October 7, 2019

Dear Administrator:

On December 10, 2019, we informed you that enforcement remedies were being imposed.

On December 2, 2019 this Department completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) as evidenced by the electronically attached CMS-2567, whereby corrections are required.

On December 5, 2019, this Department completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a survey completed on October 7, 2019 and it has been determined that your facility is not in substantial compliance. The deficiency(ies) not corrected is/are as follows:

F0561 -- S/S: E -- 483.10(f)(1)-(3)(8) -- Self-Determination
F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan
F0684 -- S/S: G -- 483.25 -- Quality Of Care
F0880 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control
F0881 -- S/S: F -- 483.80(a)(3) -- Antibiotic Stewardship Program

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required.

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 26, 2019 will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

As we notified you in our letter of October 28, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 13, 2019.

Enclosed is a copy of the CMS-2567 from these visits.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 7, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R-C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(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
{E 000}	Initial Comments An onsite revisit was conducted on December, 2, 3, 4, and 5th, 2019, to determine compliance with CMS Appendix Z Emergency Preparedness Requirements cited on October 3, 2019. The facility is now in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on December 2, 3, 4 and 5th, 2019, to follow up on deficiencies issued as a result of a recertification survey exited October 7, 2019. The facility was NOT found to be in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. In addition, the complaint investigation(s) found substantiated at the time of the recertification survey were reviewed for compliance. H5369075C and H5369077C with deficiencies at F760 were found to be corrected at the time of the revisit. H5369081C with deficiency at F725 was found to be corrected at the time of the revisit. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance	{F 000}	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R-C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	Continued From page 1 with the regulations has been attained in accordance with your verification.	{F 000}		
{F 561} SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess 2 of 3 residents (R11 and R43) for	{F 561}	1) Corrective Action: Residents R11 and R43 were interviewed	1/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R-C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

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{F 561}	Continued From page 2 bathing preference and frequency. Findings include: R11's Admission Record, identified an admit date of 3/7/18, with diagnoses of major depressive disorder, morbid obesity, type 2 diabetes mellitus, and chronic pain. R11's quarterly, Minimum Data Set (MDS), dated 9/30/19, identified R11 to have intact cognition and needed one-person physical assist with bathing. R11's care plan, revised 5/21/19, indicated bathing/showering, able to wash upper extremity (UE) with prepared cloth, extensive assist with lower extremities. Allow to complete as much as she can. Care plan lacks assistance needed with bathing, preference with showering/bathing, and does not identify how often resident would like a shower/bath. R11's plan of care (POC) response history identified R11 received bathing assistance on 11/20/19, 11/27/19, and 12/4/19. Facility bath schedule for Wing 4/5 identified R11 received bath/shower on Wednesday evening. Bathing schedule lacks information on resident preference for bathing/showering. During observation and interview on 12/4/19, at 10:23 a.m. R11 was seated in her wheelchair in the activity room. R11 stated she had a shower on Wednesday nights and stated she would like two a week. R11 stated she thought they charge you for an extra one though so she wouldn't want	{F 561}	on 12/17/19 and asked their bathing preference and frequency. Residents' Kardex and careplans were updated to reflect preference & frequency stated. 2) Corrective Action as it applies to all residents: All residents will be asked bathing preference and frequency. Information will then be added in their respective careplan, eMAR and POC (instruction and documentation area for nursing assistants) as indicated. Nursing assistant group sheets were updated with each resident's bathing preference and frequency. All nursing assistants will be trained on how to properly use the facility's whirlpool, training was completed on 12/20/19. Staff who are unable to attend the meeting, will have training prior to working the floor. 3) Date of Completion: 01/07/2020 4) Reoccurrence will be prevented by: All residents will be interviewed for preferences on admission via the Activity Interview for Daily & Activity Preferences Assessment and then updated annually and with significant change in condition. Preferences communicated with nursing staff as related to nursing care will be reflected in the care plan and eMAR and	

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{F 561}	Continued From page 3 that. R11 stated they never have asked me if I want more than one, she wouldn't mind having a bath once in a while too, she had one once and it felt so nice with the jets. R11 stated they just never offer me the bath. During interview on 12/4/19, at 2:11 p.m. nursing assistant (NA)-B stated she was contracted pool staff and was not sure if anyone down here gets a tub bath. NA-B stated she usually just gave showers. NA-B stated it did say on each resident's kardex what their preference was. Verified R11's kardex did not identify preference. NA-B stated she had not given a bath with this tub, and she was not quite sure how to work it, and no one had showed me yet. R43's Admission Record, identified an admit date of 6/26/19, with diagnoses of heart failure, morbid obesity, type 2 diabetes mellitus, and long term use of anticoagulants. R43's quarterly, Minimum Data Set (MDS), dated 9/30/19, identified R11 to have intact cognition and needed one-person physical assist with bathing. R43's care plan, revised 11/16/19, indicated bathing/showering, able to wash face with prepared cloth, extensive assist with all skin folds, under breasts and lower extremities. Encourage and allow resident to complete as much as possible. Give resident choices related to bathing vs shower. Time or day preference, or other personal requests. Care plan lacks how often resident would like a shower/bath and what her preference is.	{F 561}	POC as indicated. All Residents will be interviewed regarding preferences at quarterly care conferences and PRN as changes in condition occur. LSW or designee will audit for the completion of the Activity Interview for Daily & Activity Preferences assessment and for the preferences to be indicated in the plan of care, group sheet, and Kardex as indicated for all new admissions. Audits will be completed weekly for 1 month and then monthly for 3 months. Audits will be brought to the QAPI Committee for review. Facility will complete an audit for 100% of existing residents for plan of care, group sheet and Kardex to reflect bathing preferences. 5) Correction will be monitored by: LSW or designee; QAPI Committee	

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{F 561}	Continued From page 4 R43's kardex identified R43 preferred bathing. R43's plan of care (POC) response history identified R11 received bathing assistance on 11/16/19, 11/23/19, and 11/30/19. Facility bath schedule for Wing 4/5 identified R43 received bath/shower every Friday evening. Bathing schedule lacks information on resident preference for bathing/showering. During observation and interview on 12/4/19, at 10:18 a.m. R43 was seated in her wheelchair in the activity room. R43 stated, she had a shower on Friday nights, she would like more than one a week, and didn't know that was an option. R43 stated she would like a bath but they never offered that to me and she didn't know a bath was an option. During interview on 12/4/19, at 2:40 p.m. registered nurse (RN)-A stated she was the nurse manager of this unit, RN-A stated the only person she knew on this wing (golden oak) that would even like a bath was R40, but she was too afraid to go in the Hoyer to get her in the tub. During interview on 12/4/19, at 2:11 p.m. nursing assistant stated it did say on each resident's kardex what their preference was. NA-B verified R43's preference was a tub bath. NA-B stated she had not given a bath with this tub, and she was not quite sure how to work it, and no one had showed me yet. During interview on 12/4/19, at 2:16 p.m. the director of nursing (DON) verified their plan of correction was to complete an assessment on all	{F 561}		

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{F 561}	Continued From page 5 residents to identify a choice between tub bath and shower, but verified it did not identify bathing frequency on their activity preference assessment. The DON verified we should be asking about bathing frequency when assessing. The DON further verified there were only two residents in the building currently receive a bath twice a week. During interview on 12/4/19, at 3:22 p.m. the DON stated all residents should be appropriately assessed and their care plans should be updated to reflect a resident's choice with bathing whether it be a tub bath or shower and how many baths a resident would want a week. Facility policy, Quality of Life-Resident Self Determination and Participation, revised December, 2016, indicated, our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. 1. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plan of care, including: a. daily routine such as sleeping and waking, eating, exercise and bathing schedules.	{F 561}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	{F 656}		1/7/20

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{F 656}	Continued From page 6 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to develop a comprehensive care plan for 1 of 1 residents (R255) who was	{F 656}	1) Corrective Action: Resident R255 was reassessed for	

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{F 656}	Continued From page 7 observed to be smoking. Findings include: R255's Admission Record and diagnosis sheet included, R255 had been admitted to the facility for palliative care due to suffering malignant cancers of the brain and cervix. Additionally, the document indicated R255 had a diagnosis of nicotine dependence. During an interview on 12/4/19, 2:13 p.m. the director of nursing (DON) stated she was responsible to prepare for the needs of new admissions to the facility. The DON stated if a person was noted to have been a smoker prior to admission, she would let the nurse manager know that the new admit should have a smoking assessment done and information should be added to the baseline care plan and eventually the comprehensive care plan. The DON stated she was unaware that R255's care plan did not include any information about smoking. The DON stated she recalled, "Delegating to someone to get that done" for R255. R255's baseline care plan and comprehensive care plan failed to show that R255 continued to smoke after admission, nor were there any interventions listed to provide for on-going smoking safety/supervision or storage of smoking supplies. R255's smoking assessment was completed on 10/31/2019. The assessment noted R255 had some cognitive loss and dexterity problems, and indicated she was unable to light her own cigarette. No adaptive equipment was marked as	{F 656}	smoking safety and comprehensive care was updated to reflect resident's smoking safety and needs. 2) Corrective Action as it applies to other Residents: Facility smoking assessment policy was revised. No other residents currently smoke in the building. 3) Date of Completion: 01/07/2020 4) Re-occurrence will be prevented by: All residents will have Comprehensive Person Centered Care Plan developed by day 21 following admission that will include measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs identified in the comprehensive assessment in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being. Comprehensive Care Plan review will be completed with changes in resident needs or goals by staff nurses and Nurse Managers and with the MDS quarterly and with significant change in condition. DON or designee will audit 10% of Comprehensive Care Plans weekly for 1 month, then monthly for 3 months and	

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{F 656}	Continued From page 8 being required. The conclusion of the assessment was "safe to smoke with supervision." According to an interview with R255 on 12/3/19, 1:37 p.m. she stated she was aware of a facility no-smoking policy but that she did smoke, and planned to continue to smoke. R255 was able to relate that she was unable to smoke on the facility grounds and therefore had been directed to "go across the street" to smoke. On 12/4/19, 12:50 p.m. R255 was observed to don winter attire, request her smoking materials from the nurse, sign herself out, exit the facility, light her cigarette while walking across the street. She crossed the street safely, smoked her cigarette, extinguished it by throwing it on the ground by the curb and stepping on it. R255 then walked back and re-entered the facility. Aside from the litter, no problem was observed, resident was safe. No facility staff were in attendance or observed to be supervising R255's smoking. During the survey, on 12/5/19 a new smoking assessment was entered in R255's EHR indicating she was safe to smoke without supervision. R255's care plan was also updated on 12/5/19 indicating she would like to smoke, but her cigarettes and lighter would be stored at the nurses' station and she would be monitored for appropriate clothing choices related to the weather. In addition, the care plan indicated she would be reassessed for smoking safety every quarter and as needed. The St. Marks Living Tobacco Use Policy dated	{F 656}	share the results with the QAPI Committee. 5) Correction will be monitored by: DON or designee; QAPI committee	

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{F 656}	Continued From page 9 10/21/19, indicated the facility environment, the buildings and grounds, would be free from all tobacco products. The policy also indicated residents who were active smokers would be assessed for mobility to smoke safely and to leave the grounds. The policy stated staff would not assist residents in smoking or getting off campus grounds. The policy failed to indicate frequency of assessments, provisions for safety should a resident insist on smoking, or expectations related to care plans for persons who smoke.	{F 656}		
{F 684} SS=G	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: Based on observation, interview and record review, facility failed to follow physician orders for 1 of 1 residents (R251) observed for wound care. Findings include: R251 according to the electronic health record (EHR) Admission Record and diagnosis sheet had an unspecified open wound of the abdominal wall. R251's EHR physician's orders included an order	{F 684}	1) Corrective Action: All licensed nursing staff educated on the process to ensure wound care is completed per MD orders. Staff person involved in the treatment was re-educated on the process for this resident's wound care and completed a new wound care competency to ensure he has the knowledge, skills and abilities to complete wound care per orders.	1/7/20

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{F 684}	Continued From page 10 dated 11/26/19 outlining the following wound care: "Cleanse wound to abdominal incision with NS (normal saline, an isotonic salt solution), soak kerlix (a type of roller gauze) in NS, apply to wound base, cover with ABD pad (a large absorbent surgical dressing which pulls moisture away from the wound) and secure with tape AM for abdominal surgical wound every day shift for prevent infection." An additional order dated 10/28/19 indicated the following: "Cover old stoma site to left abdomen with ABD pad, secure with tape till healed, every day until healed, every day shift..." During an observation 12/04/19, 10:03 a.m. a registered nurse (RN)-A was providing wound care to R251 in the company of a registered nurse consultant (RNC)-A. RN-A stated he was going to check the physician's orders before going to R251's room. When RN-A entered the room he stated he had washed his hands prior to coming to the room. He then applied a pair of exam gloves in preparation for providing cares. RN-A stated he would not be able to set up his supplies on the over bed table which was filled with R251's personal items. RN-A pushed aside items on a counter near the foot of the bed, and took a packaged dressing from a drawer under the counter. RN-A then removed a pair of bandage scissors from his pocket with his gloved hands. RN-A stated he had to clean the scissors, but would prefer they had been in a package or something so he would know they were clean. He removed an alcohol pad from his pocket, wiped off the scissors, and laid them on top of the packaged dressing. RN-A then laid the blankets back from the resident and exposed the abdomen. A large ABD pad was taped to the	{F 684}	2) Corrective Action as it applies to other Residents All licensed nursing staff educated on the process to ensure wound care is completed per MD orders. Staff person involved in the treatment was re-educated on the process for this resident's wound care and completed a new wound care competency to ensure he has the knowledge, skills and abilities to complete wound care per orders. 3) Date of Completion: 01/07/2020 4) Recurrence will be prevented by: All licensed nursing staff received competency testing on completing wound care per provider orders and following infection control standards during the completion of wound care. Observational audits of one staff person completing wound care per provider orders and infection prevention standards are being completed weekly for 1 month and then monthly for 3 months. Will follow QAPI recommendations for further continued auditing. 5) Correction will be monitored by: DON or designee, QAPI Committee	

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{F 684}	Continued From page 11	{F 684}		

middle of the abdomen and a smaller, occlusive dressing (adhesive dressings which are generally meant to stay in place for several days and hold moisture next to the wound) was observed to be in place on the lower left abdomen. RN-A stated he had done the dressing change the day before and had written the date and his initials on both dressings. RN-A further stated the dressing on the lower left abdominal area did not need to be changed daily, they just looked at it "once in a while." R251 stated she had had an abscess (accumulation of infected fluid within the tissues) in that area that had been drained. RN-A was not able to describe what type of wound was under the occlusive dressing. RN-A removed the ABD pad over the midline incision wound exposing two other occlusive dressings, square in shape, one on top of the edge of the other, under the ABD and adhered to the skin surrounding the wound. RN-A stated they had been using that type of dressing before, but said the order must have recently been changed. He then removed both of the occlusive dressings over the middle abdomen exposing the wound. The wound had some gauze which was damp and colored lightly with drainage which RN-A removed from the wound. The wound was observed to be a large, open incisional wound extending up the midline of the abdomen with signs of healing, but also with some white slough (dead) tissue at the bottom of the wound and a dark central area about the size of a dime. RN-A disposed of the wound dressings and removed his gloves. He then applied fresh gloves without hand washing or hand sanitizing. He then took a zip-lock bag from the drawer with a roll of kerlix in it, took the kerlix out and cut a length which he held in his left hand, and took a container of NS solution,

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{F 684}	Continued From page 12 opened the container and poured NS over the gauze in his hand, allowing it to run into a trash can on the floor. He then needed to get a cotton tip swab which was in the drawer so reached into the drawer to get a box of swabs, set them on the bed, took out one packet which he opened. RN-A then placed the kerlix into the wound and proceeded to pack it into the opening with the swab. Following the packing, RN-A opened and applied that ABD to the wound, and taped it in place. He then covered the abdomen, pulled up the blankets and removed his gloves. Without having washed or sanitized his hands, he carried the trash to the resident's door, opened the door touching the handle on the inside, handle on the outside, the door itself and proceeded down the hall to place the trash in a dirty utility room. RN-A was observed to touch his chest, the side of his pants, put his soiled hands inside his pocket before he walked to a dispenser of alcohol-based sanitizer. During an interview on 12/04/19, 10:30 a.m. RNC-A stated RN-A had missed several opportunities for hand hygiene during the dressing change, and she noticed RN-A had not cleansed the wound following removal of the soiled dressing. She stated that according the physician's order, the wound was to be cleansed with NS prior to applying the moist packing. She also stated the order did not include the application of an occlusive dressing to cover the incisional area. RNC-A also said she was going to look into care of the wound on the lower left abdomen as the orders were not clear. RNC-A stated she expected the nurse manager to review resident orders to be sure they are written more precisely.	{F 684}		

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{F 684}	Continued From page 13 During an interview on 12/4/19, 2:52 p.m. the director of nursing (DON) stated RN-A had previously been competency tested along with the other nurses. She stated an expectation for nurses to follow physician orders as written and to practice proper hand hygiene during wound care including each time gloves are removed and after completion of cares. The Wound Care policy dated as MED-PASS Inc. 2001, revised October 2010 indicated a nurse should verify the physician order and assemble the equipment and supplies as necessary. Nurse should use disposable cloths to establish a clean field and place all items to be used during the procedure on the clean field. Prior to the procedure the policy indicated hands should be washed and dried thoroughly before gloves are applied. After removal of the dressing, the policy indicated gloves should be removed and hands washed again. The policy described steps to take for irrigation and for cleansing around the wound, but fails to clearly describe how to cleanse any given wound. Following the dressing of the wound, the policy instructs nurses to dispose of supplies, clean the area and wash hands after glove removal.	{F 684}		
{F 880} SS=F	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.	{F 880}		1/7/20

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ST MARKS LIVING	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

(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 880}	Continued From page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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.	{F 880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 880}	Continued From page 15 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to follow standard infection control practices for 1 of 1 residents (R251) observed during wound care. Findings include: R251 according to the electronic health record (EHR) Admission Record and diagnosis sheet had an unspecified open wound of the abdominal wall. R251's EHR physician's orders included an order dated 11/26/19 outlining the following wound care: "Cleanse wound to abdominal incision with NS (normal saline, an isotonic salt solution), soak	{F 880}	1) Corrective Action: The nurse cited with incorrect technique counseled and educated on appropriate Infection Control Technique by completing additional return demonstration to show competence. All licensed nursing staff educated via competency testing on the process to ensure wound care is completed per provider orders and using appropriate infection control standards. 2) Corrective Action as it applies to other Residents	

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{F 880}	Continued From page 16 kerlix (a type of roller gauze) in NS, apply to wound base, cover with ABD pad (a large absorbent surgical dressing which pulls moisture away from the wound) and secure with tape AM for abdominal surgical wound every day shift for prevent infection." During an observation 12/04/19, 10:03 a.m. a registered nurse (RN)-A was providing wound care to R251 in the company of a registered nurse consultant (RNC)-A. When RN-A entered the room he stated he had washed his hands prior to coming to the room. He then applied a pair of exam gloves in preparation for providing cares. RN-A stated he would not be able to set up his supplies on the over bed table which was filled with R251's personal items. RN-A pushed aside items on a counter near the foot of the bed, and took a packaged dressing from a drawer under the counter. RN-A then removed a pair of bandage scissors from his pocket with his gloved hands. RN-A stated he had to clean the scissors, but would prefer they had been in a package or something so he would know they were clean. He removed an alcohol pad from his pocket, wiped off the scissors and laid them on top of the packaged dressing. RN-A then laid the blankets back from the resident and exposed the abdomen. A large ABD pad was taped to the middle of the abdomen, along with two occlusive dressings which RN-A removed exposing the wound. RN-A then removed some soiled kerlix gauze from the wound. The wound was observed to be a large, open incisional wound extending up the midline of the abdomen with signs of healing, but also with some white slough (dead) tissue at the bottom of the wound and a dark central area about the size of a dime. RN-A	{F 880}	The nurse cited with incorrect technique counseled and educated on appropriate Infection Control Technique by completing additional return demonstration to show competence. All licensed nursing staff educated via competency testing on the process to ensure wound care is completed per provider orders and using appropriate infection control standards. 3) Date of Completion: 01/07/2020 4) Recurrence will be prevented by: DON or designee will audit wound care via observation once weekly for 1 month and then once monthly for 3 months. Audit results will be shared with the QAPI Committee. 5) Correction will be monitored by: DON or designee, QAPI Committee	

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{F 880}	Continued From page 17	{F 880}		

disposed of the wound dressings and removed his gloves. He then applied fresh gloves without hand washing or hand sanitizing. He then reached into a drawer contaminating his gloves, took a zip-lock bag from the drawer with a roll of kerlix in it, took the kerlix out and cut a length which he held in his left hand, and took a container of NS solution, opened the container and poured NS over the gauze in his hand, allowing it to run into a trash can on the floor. He then needed to get a cotton tip swab which was in the drawer so reached into the drawer with his contaminated gloves to get a box of swabs, set them on the bed, took out one packet which he opened. RN-A then placed the kerlix into the wound and proceeded to pack it into the opening with the swab. Following the packing, RN-A opened and applied the ABD to the wound, and taped it in place. He then covered the abdomen, pulled up the blankets and removed his gloves. Without having washed or sanitized his hands, he carried the trash to the resident's door, opened the door touching the handle on the inside, handle on the outside, the door itself and proceeded down the hall to place the trash in a dirty utility room. RN-A was observed to touch his chest, the side of his pants, put his soiled hands inside his pocket before he walked to a dispenser of alcohol-based sanitizer.

Immediately following the observation of wound care, RN-A was interviewed about hand hygiene. He said he should wash hands before touching a resident, and in-between the care of residents. RN-A stated it was hard to do adequate hand hygiene in the facility as they did not have sinks for staff use or alcohol based cleanser available. RN-A stated he had not recognized that he had

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{F 880}	Continued From page 18	{F 880}		

touched the door and doorknobs with contaminated hands, and stated he had not thought of disinfecting them after he had touched them. RN-A also said it was hard to find enough time to accomplish cleaning given the time allowed for cares. He also confirmed he should have created a clean area to set up the wound care supplies.

During an interview 12/04/19, 10:30 a.m. RNC-A stated RN-A had missed several opportunities for hand hygiene during the dressing change, and she noticed RN-A had not cleansed the wound following removal of the soiled dressing. RNC-A said the facility did not have a policy restricting the use of sinks in resident rooms if nothing else was available for hand-washing, and also stated alcohol based sanitizers are available and can be placed in with resident wound care supplies.

During an interview on 12/4/19, 2:52 p.m. the director of nursing (DON) stated RN-A had previously been competency tested along with the other nurses. She stated an expectation for nurses to follow physician orders as written and to practice proper hand hygiene during wound care including each time gloves are removed and after completion of cares.

The Wound Care policy dated as MED-PASS Inc. 2001, revised October 2010 indicated a nurse should verify the physician order and assemble the equipment and supplies as necessary. Nurse should use disposable cloths to establish a clean field and place all items to be used during the procedure on the clean field. Prior to the procedure the policy indicated hands should be washed and dried thoroughly before gloves are

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{F 880}	Continued From page 19 applied. After removal of the dressing, the policy indicated gloves should be removed and hands washed again. The policy described steps to take for irrigation and for cleansing around the wound, but fails to clearly describe how to cleanse any given wound. Following the dressing of the wound, the policy instructs nurses to dispose of supplies, clean the area and wash hands after glove removal.	{F 880}		
{F 881} SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to fully operationalize an antibiotic stewardship program in which antibiotic use would be monitored and analyzed for appropriate and effective use to prevent antibiotic resistance. The deficient practice had the potential to effect all residents who reside in the facility Findings include: According to the facilities plan of correction (POC) from their annual 2019 survey, the POC indicated the facility would be "implementing the use of software ABX Tracker on 11/14/19 to establish and maintain an Antibiotic Stewardship	{F 881}	1) Corrective Action: No individual resident cited in this area. 2) Corrective Action as it applies to all Residents: Facility implemented the use software ABX Tracker on 11/14/2019 to establish and maintain an Antibiotic Stewardship Program. Licensed Nursing staff were retrained on their responsibilities for antibiotic stewardship and as it relates to use of ABX tracker.	1/7/20

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{F 881}	Continued From page 20 Program. The software is designed to establish protocols and a system to monitor antibiotic use, create a mode of documentation, investigation outbreak management and surveillance of infections and antibiotic use." Furthermore, the facility designated a date of 11/18/2019 to have Nurse Managers responsible for auditing antibiotic entry and follow-up by ABX Tracker Daily ...DON or designee will audit the use of ABX Tracker for completion and accuracy once weekly for 1 month and then monthly for 3 months ..." According to record review and interview on 12/4/19, at 2:19 p.m. the director of nursing (DON) demonstrated the new computer application, ABX Tracker, the facility had started using and stated, "it's (the antibiotic stewardship program) in several bits and pieces." The DON stated the nurse managers had been introduced to the computer software, but had not yet been utilizing it. The DON stated she had been responsible to enter the names of residents confirmed to have been diagnosed with an infection requiring an antibiotic. This created a line listing of names, types of infections and types of antibiotics; however, DON stated, "there are more functions I haven't used." The DON stated they were not entering the information about residents who had symptoms of infection, but were not yet diagnosed or prescribed antibiotics even though the ABX Tracker did have a "watch and wait" section for such tracking. The software was observed to allow the facility to enter lab and microbiology data related to the infection and to testing for antibiotic resistance. Such lab/microbiology and sensitivity information was not observed to have been entered into the	{F 881}	Facility is actively seeking an Infection Control Nurse to fill the open position. In the interim, DON or designee will be assigned the duties of the Infection Preventionist. All residents with symptoms of infection will be entered into ABX Tracker to ensure appropriate stewardship and surveillance. 3) Date of Completion: 01/07/20 4) Reoccurrence will be prevented by: Nurse Manager or designee will be responsible for auditing antibiotic entry and follow-up by using ABX Tracker daily. Infections will be reviewed and discussed at daily standup meeting with the IDT to ensure appropriate interventions are in place. DON or designee will audit the use of ABX Tracker for completion and accuracy once weekly for 1 month and then monthly for 3 months. Results will be shared with the QAPI Committee. 5) Correction will be monitored by: DON or Designee, QAPI Committee	

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{F 881}	Continued From page 21 software. The DON demonstrated the ABX Tracker would allow the entry of "posts" where any findings, actions or analysis could be documented; however, the DON confirmed they had not yet begun to document such information. The DON stated they would discuss infections during their morning meeting, but confirmed the information was not documented to allow for the tracking of trends, appropriate antibiotic use or to allow for benchmarking, summative assessment or analysis of antibiotic use, ordering patterns and effectiveness in preventing antibiotic resistant infections within the facility. A request was made for antibiotic sensitivity reports to show microbiology reports had been reviewed for appropriate antibiotic prescribing. According to an Email sent 12/6/19, the DON wrote, "Although our ABX tracker program has the capability to print off antibiotic sensitivity reports I do not have one available for November as I did not enter the information into the system." The Antibiotic Stewardship policy dated as "2001 MED-PASS, Inc. (Revised December 2016) was provided. While the policy calls for staff education for the appropriate use of antibiotics, and orders to include information about side effects, the policy fails to include antibiotic use protocols or provide a system for monitoring resident outcomes. The policy also does not provide a plan for reducing antibiotic resistance through tracking and monitoring antibiotic types, length of therapy or review of patterns of prescribing; nor does the policy indicate a program for analysis of facility antibiotic use for performance improvement.	{F 881}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6O8Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00394

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245369**

2.STATE VENDOR OR MEDICAID NO.
(L2) **055842700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MARKS LIVING**
(L4) **400 - 15TH AVENUE SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/07/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **61** (L18)
13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 11/22/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/09/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 28, 2019

Administrator
St. Marks Living
400 - 15th Avenue Southwest
Austin, MN 55912

RE: CCN 245369
Cycle Start Date: October 7, 2019

Dear Administrator:

On October 7, 2019, survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 26, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 26, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 26, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC was the NATCEP trigger)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 26, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Marks Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 26, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731 Fax: (507) 206-2711

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 7, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

(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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 9/30/19 through 10/4/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an	E 009		11/18/19

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

Electronically Signed | 11/05/2019

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E 009	Continued From page 1 emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include a process for cooperation, collaboration and contacts with local, regional, state, and federal emergency preparedness officials' efforts for participation in collaborative planning efforts in their emergency plan. This had the potential to affect all 55 current residents of the facility. Findings include: In review of the facility's Emergency Disaster Plan dated September 2019, the facility failed to include a process for cooperation, collaboration, and to make any contacts with regional, state, and federal emergency preparedness officials' to maintain an integrated response during a disaster or emergency situation. There was no indication of the facility's efforts to contact such regional, state or federal officials for participation in a collaborative and cooperative effort in their emergency plan. During interview on 10/4/19, at 11:34 a.m. the administrator stated she thought this meant public health, so we got the fire department and police involved in our plan. The administrator verified the facility had not attempted to contact regional, state or federal officials.	E 009	By 11/1/19, the disaster plan manual will be reviewed internally by the Executive Director. By 11/8/19 the disaster plan will be sent to the local authorities for review and approval. All residents have the potential to be affected by the deficient practice. The annual review of the Emergency Disaster Plan with our local authorities will be put on our electronic preventive maintenance program TELS, which will annual notify us it is time to have the emergency preparedness binder reviewed. The Executive Director, Environmental Services Director or designee will bring the disaster manual to the November 2019 QAPI meeting to show that the manual has been reviewed, updated and approved. The plan will be reviewed annually thereafter.	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 030		11/18/19

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E 030	Continued From page 2 and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees.	E 030		

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E 030	Continued From page 3 (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility's communication plan failed to include all required information including names and contact information for the following: patients' physicians. This had the potential to affect all residents currently residing in the facility. Finding include: In review of the facility's Emergency Disaster Plan dated September 2019, revealed the plan did not include a list of residents' individual physicians. On 10/4/19, at 9:55 a.m. the administrator stated	E 030	On 11/1/19, the Emergency Disaster Plan was updated to include the location of all resident□s primary medical providers/physicians contact information which is available for access at each nurses station and in the resident□s medical record. All residents have the potential to be affected by the deficient practice. This update in the Emergency Disaster Plan to identify the location of residents□ medical provider/physician contact	

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E 030	Continued From page 4 the plan included the phone numbers for the medical director and nurse practitioner. The administrator verified the plan did not include individual physician for the residents, stated the plan would be difficult to be maintained as the transitional care unit residents had their own physicians from the community, and were not assigned facility physicians.	E 030	information will be reviewed annually as electronically triggered in our preventative maintenance TELS system. The Executive Director, Environmental Services Director or designee will bring the disaster manual to the November 2019 QAPI meeting to show that the manual has been reviewed, updated and approved. The plan will be reviewed annually thereafter.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local	E 031		11/18/19

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E 031	Continued From page 5 emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Disaster Plan included contact information for federal, tribal and regional emergency preparedness staff. This had the potential to affect all 55 residents currently residing in the facility. Findings include: The facility's emergency preparedness plan was reviewed with the administrator. The plan-included components of a communication plan however, lacked documentation of contact information for federal, tribal, regional emergency preparedness staff. On 10/4/19, at 12:12 p.m. the administrator verified this information.	E 031	On 11/1/19, the contact information for the federal, tribal and regional emergency preparedness staff was added to the Emergency Disaster Plan. All residents have the potential to be affected by the deficient practice. The contact information of federal, tribal and regional emergency preparedness staff will be added to the Emergency Disaster Manual and will be reviewed annually as electronically triggered in our preventative maintenance TELS system. The Executive Director, Environmental Services Director or designee will bring the disaster manual to the November 2019 QAPI meeting to show that the manual has been reviewed, updated and approved. The plan will be reviewed annually thereafter.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 032		11/18/19

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E 032	Continued From page 6 (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Disaster Plan addressed primary and alternative means of communication with during an emergency. This had the potential to affect all 55 residents currently residing in the facility. Findings include: The facility's emergency disaster plan was reviewed with the administrator and revealed the communication plan lacked procedures addressing primary and alternative means of communication with Federal, State, tribal, regional, and local emergency management agencies during an emergency. During interview on 10/4/19 at 2:48 p.m., the administrator verified this information.	E 032	On 11/1/19, a Primary and Alternative Communication plan to use during an emergency was created and added to the Emergency Disaster Plan. All the residents have the potential to be affected by the deficient practice. A review of the emergency disaster plan including review of the Primary and Alternative Communication Policy within the plan will be put on our electronic preventive maintenance program TELS, which will trigger an annual reminder to review the emergency disaster manual including the policy on Primary and Alternate Communication in an Emergency. The Executive Director, Environmental Services Director or designee will bring the disaster manual to the November 2019 QAPI meeting to show that the Primary and Alternate Communication policy has been added to the Emergency plan and then reviewed annually thereafter.	

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E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their communication plan included a means of providing information about the facility's occupancy, needs, and ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This deficient practice had the potential to affect all 55 residents currently residing in the facility.	E 034	By 11/8/19, a profile of the resident population with their conditions plus authority to communicate bed availability will be added to the Emergency Disaster Plan and will be made available to Emergency personnel and/or Incident Command Center in the event of a disaster. All the residents have the potential to be	11/18/19

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E 034	Continued From page 8 Findings include: A review of the facility's Emergency Disaster Plan dated September 2019 revealed the plan did not address providing information about the facility's occupancy, needs and ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. On 10/4/19, at 12:17 p.m. the administrator verified this information.	E 034	affected by the deficient practice. A review of the emergency disaster plan including a resident profile with conditions plus authority to communicate bed availability within the plan will be put on our electronic preventive maintenance TELS program, which will trigger an annual reminder to review the emergency disaster plan including a review of the resident profile. The Executive Director, Environmental Services Director or designee will bring the disaster manual to the November 2019 QAPI meeting to show that a resident profile has been added to the Emergency Disaster plan. The plan will be reviewed annually thereafter.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Disaster Plan (EDP) included a method for sharing	E 035	On 11/1/19, a policy was created to communicate emergency disaster preparedness information with residents	11/18/19

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E 035	Continued From page 9 information the facility had determined appropriate, with residents and their families or representatives. This had the potential to affect all 55 residents residing in the facility and their families/representatives. Findings include: In review of the facility's EDP dated September 2019, there was no indication the facility had a system in place to share information with clients and their families or representatives. On 10/4/19, at 12:16 p.m. the administrator confirmed the facility had not determined the information deemed appropriate to share with residents and their families/representatives and had not established a method to share information regarding the facility's EDP with the clients and their families or representatives.	E 035	and their families and was added to the Emergency Disaster Plan. On 11/18/19, a resident meeting will be held to review the emergency disaster preparedness plans with residents. All residents and responsible parties/POA□s will also receive a letter instructing them on where to locate The Emergency Preparedness Manual which will be available for review on there own or with a member of the management team. All the residents have the potential to be affected by the deficient practice. A review of the Emergency Disaster Manual including review of the Resident and Family Communication Policy within the plan will be put on our electronic preventive maintenance program TELS. TELS will trigger an annual reminder to review the Emergency Disaster manual including the policy on Resident and Family Communication. Along with the annual review of the Emergency Disaster Manual, we will add information on the Emergency Disaster Plan to the admission packet with an acknowledgment sign off form for all new residents admitting to the facility. The Executive Director, Environmental Services Director or designee will bring the resident sign in sheet and ;updated Emergency Disaster Manual to the November 2019 QAPI meeting to show that the resident meeting has been completed. Communicating emergency	

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E 035	Continued From page 10	E 035	disaster policies with residents and families has been added to the emergency disaster manual and this policy will be reviewed annually going forward to ensure the resident and family have received the information on emergency disaster preparedness.	
F 000	INITIAL COMMENTS On 9/30/19 through 10/07/19, a standard survey was completed at your facility by the Minnesota Department of Health. A complaint investigation was also conducted. St. Mark's Living was found not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were substantiated: H5369075C and H5369077C with deficiency at F760 H5369076C, H5369079C and H5369082C with no associated deficiency, H5369081C; deficiency at F725 The following complaints were not substantiated: H5369078C, H5369080C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipts of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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F 000	Continued From page 11 regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to complete a self-administration of medication (SAM) assessment, for 1 of 4 resident (R10) reviewed for medication administration. Findings include: During an interview on 9/30/19, at 4:47 p.m. R10 stated except for one nurse, staff leave the applesauce and some water in 2 separate containers and R10 then takes her medication slowly. During observation on 10/1/19, at 9:56 a.m. R10 was seated in her recliner in her room. R10's pills were observed in a medication cup in front of her on her lap table. R10 was noted to be taking her pills one at a time, with no supervision. R10's quarterly Minimum Data Set (MDS) assessment dated 7/14/19, indicated R10 was cognitively intact and required set up assistance with eating. R10's Admission Record, identified diagnoses of heart failure, anxiety disorder and weakness.	F 554	1. Corrective Action: R10 was assessed for competency of self administration of medications on 10/2/2019. It was determined that she was competent to self administer medication, which medications and her preferred method. Care plan, and eMAR were updated to reflect the self administration preferences. 2. Corrective Action as it applies to other Residents: All residents who request self administration of medications will be assessed to determine competency and preferences. Care plan and eMAR will be updated to reflect the self administration including the medication and method. Self administration of medications will be assessed for the residents who wish to self administer upon admission, quarterly and with significant change of condition. Care plan and eMAR will be updated to reflect preferences.	11/18/19

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F 554	Continued From page 12 R10's care plan revised 7/24/19, identified a focus of activity of daily living (ADL) self-care performance deficit related to impaired mobility and arthritis ...Goal: will maintain current level of function ...intervention: is able to feed self and prefers to eat in her room. During observation and interview on 10/2/19, at 10:23 a.m. licensed practical nurse (LPN)-C prepared R10's morning medications in a medication cup, with a small plastic glass of applesauce, and was observed to spoon fed R10 the applesauce with the medications. R10 stated, the others leave the pills with the applesauce and I take them. LPN-C said, " I cannot leave the pills with you." During a follow up interview on 10/2/19, at 2:07 p.m. R10 stated, "I usually get my pills in a cup, the nurse brings them in and leaves them here with some applesauce so to take them at my own pace." During interview on 10/2/19, at 2:30 p.m. the director of nursing (DON) verified R10 had not had a SAM assessment completed. Although the facility's policy for SAM assessments was requested, it was not received.	F 554	3. Date of Completion: 11/18/2019 4. Recurrence will be prevented by: Licensed Nursing personnel will be educated on the Self Administration of Medications Assessment and policy at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/2019. DON or designee will audit all new admissions for need and completion of assessment of self administration of medications to determine if appropriate interventions are listed in the care plan and eMAR. Audits will be completed weekly for 1 month and then monthly for 3 months. 5. Correction will be monitored by: DON or designee. QAPI Committee	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		11/18/19

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F 561	Continued From page 13 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to verify resident choices for bathing, wake-up and bedtime times and medication administration for 4 of 4 residents (R32, R40, R151, R10) reviewed for choices. The findings include: R32 During an interview on 9/30/19, at 6:50 p.m. R32 stated the facility did not give him a choice on when he gets up in the morning and had to go to bed when staff told him he had to. R32 also	F 561	F561 1.Corrective Action: Residents R32, R40, R151, and R10 were interviewed by 11/6/2019 to determine preferences via the Activity Interview for Daily & Activity Preferences assessment. Residents care plans updated to reflect their preferences for activities and cares. POC and eMAR updated to reflect preferences. 2. Corrective Action as it applies to other Residents:	

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F 561	Continued From page 14 stated he could not have showers or baths because of the external fixator on his left leg, and would only get bed baths when it was convenient for facility staff to give him one. R32 stated he had never refused to bathe. R32's facility Admission Record dated 10/2/19, indicated R32 was admitted to the facility on 8/30/19, with diagnoses of fracture of left tibia, cellulitis and sepsis diagnosis added on 9/17/19. R32's admission Minimum Data Sheet (MDS) dated 9/6/19, indicated R32 did not have cognitive impairment and did not have rejection of care behaviors. The MDS also indicated R32 thought it was very important to choose his own bedtime and very important to choose between a tub bath, shower, bed bath, or sponge bath. The MDS also indicated R32 required extensive assistance from two or more staff for toileting and transfers, and extensive assistance from one staff for bed mobility and dressing. The MDS also indicated bathing did not occur during the assessment period. R32's care plan dated 9/20/19, and Kardex printed on 10/4/19, did not identify R32's bathing preferences and/or preferences to wake up or bedtimes. During an interview on 10/2/19, at 12:01 p.m. nursing assistant (NA)-H stated resident bath days were written on a calendar in a binder kept at the nurses station. NA-H walked over to the nurse's station and was unable to locate the binder. NA-H was not aware of when R32 received his bath/shower, and was not aware of what time R32 preferred to get up in the morning or go to bed at night.	F 561	All residents will be interviewed via the Activity Interview for Daily & Activity Preferences and the information will be added in their respective care plan, eMAR. and POC (instruction and documentation area for nursing assistants) as indicated. 3. Date of Completion: 11/18/2019 4. Re-occurrence will be prevented by: Activities staff, and LSW educated on the Activity Interview for Daily and Activity preferences assessment and procedure on 10/30/2019. All residents will be interviewed for preferences on admission via the Activity Interview for Daily & Activity Preferences Assessment and then updated annually and with significant change in condition. Preferences communicated with nursing staff as related to nursing care will be reflected in the care plan and eMAR and POC as indicated. All Residents will be interviewed regarding preferences at quarterly care conferences and PRN as changes in condition occur. LSW or designee will audit for the completion of the Activity Interview for Daily & Activity Preferences assessment and for the preferences to be indicated in the plan of care, eMAR, and POC as indicated. Audits will be completed weekly for 1 month and then monthly for 3	

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F 561	Continued From page 15 During an interview on 10/2/19, at 12:05 p.m. NA-G was not able to find the bath/shower binder. NA-G stated residents were asked upon admission their shower preference and/or the shower/bath was assigned based on resident room number. NA-G stated to his knowledge R32 had not received a shower/bath since admission. NA-G stated since the residents were short term on the unit, every morning staff would go into their room and ask if the residents wanted to get out of bed, he would ask them "on the fly". During an interview on 10/2/19, at 12:06 p.m. registered nurse (RN)-B stated R32 received a shower this morning; a plastic bag was placed over the external fixator. RN-B stated she was not aware if R32 had received a shower. During an interview on 10/2/19, at 12:33 p.m. RN-C stated residents were asked upon admission if they preferred bed bath, shower, or sponge bath and if they wanted their bathing choice in the morning or evening. RN-C indicated residents were not asked preferences in frequency and the facility did not use a form where preferences were recorded. RN-C indicated the facility assessments did not address what time residents preferred to get up and/or go to bed. RN-C indicated ideally the information should be on the care plan or Kardex. RN-C reviewed R32's care plan and confirmed the care plan did not address preferences for bathing or wake/go to bed times. R40 During an interview on 10/4/19, at 8:29 a.m. R40 sat on her bed. R40 stated she preferred tub	F 561	months. Audits will be brought to the QAPI Committee for review. 5. Correction will be monitored by: LSW or designee QAPI Committee	

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baths and loved to sit in the whirlpool tub because it feels so good. R40 stated she has not gotten to take baths, and that staff put her in the shower without asking her what her preference was. R40 indicated there was one girl who was good about getting her to the bath, but she needed another person to help. R40 stated "it's too hard to get me into the tub", and they (nursing staff) don't put me in the tub because there isn't enough staff. "It's hard to get me in the bathtub", and stated there was not enough staff to help R40. R40 stated she was only bathed once per week, that was all the facility offered, and has been told she could not have anymore a week. R40 indicated that she would like at least one more bath a week.

R40's annual Minimum Data Set (MD) dated 9/10/19, indicated R40 did not have cognitive impairment and did not have rejection of care behaviors. The MDS indicated R40 required extensive assistance from two or more staff for transfers and was dependent on two staff members for bathing. The MDS also indicated R40 thought it was somewhat important to have a choice between tub baths, sponge baths, and showers.

R40's care plan dated 8/19/19, included R40 required extensive assistance from one staff for showers weekly and as needed.

R40's progress note dated 9/29/19, at 10:32 a.m. included "Shower was given."

During an interview on 10/4/19, at 10:48 a.m. registered nurse (RN)-E stated bath days were determined by a combination of things; facility now used preference interview and was previously based on room number. RN-E

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indicated staff try the best they can to accommodate. RN-E indicated R40 should be given a tub bath per her request and not a shower; and staff should accommodate her request for two baths a week.

R151

During an interview 9/30/19, at 3:50 p.m. R151 sat in a wheelchair in her room. R151 stated she has not been offered a choice in frequency of bathing, stated she would like at least two showers a week. R151 indicated she could not have a tub bath because of the incision on her hip; and has only had one shower since admission. R151 stated she had not refused staff offers of showering.

R151's facility Admission Record dated 10/4/19, indicated R151 was admitted to the facility on 9/13/19, with diagnosis of displaced fracture of the base of left femur and obesity.

R151's admission Minimum Data Set (MDS) dated 9/20/19, indicated R151 did not have cognitive impairment and did not have rejection of care behaviors. The MDS indicated it was very important to R151 to have a choice between tub bath, shower, bed bath, or sponge bath. The MDS also indicated R151 required extensive assistance from one person for toileting, dressing, and personal hygiene and R151 was not bathed during the assessment period.

R151's scheduled MDS dated 9/25/19, indicated R151 required assistance for bathing.

R151's baseline care plan dated 9/15/19, did not identify bathing preferences, or specify type of

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bathing (shower, tub bath, sponge bath).

R151's care plan dated 9/20/19, did not identify a bathing frequency or specify type of bathing.

R151's Kardex dated 10/4/19, included "bathing in the evening", however did not identify type of bathing and did not identify a bathing frequency.

R151's record did not identify when R151 had been given a shower and lacked documentation R151 had refused any bathing.

During an interview on 10/2/19, at 12:04 p.m. nursing assistant (NA)-G indicated resident bathing days were written on a calendar; in some cases the bath day corresponded with the resident's room number. NA-G stated R151 was supposed to bathed Tuesday evenings. NA-G stated if a resident refused bathing then it should be documented, and the nurse was supposed to be made aware.

During an interview on 10/2/19, at 12:05 p.m. registered nurse (RN)-C stated residents were asked upon admission if the preferred bed bath, shower, or sponge bath and if they wanted their bathing choice in the morning or evening. RN-C indicated residents were not asked preferences in frequency and the facility did not use a form where preferences were recorded. RN-C stated R151 had refused showers because of pain and indicated R151's record did not identify refusals; refusals should be documented. RN-C stated if a resident requested more baths/showers they would try and accommodate the resident. RN-C reviewed R151's care plan and Kardex and confirmed R151's bathing preferences were not identified other than the preference to be bathed

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in the evening. RN-C indicated bathing preferences should be identified on the care plan and Kardex.

During an interview on 10/4/19, at 3:55 p.m. director of nursing (DON) indicated that the residents preferences should be in the care plan and Kardex; preferences for bathing and wake up times/bed times should also be identified. DON stated that if a resident is refusing bathing; staff should re-attempt and provide education; refusals should be documented.
R10

During an interview on 9/30/19, at 4:47 p.m. R10 stated, there is one nurse here who puts my pills in applesauce all at once and then I end up throwing up. R10 added she does not like them all at once. R10 said, the nurse has told R10 that is the way she wanted her medications, but R10 said she has not said that. R10 said she only wants her night pill in applesauce. The other nurses leave the applesauce and the water in 2 separate containers and R10 said she take them slowly. R10 identified licensed practical nurse (LPN)-C was the nurse who continued to give all the medications in applesauce all at once.

R10's quarterly Minimum Data Set (MDS) assessment dated 7/14/19, indicated R10 was cognitively intact and required set up assistance with eating.

R10's Admission Record, identified diagnoses of heart failure, anxiety disorder and weakness.

R10's care plan revised 7/24/19, identified a focus of activity of daily living (ADL) self-care performance deficit related to impaired mobility

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and arthritis ...Goal: will maintain current level of function ...intervention: is able to feed self and prefers to eat in her room.

During observation and interview on 10/02/19, at 10:23 a.m. LPN-prepared R10's morning medications in a medication cup, with a small plastic glass of applesauce. LPN-C entered R10's room and walked up to where R10 was seated in her recliner. R10 had a tray table in front of her and LPN-C stood over her. R10 then stated to LPN-C, I am not taking them if they are all in the applesauce. LPN-C stated, well how do you want them then? R10 stated, the others leave the pills with the applesauce and I take them. LPN-C said in a harsh voice, "they are not in the applesauce!" R10 stated, when did you change? LPN-C interrupts R10 and stated she could not leave the pills with R10 and proceeds to give a green pill in a small amount of applesauce and spoons it into R10's mouth. R10 asked LPN-C again, how come you changed today and did not put them all in applesauce? LPN-C ignored R10 and continued to give R10 one pill at a time in the applesauce. R10 noted to take a drink of water with each pill. R10 started to cough and grabbed a Kleenex to cough into. Still coughing, R10 stated, I would like to take the Tylenol now because that one is the hardest one to take. LPN-C sighed loudly and stated well I already have one in the applesauce now, I will have to give you the Tylenol after this one. At 10:31 a.m. R10 stated, I need more applesauce that one did not go down. LPN-C spoons another pill in R10's mouth and stated in a loud voice, "Well that's all the applesauce I have!" R10 started to cough again and stated in a light voice, that one did not go down, do you have any more applesauce? LPN-C puts the rest of the

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applesauce in R10's mouth and stated, that's all I have, I will have to come back! R10 continued to cough. LPN-C standing over R10 with her hands placed on her hips stated in a harsh voice, well did it go down? R10 stated, "I need more applesauce", in between coughs. LPN-C walked out of the room. R10 turned to writer and said, she never does it that way, she always brings them in applesauce. R10 added she was not sure why LPN-C did it different this time. At 10:34 a.m. R10 was still coughing, and stated, she gave them to me too fast. At 10:35 a.m. LPN-C walked back in the room with more applesauce and spoon fed it to R10. R10 asked, is there anyway the Tylenol could be broken into two? LPN-C stated in a loud voice, we could, but it would have a rough edge, you can try it that way tomorrow. R10 stated, I guess so. LPN-C continued to spoon feed R10's medication one at a time with a small amount of applesauce and R10 would cough in between. LPN-C was finished and left the room.

During interview on 10/02/19, at 10:38 a.m. R10 "It's awful when you sit and the pills are right here, R10 pointed to her neck, because your pills are taken too fast." R10 said the only one she wants in applesauce was her sleeping pill at night, not all of them. R10 stated, LPN-C has never gone after more applesauce before, and said the reason must be because the surveyors were there.

During a follow up interview on 10/02/19, at 2:07 p.m. R10 stated, the other nurses brings the pills in a cup with some applesauce and water to take them at her own pace. LPN-C started giving them to R10 all in applesauce and R10 said she has told her over and over, and feels LPN-C

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F 561	Continued From page 22	F 561		

doesn't listen to R10's request. When LPN-C does it, she spoons them in, and liked to do it fast. R10 said she can't have them fast or else she may throw up. R10 said, "It feels like you are choking and that is miserable? R10's wish was LPN-C would just do it the way R10 feels good about. R10 said she was able to take her own medications but LPN-C puts them all in the applesauce and spoons them in R10 mouth. R10 added, "I wish she would just let me do it at my own pace."

During interview on 10/02/19, at 2:30 p.m. director of nursing (DON) stated, my expectation in regards to administering medications to a resident is to allow the resident a choice, unless contraindicated by the physician.

Facility policy Resident Rights Guidelines for All Nursing Procedures dated 10/2010, indicated staff are provided with education pertaining to resident rights which included: Resident freedom of choice, Resident/family participation in care planning.

Facility policy Quality of Life-Resident Self Determination and Participation dated 12/2016, included: Our facility respects and promotes the right of each resident to exercise his autonomy regarding what the resident considers to be important facets of his or her life. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care including: daily routine, such as sleeping and waking, eating, exercise, and bathing schedules. In order to facilitate resident choices, the administration staff: inform the resident and family member of the residents' right to

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F 561	Continued From page 23 self-determination and participation in preferred activities. gather information about the residents' personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; include information gathered about the resident's preference in the care planning process.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		11/18/19

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F 565	Continued From page 24 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure concerns raised at the resident council meetings were addressed and presented back to the council, for 5 of 5 residents (R11, R3, R2, R43, R31) who were present during the resident council meeting. Findings include: On 10/1/19, at 11:46 a.m. R11 gave permission to review the last 6 months of resident council meeting minutes. The meeting minutes identified resident council concerns that carried over from month to month. The minutes did not identify how the facility addressed the council's concerns. Council minutes dated 6/28/19, indicated residents voiced concerns pertaining to not enough staff, and food quality and variety. Council minutes dated 7/29/19, indicated residents' concerns remained the same since the previous month in addition to concerns of, nursing staff seemed more rushed, call light response time, and rude staff. Council minutes dated 8/28/19, indicated residents' concerns remained the same, with some small improvements from the past month although the notes did not identify where the improvements were. The minutes indicated	F 565	1. Corrective Action: Activities Director held a Resident Council Meeting on 10/21/19 and collected all resident concerns. Concerns were shared with the Interdisciplinary Team for follow-up via concern form with a date for follow-up indicated. Leadership staff were educated on the complaint/concern process on 10/20/19 to ensure that they understand the process moving forward. 2. Corrective Action as it applies to other Residents: Resident Council meetings will be scheduled monthly on a routine basis and conducted jointly by the Activities Director and LSW. Resident council meeting minutes will be discussed at Stand Up the day following the council meeting. Any concerns or grievances brought up during resident council will be redirected via form to the appropriate department with a return date assigned. Follow-up on all grievances will be discussed at next month□s resident council or with the specific resident if concern is resident specific. Concerns will be logged in a	

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F 565	Continued From page 25 residents voiced concern about beds not being made in a timely fashion and felt as though nursing staff were not taking their time and residents were feeling rushed. Council minutes dated 9/23/19, indicated residents' concerns remained the same. The minutes indicated residents voiced concerns with beds not made in a timely fashion, preferences/choice for wake and sleep times, long call light times, and noise levels. On 10/2/19, at 12:57 p.m. a resident council meeting was held with R11, R3, R2, R43, R31 and survey team. When asked the following questions: Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? Does the Grievance Official respond to the resident or family group's concerns? If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response? The residents unanimously responded no and how grievances were resolved or what the facility's plan was to resolve grievances was not discussed. The resident's shared they have had multiple concerns with staffing issues, call light response time was described as ridiculous, disrespectful staff, choices and preferences pertaining to bathing, wake/sleep times, and food quality. During an interview on 10/4/19, at 4:16 a.m. administrator stated activity director (AD) would bring up the resident council concerns at the interdisciplinary team meetings. Administrator indicated an expectation that the appropriate department address the resident council's concerns and AD would then relay the information	F 565	binder and brought to QAPI. 3. Date of Completion: 10/18/2019 4. Recurrence will be prevented by: Activities Director or LSW will audit monthly resident concerns to ensure proper follow-up of distributing to the appropriate department head. 5. Correction will be monitored by: Activities Director or LSW QAPI Committee	

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F 565	Continued From page 26 back to the resident council. During an interview on 10/4/19, at 4:54 p.m. AD indicated she was the person responsible for assisting residents with the resident council meetings. AD reviewed the council minutes; and confirmed resident council concerns were ongoing from month to month and that the minutes did not identify how the resident council's grievances were addressed or resolved. AD stated she would bring up the resident council concerns at the interdisciplinary team meetings after the resident council meeting and expected the corresponding department to investigate and address the concerns. AD stated the departments would not get back to her with any resolution of the concerns; although anything from maintenance were usually resolved timely and dietary manager was trying to resolve concerns related to food quality and menu choices. AD confirmed none of the concerns pertaining to dignity, staffing, and call light issues have not been resolved and to her knowledge there was not a plan for resolution in place.	F 565		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		11/18/19

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F 655	Continued From page 27 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a baseline care plan for smoking for 1 of 1 residents (R152) reviewed for smoking. Findings include	F 655	1. Corrective Action: Resident R152 was assessed for ability to smoke safely on 9/30/19. Resident was determined to be safe smoking off facility grounds.	

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F 655	Continued From page 28 During an interview on 10/2/19, at 11:29 a.m. R152 indicated she smoked cigarettes, and was aware the facility was a non-smoking facility. R152 stated she was on the patch in the hospital and was supposed to continue the nicotine patches. R152 stated she would sneak out and go smoke and would smoke 20 feet from the door and the nurses would come outside and get her. R152 stated she was capable of wheeling herself outside, open the door, light and manage her own cigarette without burning herself, and while residing at the facility has not sustained any burns. R152 facility Admission Record indicated R152 was admitted to the facility on 9/19/19. R152's base line care plan dated 9/19/19, did not identify history of smoking or nicotine dependence. R152's progress note dated 9/27/19, at 9:43 p.m. included resident, "has been sneaking outside and asking residents family members to buy her cigarettes and asking them if she can smoke with them, did speak to her about this she did become angry and did say yes she has been doing that but will stop, explained that she is aware we are a non smoking facility and that she still chose to come here, did give this writer 4 cigarettes she had in possession from another resident." R152's progress note dated 9/28/19, at 1:08 p.m. included "res [resident] went outside without supervision-found her on side door smoking. Res was cooperative and come in. reminded res of not able to be outside unattended and too close to facility".	F 655	Resident discharged from facility on 10/1/19. 2. Corrective Action as it applies to other residents: All residents admitted will have their baseline care plans reviewed for accuracy and completion to ensure that all information necessary to address healthcare and safety needs, including smoking is included. St. Marks Smoking Policy Implemented on 10/21/19. Smoking Policy added to admission process on 10/21/19 added directly to the admission agreement & included in the information provided to resident/families upon admission. Facility will also obtain a signed Acknowledgment of Information by resident / families at time of admission explaining their understanding of the facility□s smoking policy. Smoking assessment will be completed upon admission for any resident who smokes and interventions added to the Baseline care plan. 3. Date of Completion: 11/18/19. 4. Re-occurrence will be prevented by: Licensed Nurses will be educated on the	

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F 655	Continued From page 29 R152's progress note dated 9/30/19, included "This writer also reinforced the non-smoking policy to resident by explaining there is no smoking on the facility grounds with no exceptions. Nursing has reported that resident was seen smoking outside the front and side doors. Resident was notified of non-smoking policy by the SW [social worker] before admission at the acute care hospital and upon admission to the facility here. She verbally agreed to this however she has not been compliant with the non-smoking rules. Will continue to monitor." R152's behavior note dated 10/2/19, included "resident has been offered nicotine patches and gum to help quit smoking but resident refuses. Resident has also been talked to by the unit manager who explained St. Mark Livings policy." The note indicated the interventions were not effective. During an interview on 10/1/19, at 9:32 a.m. registered nurse (RN)-B, indicated the facility was a non-smoking. RN-B stated R152 would sneak outside and smoke cigarettes, would not sign herself out or alert nursing staff, and has been provided education. During an interview on 10/4/19, at 3:14 p.m. director of nursing (DON) stated the facility was a non-smoking facility and R152 was aware of that prior to admission. DON indicated R152 was capable of signing herself out of the facility and leave the property to smoke. DON confirmed R152's baseline care plan did not address smoking and should have.	F 655	smoking policy and assessment at a mandatory meeting on 11/7/2019. Nursing Assistants will have Smoking Policy reviewed at a staff meeting on 11/12/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. All residents will have a baseline care plan completed within 48 hours of admission that addresses healthcare and safety needs necessary to properly care for the resident. Smoking assessment will be completed upon admission for any resident who smokes and interventions added to the Baseline Care plan. DON or designee will audit all new admissions weekly for 1 month and then monthly for 3 months to ensure baseline care plans are completed accurately. Audit results will be shared with the QAPI committee for need of further action. 5. Correction will be monitored by: DON or designee QAPI committee	
F 656	Develop/Implement Comprehensive Care Plan	F 656		11/18/19

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F 656 SS=D	Continued From page 30 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 31 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan for facial hair removal for 1 of 1 resident (R5) who was dependent on staff assistance for activities of daily living (ADL's). The facility failed to implement care plan interventions for repositioning for 1 of 3 residents (R5) reviewed for pressure ulcers. In addition, the facility failed to implement the care plan for toileting for 2 of 4 residents (R5 and R23) reviewed. Findings Include: Hair removal R5's care plan revised 4/13/19 included R5 had an ADL self-care performance deficit. Interventions included, "PERSONAL HYGIENE ROUTINE: Extensive to total assist of 1. Assist with facial hair removal (resident at times will refuse but please continue to encourage staff assistance). R5 was interviewed and observed on 10/01/19, at 9:15 a.m. R5 had several facial hairs on her lower chin. R5 stated the facial hair should be cut off and stated she would want them [staff] to do that for her. R5 was observed 10/02/19, at 8:39 a.m. sitting in her wheelchair eating breakfast. The facial hairs on her chin remained.	F 656	1. Corrective Action: Resident R5 was shaved on 10/3/2019. Her care plan review will be completed by 11/8/19 and updated to include shaving, toileting and repositioning plans and skin breakdown interventions. R23's care plan was reviewed and updated to reflect her needs. Staff to assist resident from dining room after meals and assist to bathroom. Staff to assist to toilet before/after every meal/activity and offer when signs of agitation or restlessness are noted. Staff assist resident from dining room after meals and assist to bathroom. Staff not leave resident alone on the toilet. 2. Corrective Action as it applies to other Residents: All resident care plans will be reviewed by 11/18/19 to ensure appropriate interventions are in place to address residents individual needs. 3. Date of Completion: 11/18/19 4. Re-occurrence will be prevented by: Licensed Nurses will be educated on the development of Comprehensive Care	

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F 656	Continued From page 32 R5 was observed on 10/3/19, at 7:05 a.m. sitting in the common area of the facility and facial hairs remained on her chin. On 10/02/19, at 3:33 p.m. licensed practical nurse (LPN)-A stated facial hair should be removed during morning cares and if not the next shift should get it. LPN-A verified R5 facial hairs. LPN-A stated the facial hair on her face was scattered and was about 1/2 inch long. On 10/03/19, at 9:52 a.m. the director of nursing (DON) stated the expectation would be for the staff to follow the residents' preference for shaving and to keep them clean-shaven and maintained per their care plan. Repositioning/Toileting R5 was continuously observed on 10/2/19, from 8:39 a.m. until 11:01 a.m. -At 8:39 a.m. R5 was in the dining room eating breakfast. A unidentified staff member wheeled R5 out of the dining room, took her to a nursing station, put in her dentures and returned R5 to the dining room. R5 was observed to have a blue foot protector on her right foot and legs were in a dependent position -At 8:53 to 9:06 a.m. R5 remained in dining room eating her breakfast -At 9:08 a.m. a volunteer wheeled R5 from the dining room to her room. -At 9:27 to 9:43 a.m. R5 was sitting in her room in her wheelchair. No staff has entered her room since she returned from the dining room. -At 9:44 a.m. an unidentified staff member wheeled resident to get in line for the podiatrist. The unidentified staff member did not offer to toilet or reposition R5.	F 656	plans at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. All residents will have Comprehensive Person Centered Care Plan developed by day 21 following admission that will include measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs identified in the comprehensive assessment in order to maintain the resident□s highest practicable physical, mental, and psychosocial well-being. Comprehensive Care Plan review will be completed with changes in resident needs or goals by staff nurses and Nurse Managers and with the MDS quarterly and with significant change in condition. DON or designee will audit one Comprehensive Care Plan weekly for 1 month, then monthly for 3 months and share the results with the QAPI Committee. 5. Correction will be monitored by: DON or designee QAPI committee	

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F 656	Continued From page 33 -At 9:48 a.m. R5 remained in line for the podiatrist. There are eight residents in front of her waiting to be seen. -At 10:00 a.m. an unidentified activity staff member holding a balloon moved R5's wheelchair to another spot in line and R5 she was now playing balloon ball with her and other residents. -At 10:05 to 10:21 a.m. R5 continued to play ball game while sitting in her wheelchair waiting to be seen by the podiatrist. -At 10:22 a.m. R5 told an unidentified staff member she would like to go back to her room. The staff member took her back to her room. R5 was not toileted or repositioned. -At 10:29 to 10:36 a.m. R5 was in room, sitting in her wheelchair, with her feet in a dependent position. - At 10:46 a.m. nursing assistant (NA)-D wheeled R5 to another hall to get her weight while sitting in her wheelchair. -At 10:49 a.m. NA-D returned R5 to her room, gave her the call light, asked if she would like the television on. NA-D did not offer to reposition or toilet R5. When interviewed, NA-D stated he offered to toilet her when he brought her to her room about 20 minutes ago. -At 10:56 to 11:01 a.m. R5 remained in her room sitting in her wheelchair with her legs in a dependent position. -At 11:11 a.m. R5 was toileted by nursing assistants (NA)-C and NA-E after surveyor intervened and requested R5 be toileted and repositioned. R5 was observed by nurse surveyor to have a red left inner thigh fold where clothing had been and a small bowel movement smear. R5 was observed to have red areas from folds of clothing, all fold areas pale pink but blanchable. R5 had no open areas or purple areas.	F 656		

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R5's POTENTIAL FOR SKIN BREAKDOWN care plan last revised 7/17/19 included, Interventions included: Prompt and assist resident with Q [every] 2 hours repo [reposition] when in a sitting and laying position. Identify potential causative factors and eliminate/resolve when possible. Encourage frequent repositioning. Right leg in long cast, keep leg elevated on pillow blue boot on at all times, float both heels in bed. Repo side to side every 2 hours with new limited mobility. Check and change every 2 hours and PRN while non-weight bearing."

On 10/02/19, at 10:51 a.m. nursing assistant (NA)-D stated he did not offer to toilet R5 before or after he took her to be weighed. NA-D stated he offered to toilet R5 about 20 minutes ago when he took her to her room. Surveyor had been completing a continuous observation of resident, since 8:39 a.m. NA-D was not observed to be with R5 until he took her to be weighed at 10:46 a.m.

On 10/02/19, at 11:34 a.m. NA-C and NA-E stated they just toileted her about 20 minutes ago. NA-C stated R5 was up this morning when she got here. Neither NA-C nor NA-E had assisted with toileting R5 until surveyor intervened and asked for R5 to be toileted about twenty minutes ago.

On 10/02/19, at 11:37 a.m. NA-C stated she was here at 6:00 a.m. and R5 was dressed and ready.

On 10/02/19, at 11:42 a.m. NA-D stated he got R5 up took her to the dining room for breakfast. NA-D stated he got her up around 7:00 and 7:30 a.m. NA-D stated he changed her in bed at this

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time. NA-D stated he was a float aide on both 400 and 500 wings and I got busy. NA-D verified the last time he toileted and reposition R5 was when he got her up in the morning between 7:00 and 7:30 a.m. NA-D stated he did not toilet her or reposition R5 since he got her up and stated he did not know if anybody else had.

On 10/02/19, at 11:59 a.m. the director of nursing (DON) stated they (staff) should follow the care plan to toilet and reposition R5 every two hours.

On 10/03/19, at 1:22 p.m. NA-C stated R5 was supposed to be toileted and repositioned every two hours. NA-C stated R5 gets up by the staff member that started work at 4:00 a.m. and she did not go back to bed until after lunch. NA-C Stated this was a problem for the residents for toileting and repositioning. NA-C stated on my shift we are getting them (residents) up then it is breakfast, then it is our breaks and answering call lights for the residents that are more with it. NA-C stated with R5 she was getting up between 4:00 and 6:00 a.m. and was ready for the day. NA-C stated the next time R5 was toileted and repositioned would be after lunch, when we are doing our next rounds because we do not have adequate time to do the cares. NA-C stated even then it can be a conflict because we have to go to activities and we have to hunt them down.

R23's toileting

R23's quarterly minimum data set (MDS), dated 8/13/19, identified R23 to have severe cognitive impairment, frequently incontinent of urine, and required 2 person extensive assist with toileting.

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R23's care plan, revised 8/14/19, included ADL (activity of daily living) function-diagnosis and history of pubic fracture (pelvis), depression, dementia, macular degeneration, cataracts, chronic pain, osteoporosis, DJD (degenerative joint disease). Often declining to ambulate. R23 will continue to participate in ADL's as able through next review. Intervention include toileting with extensive assist of 1. Assist to the toilet every 2 hours while awake and PRN (as needed), assist to toilet after meals, assist to get up at 4 am and use the bathroom. Incontinent product (pull ups) is used. Staff complete peri cares.

During interview on 10/02/19, at 2:50 p.m. in R23's room, family member (FM)-B stated, they visit R23 every morning and has primary concerns of R23's falls and she never gets to the bathroom. They [staff] have her sitting up to that table as FM-B pointed to the dining table on 4/5 unit in the common area right outside of R23's room. R23 will tell FM-B she has to go to the bathroom, FM-B will tell the aides and they will say, "Well you have to wait because we need 2 to take her to the bathroom". FM-B added, for a while they were using the bedpan on R23 and even the doctor said she needed to be taken to the toilet. Then the aides acted mad that they had to bring her to the toilet. FM-B comes every day from 9:00 am until around noon and added the biggest concern was that they are not getting her to the bathroom, and then R23 tries to do it herself and she falls, that makes me very upset. I do not think there is enough staff, all of a sudden they all just disappear, and then you see one with a pop in their hand. I am here every day like clockwork and this is how it is. We have made this complaint to administration, it must have went in one ear and out the other, and nothing

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changes.

R23 was continuously observed on 10/3/19, from 7:07 a.m. until 9:58 a.m.
At 7:07 a.m. R23 was seated in a Broda chair in her room, nursing assistant (NA)-E observed leaving R23's room carrying a clear garbage bag containing a brief, and disposed of it in the soiled utility room.
At 7:11 a.m. NA-E wheeled R23 from her room and pushed her up to the dining table on the 4/5 Unit, in the common area outside her room.
At 7:28 to 7:43 a.m. R23 continued to be seated up to the table in her Broda chair with her eyes closed.
At 7:54 a.m. R23 continued to be seated up to the table in the Broda chair, with her eyes opened, and had a Kleenex in her right hand.
At 7:56 a.m. NA-C walked by and stated to R23, well you look wide awake today. R23 stated, "Ya."
At 8:06 a.m. R23 continued to be seated up to the table in her Broda chair.
At 8:12 a.m. R23 was wheeled to the main dining room and brought to the table where 3 other residents are assisted with eating.
At 8:20 a.m. R23 remained seated at the dining room table.
At 8:25 a.m. R23 remained seated in her Broda chair up to the table in the main dining room, looking around.
At 8:36 a.m. R23 was served breakfast. R23 was independently eating her jellied toast.
At 8:46 a.m. R23 ate all of her toast, took a drink of her thickened water, remaining beverages at the table remain untouched.
At 8:56 a.m. NA-C walked up to R23 and asked, are you working on your drinks? R23 stated, "Ya." NA-C walked away and began removing

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the other residents from the table, as they were done eating. R23 seated at the table, had fried egg and all beverages left to eat and drink.
At 9:04 a.m. NA-C wheeled R23 from the main dining room and back up to the table on the 4/5 Unit, brings her cranberry juice and sets it in front of R23 at the table and walked away.
At 9:10 a.m. NA-C told NA-E that she was going to take a break. NA-C then left the floor. NA-E was seated at the table where R23 was. 2 other unknown residents were noted to be eating their breakfast.
At 9:18 a.m. R23 continued to be seated up to the table in her Broda chair, with her eyes closed. At 9:26 a.m. R23 noted to have drank half of her glass of cranberry juice.
At 9:27 a.m. NA-C was back on the floor from her break, NA-E told NA-C she was going to take a break now.
At 9:32 a.m. when R23 was asked what she is going to do for fun today R23 stated, sleep, and then started laughing. R23 started talking about a yellow canary that she had when she was little that she really enjoyed.
At 9:37 a.m. trained medication aide (TMA)-A brought R23 her morning medications and gave her a glass of water with it.
At 9:46 a.m. NA-E was back on the floor from break, R23 continued to be seated in her Broda chair up to the table.

During interview on 10/3/19, at 9:57 a.m. NA-C was asked the last time R23 was offered to be toileted. NA-C replied, I am not sure, I didn't get R23 up today.

During interview on 10/3/19, at 9:58 a.m. NA-E was asked the last time R23 was offered to be toileted and NA-E stated, I haven't had a chance

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F 656	Continued From page 39 to toilet R23 yet, she is supposed to be offered every 2 hours. I last toileted her around 7am when I got her up this morning. During interview on 10/03/19, at 2:03 p.m. NA-C and NA-E stated, we usually have time to toilet R23 when we first get her up before and after lunch. We don't have time to take her every 2 hours, we just don't have enough staff, and it has been this way since May when they cut our staffing. During interview on 10/03/19, at 2:54 p.m. FM-B stated, why can't they just bring her to the bathroom when they are supposed to, then she won't keep falling. During interview on 10/04/19, at 12:05 p.m. the director of nursing (DON) stated, my expectation is be sure residents are truly evaluated for their toileting needs, R23's toileting plan was not personalized. The staff were not following the care plan. I am going to make a personalized care plan for her toileting.	F 656		
F 677 SS=D	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: Based on observation, interview and document review, the facility failed to ensure grooming needs for facial hair removal was provided for 1 of 4 resident (R5) reviewed who was dependent on staff assistance with activities of daily living	F 677	1. Corrective Action: Staff shaved resident R5□s chin hairs on 10/3/2019. Shaving needs and facial hair removal was updated in her care plan on	11/18/19

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F 677	Continued From page 40 (ADL's). Findings Include: R5 was interviewed and observed on 10/01/19, at 9:15 a.m. R5 had several facial hairs on her lower chin. R5 stated the facial hair should be cut off and stated she would want them to do that for her. R5 was observed 10/02/19, at 8:39 a.m. sitting in her wheelchair eating breakfast. The facial hairs on her chin remained. R5 was observed on 10/3/19, at 7:05 a.m. sitting in the common area of the facility and facial hairs remained on her chin. R5's quarterly Minimum Data Set (MDS) assessment dated 7/5/19; identified R5 required extensive assist of one for personal hygiene needs and had intact cognition with a brief interview mental score of 14. R5's care plan revised 4/13/19 included R5 had an ADL self-care performance deficit. Interventions included, "PERSONAL HYGIENE ROUTINE: Extensive to total assist of 1. Assist with facial hair removal (resident at times will refuse but please continue to encourage staff assistance. On 10/02/19, at 3:33 p.m. licensed practical nurse (LPN)-A stated facial hair should be removed during morning cares and if not the next shift should get it. LPN-A verified through observation of R5 facial hair. LPN-A stated the facial hair on her face was scattered and was about 1/2 inch long.	F 677	10/31/19. 2. Corrective Action as it applies to other Residents: All residents will be evaluated for shaving needs. Shaving interventions and preferences will be added to care plan and tasks in POC. 3. Date of Completion: 11/18/19 4. Re-occurrence will be prevented by: Nursing Assistants will be educated on shaving interventions at a mandatory meeting on 11/12/2019 and Licensed nurses will be educated on ensuring shaving has been completed at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. All residents will be evaluated on admission for shaving needs. Shaving will be added in to tasks in POC indicating resident preference. DON or designee will audit 4 residents weekly for 1 month, and then monthly for 3 months and report the results to the QAPI committee. 5. Correction will be monitored by: DON or designee QAPI committee	

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F 677	Continued From page 41 On 10/02/19, at 3:39 p.m. nursing assistant (NA)-B stated facial hair was usually shaved in the morning and if we notice the facial hair it (facial hair removal) can also be done at night. On 10/03/19, at 9:52 a.m. the director of nursing stated the expectation would be for the staff to follow the residents' preference for shaving and to keep them clean-shaven and maintained per their care plan. On 10/03/19, at 1:22 p.m. nursing assistant (NA)-C stated we provide shaving assistance to female residents when we have time and stated we do not have time to provide shaving during our shifts. NA-C stated occasionally if we have down time I will try to do it (female shaving) real fast, if I see someone with facial hair. A policy and procedure for shaving female residents was requested and not provided.	F 677		
F 684 SS=G	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: Based on observation, interview and document review, the facility failed to comprehensively	F 684	1. Corrective Action:	11/18/19

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F 684	Continued From page 42 assess and provide treatment for 1 of 1 resident (R148) who exhibited acute symptoms of urinary tract infection, 1 of 3 residents (R32) who had non pressure related skin injuries, and 3 of 3 residents reviewed for edema (R151, R40 and R22) who experienced weight increases. R148 experienced harm when treatment was delayed and he was diagnosed with urosepsis (sepsis that is caused by urinary tract infection) and required hospitalization. R32 experienced harm when the resident developed redness, warmth and fever, care was delayed and the resident required hospitalization to treat cellulitis and sepsis. Findings include Urosepsis During an interview on 9/30/19, at 6:26 p.m. family member (FM)-A stated R148 was hospitalized last Sunday (9/22/19), for treatment of an urinary tract infection. FM-A stated R148 had experienced a high fever Friday night (9/20/19), the facility had tried to get a hold of the doctor however, was unable to reach him. FM-A stated R148 continued to run a fever on Saturday (9/21/19), but didn't think the physician had ever been reached. FM-A then stated R148 ended up being admitted to the hospital for a couple of days with an E.Coli (Escherichia coli, a type of bacterial) infection. R148's facility Admission Record dated 10/4/19, indicated R148 was admitted to the facility on 9/19/19, with diagnoses that included aftercare of joint replacement, diabetes type II and benign prostatic hyperplasia (BPH). Facility standing orders approved by the physician	F 684	R148 was assessed and record was reviewed to evaluate for any noted condition warranting intervention 10/8/2019 including preventative monitoring for signs/sx of infection. R148 had comprehensive evaluation with primary care provider on 10/9/2019. Monitoring continued until discharge on 10/25/2019. R32 was assessed and record was reviewed to evaluate for any noted condition warranting intervention on 10/8/2019 which included implementing preventive monitoring for signs/sx of infection. R32 plan of care and preventative measures reviewed and updated 10/31/2019. R151 was assessed and record was reviewed to evaluate for any noted condition warranting intervention on 10/5/2019, updated on 10/15/2019, updated 10/31/2019. R40 was assessed and record was reviewed to evaluate for any noted condition warranting intervention on 10/21/2019, and 10/31/2019. R22 was assessed and record was reviewed to evaluate for any condition warranting intervention on 10/21/2019 and again on 10/30/2019 2. Corrective Action as it applies to other Residents: All residents will be evaluated for changes	

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F 684	Continued From page 43 on 12/12/18, included "Notify physician if fever [2.4 degrees over baseline/normal temperature] persists up to 24 hours, or if condition warrants." R148's baseline care plan dated 9/19/19, did not address R148's risk for infection and/or interventions for signs/symptoms of infection. R148's admission progress note 9/19/19, indicated R148 was alert and oriented to person, place and time; and indicated the resident required two person assist for activities of daily living. R148's record was reviewed from 9/19/19, through 9/22/19, the record indicated R148 developed an increase in body temperature without further assessment of signs/symptoms of infection, consistent implementation of interventions, evaluations of intervention effectiveness, or timely physician notification of R148's change in condition. -On 9/19/19, R148's temperature was recorded as 98.0 degrees F (Fahrenheit) -On 9/20/19, at 5:00 p.m. R148's temperature was recorded as 103.8 F -On 9/20/19, at 7:15 p.m. temperature recorded was 102.6 F -On 9/20/19, at 8:28 p.m. temperature recorded was 100.5 F Although R148 ran a high fever, the progress notes from 9/20/19, did not identify further assessment of R148's fever, other possible signs/symptoms of infection, and/or interventions that were put into place. In addition, R148's medication administration record (MAR) did not reflect administration of fever reducing medications (acetaminophen) on 9/20/19.	F 684	in clinical condition. Any changes will be immediately communicated to their provider and appropriate interventions put into place. 3. Date of Completion: 11/18/19 4. Reoccurrence will be prevented by: Facility educated Nurses on the use of Stop & Watch, SBAR tool and to immediately communicate change of condition to providers at a mandatory meeting on 11/7/19. Nursing Assistants will be educated on the use of the Stop and Watch tool to communicate changes in resident condition to the licensed nurses at a mandatory meeting on 11/12/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. Nurses will be educated at a mandatory meeting on the use eInteract Clinical Pathways and facility protocols to address changes in resident conditions. Nurses will follow the clinical guidelines and protocols to provide appropriate interventions for the resident condition to prevent further decline proceed with provider notification as appropriate. Policies for Change of Condition, Antibiotic Monitoring, Implementation of Orders, Care Plan Revision, Physician Services, and Nursing Assessment will be reviewed. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the	

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F 684	Continued From page 44 Although R148's family indicated they thought the facility had attempted to reach the physician without success, progress notes lacked evidence of any attempts to notify the physician. R148's medication administration note dated 9/21/19, at 2:41 a.m. indicated R148 was administered acetaminophen for fever of 100.2. No reassessment of medication effectiveness was documented until a follow-up note at 5:33 a.m. indicated the medication was effective and the temperature had come down to 97.9 degrees F. R148's medication administration note dated 9/21/19, at 4:38 p.m. indicated R148 was administered acetaminophen for a fever of 100.8 F. A follow-follow up note documented at 7:36 p.m. indicated the medication was effective with a pain score of zero, but did not identify the resident's temperature. R148's skilled nursing note dated 9/21/19, at 9:16 p.m. included, "has been running a fever off and on; when temp [temperature] is elevated resident is confused." Summary/Additional Information section included, "Resident has been running a fever last 24 hours, becomes afebrile with APAP [acetaminophen] and cool wash clothes applied to forehead. Started 72 hr [hour] diary for suspected UTI [urinary tract infection]. Resident complained of urgency and some burning sensation when voiding." R148's record continued to lack evidence of physician notification even though R148 continued to have increased temperature, change in cognition, and signs/symptoms of urinary tract infection.	F 684	information and sign off by 11/15/19. Changes in resident condition will be monitored in the PCC dashboard by the Nurse Manager or designee and communicated to DON and IDT at daily standup. All changes will be evaluated for need of further intervention, need for provider notification and use of clinical pathways and facility protocols. Nurse Managers and DON will audit PCC dashboard daily ongoing for changes in resident condition and provide appropriate direction as indicated. 5. Correction will be monitored by: DON or designee QAPI committee	

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R148's medication administration progress note dated 9/22/19, at 5:42 a.m. indicated R148 was administered acetaminophen for temperature of 102.0 F. R148's record indicated the effectiveness of the medication was not reassessed until 8:15 a.m., more than two hours later. The follow-up note at 8:15 a.m. included medication "ineffective Resident's current temp is 102.0 F."

R148's medication administration progress note dated 9/22/19, at 1:45 p.m. indicated R148 was administered acetaminophen for temperature of 101.5 F. The record lacked any evidence of additional assessment of medication effectiveness until 4:20 p.m. that same day. The progress note at 4:20 p.m. included: "Resident fever not breaking. Ice packs under arms. APAP administered, resident was confused and appeared to be weak. Discussed with wife the option of sending to ER [emergency room] for evaluation. Wife agreed." A follow-up progress note at 4:45 p.m. indicated R45 was transferred to the hospital.

A progress note dated 9/22/19, at 9:36 p.m., indicated the facility had been notified by the hospital R148 had been admitted to the hospital for treatment of a bladder infection.

R148's hospital Discharge Summary note dated 9/27/19, indicated R22 was admitted to the hospital on 9/22/19, with diagnosis of non-catheter associated urinary tract infection with severe sepsis E.Coli. The summary included: [R148] presented to the emergency room with a fever and cough that started two days prior (9/20/19). The highest the patient's temperature

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has reached was 105 degrees, "Wife reports that nursing home staff did notice that he had foul-smelling urine, in the ER UA [urinalysis] was positive." Urinalysis came back with E. coli with multiple resistants. The note further indicated R148 required treatment with antibiotics, Cefepime (antibiotic), later switched over to Bactrim (antibiotic).

During an interview on 10/3/19, at 12:02 p.m. registered nurse (RN)-B stated she had not worked the weekend R148 got sick. However, RN-B stated the physician should have been notified of R148's fever on 9/20/19. RN-B reviewed R148's record with the surveyor and verified nursing progress notes from 9/20/19, did not identify interventions and/or any further assessments when R148's fever was identified. RN-B stated she would have completed further assessments and tried to identify the cause and/or assess for other signs and symptoms of infection.

During an interview on 10/3/19, at 12:23 p.m. registered nurse (RN)-C stated she was the nurse manager for the transitional care unit. RN-C stated she had not been notified of R148's change in condition on 9/20/19, when R148 developed fever, nor when it was ongoing and R148 had a change in cognition, and symptoms of urinary tract infection. RN-C stated there had been ongoing communication problems related to inconsistent staffing and the use of temporary agency nurses. RN-C reviewed R148's record with the surveyor and confirmed the physician was not notified but should have been. RN-C further confirmed the record lacked evidence of any further evaluation of R148's fever and/or other signs/symptoms of infection until late

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9/21/19. RN-C stated she would have expected nurses to have looked at R148's new incision and assess for signs of urinary tract infection and complete documentation of all assessments and evaluations. In addition, RN-C verified R148's record lacked evidence of medication administration of acetaminophen for fever control on 9/20/19, which should have been administered per physician order.

During an interview on 10/4/19, at 2:52 p.m. the director of nursing (DON) stated the physician should have been notified of R148's elevated temperature on 9/20/19, and stated nursing should have assessed and evaluated the elevated temperatures further, and documented all assessments/evaluations and interventions.

The facility's 6/2014 policy Urinary Tract Infections/Bacteriuria-Clinical Protocol, included: ... 2) Staff and practitioner will identify individuals with signs and symptoms suggesting a possible urinary tract infection. a) Nurses should observe, document, and report signs and symptoms in detail and avoid premature diagnostic conclusions.

Non pressure related skin issue

During an observation and interview on 9/30/19, at 7:10 p.m. R32 sat in his wheelchair with family member (FM)-D at bedside. R32 was observed to have an external fixator on his left leg. FM-D stated he had visited R32 almost daily since admission. R32 stated he had broken his leg and had surgery. R32 also stated after admission to the facility the left leg had become infected. FM-D stated before R32 was readmitted to the hospital, R32's leg had redness and warmth for a week

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prior to seeing a physician. FM-D stated he was seen by a facility physician first and then went to the orthopedic physician who put him on antibiotics. However, FM-D stated the leg continued to get worse. FM-D stated the day R32 was sent into the hospital he was despondent, lethargic, and had really low blood pressure. FM-D indicated R32 had been admitted to the hospital for cellulitis, was septic, and also had a pneumonia component. FM-D then indicated he had concerns that R32's dressing changes were not being completed as prescribed by the orthopedic physician. FM-D stated when R32 had come back from the hospital, the dressing was only supposed to be changed once per day, however, they had that clarified at his next appointment, and an order was written for twice a day dressing changes. FM-D stated he has told nursing staff multiple times that the dressing changes were supposed to be done twice per day but they continued to only change them once a day.

R32's facility Admission Record dated 10/4/19, indicated R32 was admitted to the facility on 8/30/19, with diagnosis that included fracture of shaft of left tibia, peripheral vascular disease, hypertensive and chronic kidney with heart failure, chronic obstructive pulmonary disease; cellulitis and sepsis diagnosis were added to the diagnosis list 9/17/19.

R32's admission Minimum Data Set (MDS) assessment dated 9/6/19, indicated R32 did not have cognitive impairment, the primary diagnoses for admission were fractures and other multiple trauma. The MDS indicated R32 had surgical wounds required surgical wound care, application of non-surgical dressings, and applications of

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ointments/medications to area(s) other than to his feet.

R32's MDS dated 9/24/19, included the aforementioned information as well as a diagnosis of septicemia.

R32's pressure ulcer/injury Care Area Assessment (CAA) dated 9/12/19, included: "Resident has 5 surgical pins on left lower extremity. Dressing changes to these areas are being done twice daily. Areas are healing well with no signs of infection noted at this time. Skin is otherwise intact." Staff will monitor skin and report changes for further evaluation/intervention/treatment as appropriate.

R32's baseline care plan dated 8/30/19, indicated R32 had a potential for impaired skin integrity related to left leg external fixator, with the associated goal that R32 would be free of any skin-related infection by the end of the review date. The interventions included daily treatments to left leg fixator pins and observe for signs/symptoms of infection and report to the MD.

R32's physician orders included:
Amoxicillin-Pot (potassium) Clavulanate (an antibiotic) give one tablet two times a day for 5 doses for respiratory infection until 9/19/19 (start date 9/17/19, end date 9/19/19).
Wound care: Pin site dressing change daily on the evening shift. Cleanse pin sites with Betadine solution or peroxide daily. Apply Xeroform petroleum gauze to pin sites. Cover with 4 x 4 gauze and cling and ace wrap. (start date 8/30/19, end date 9/5/19)
Wound care: Cleanse left lower leg pins with Betadine, apply Xeroform gauze to each pin

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cover with Kerlix change twice per day (start date 9/6/19, end date 9/17/19)
Wound Care : Apply Xeroform gauze over the external fixator holes once a day and cover with gauze pad one time a day (start date 9/18/19, end date 10/2/19)

R32's Clinic Referral visit form dated 9/26/19, included an order to change the dressings on the left lower extremity twice per day. R32's record lacked evidence the order had been transcribed into the electronic medical record and implemented. Information regarding this was requested, but was not provided.

R32's September medication administration record (MAR), indicated only 4 of the 5 doses of the Amoxicillin were administered. R32's record did not address why the 5th dose was omitted, and lacked evidence of physician notification or change in order.

R32's progress notes were reviewed; progress notes indicated R32 developed signs and symptoms of infection in the left lower extremity and the physician was not immediately notified.

Progress note dated 9/5/19, indicated R32 was seen by the orthopedic surgeon who gave an order to change the dressings to pin sites twice daily. The note also indicated that R32 was not feeling well and the nurse was unable to obtain a blood oxygen saturation. Further the note indicated the nurse was unable to auscultate lung sounds in the lower lobes, and was only able to auscultate minimal air exchange in the upper lobes.

A progress note dated 9/6/19, indicated the nurse

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was unable to obtain blood oxygen saturations. The progress note did not address lung sounds.

A progress note dated 9/6/19, indicated R32's left lower extremity dressing was changed per physician order, and described as: "Drainage noted from the pin site to the inside of the heel." The note indicated R32 tolerated well.

Progress note dated 9/7/19, at 12:25 p.m. included "Changed dressing to left leg. Five pin sites and scabbed area on top of foot, cleansed with Betadine. Applied Xeroform to pin sites, covered with split dressing, wrapped with Kerlix and covered with Ace wrap. Pin sites had minimal drainage, some blooded [sic] noted on the drainage pad from the second pin site down from the knee and on the pin site to the inside of the left heel. Scabbed area on top of foot is a light red in color. Will monitor over the weekend."

Progress note dated 9/7/19, at 9:31 p.m. included, "left leg shin is very red and warm to touch. Request NP [nurse practitioner] look at leg on Monday. Pin sites look good, drainage from pin site to the inside of heel and also from the second pin site down from knee."

Progress note dated 9/8/19, at 7:21 a.m. indicated Tylenol was administered for temperature of 101.4. A subsequent note at 9:51 a.m. included "Effectiveness a little better, fever down to 100.4"

Progress note dated 9/8/19, at 12:00 p.m. included, scabbed area on top of foot is red and left shin is reddish and warm to touch. No complaints of shortness of breath, respirations were after transferring to bed from wheelchair.

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"Resident not feeling well this morning complained of body chills and aches. Temp was 101.4, Tylenol was given. Temp has steadily decreased since taking Tylenol."

Progress note dated 9/8/19, at 9:56 p.m. included pin site directly below knee had small amount of drainage, pin site to inside left heel had small amount of drainage. Pin sites are pink. "Wound on top of left foot is still red, marked boarder of red area to determine if irritation is getting bigger." The note also included, antibiotic ointment was applied to the area on top of the foot.

Progress note dated 9/9/19, at 12:55 p.m. indicated R32 was seen by the nurse practitioner (NP) who had recommended R32 be seen by orthopedic surgeon. A subsequent progress note indicated R32 was seen by the orthopedic surgeon who prescribed another antibiotic, Keflex 500 milligrams every 6 hours.

Progress notes dated 9/12/19, at 2:56 a.m. progress note indicated R32 was having significant pain in left foot and leg. A subsequent note at 7:12 a.m. indicated R32 had an appointment with orthopedic surgeon, experienced a near miss fall and R32 had to be lowered to the floor. A subsequent note at 12:07 p.m. indicated R32 would be admitted to the hospital.

The hospital note dated 9/13/19, at 3:10 p.m. included: "When [R32] was admitted on 9/12/19 he was very sick. [R32] was unresponsive and they had to put in an art [sic] line and a central line. [R32's] hemoglobin was 6.5 and he was given 1 unit of blood. [R32 is receiving IV

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[intravenous] antibiotics and fluids. They are not sure the source of the infection, possible cellulitis."

R32's After Visit Summary dated 9/17/19, indicated R32 had been admitted to the hospital for sepsis. In addition, R32 was found to have concerns including: failed outpatient cellulitis treatment, acute renal failure, hypertension, hyperkalemia and was admitted to the intensive care unit. The note indicated sepsis was possibly from left leg cellulitis (caused by skin scratch over left shin) and unlikely from the hardware. The associated Discharge Summary physician note, identified the admission diagnosis as "severe sepsis" with a discharge diagnosis of septic shock. "Patient was found to be in septic shock secondary to left lower extremity cellulitis in the setting of recent orthopedic surgery. Orthopedics was consulted and did not feel that it was related to the hardware and that was not discontinued."

R32's record was reviewed from 9/17/19 through 10/2/19, lacked skin evaluations, evaluation of antibiotic effectiveness, and evidence of monitoring for signs and symptoms of infection.

During an interview on 10/2/19, at 2:38 p.m. registered nurse (RN)-B stated R32 received once a day dressing changes to the left leg. RN-B stated after R32 was readmitted from the hospital the orders were changed from twice a day to once a day per the hospital discharge summary. RN-B stated after admission to the facility, R32's pin sites were not draining very much, RN-B reviewed the progress notes and stated the physician should have been notified when R32 started to show signs/symptoms of infection and should not have waited until the NP would be in

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the facility. RN-B reviewed the physician visit form and confirmed the physician had written an order to clean R32's pin sites twice a day.

During an interview on 10/2/19, at 2:40 p.m. RN-C reviewed R32's progress notes and stated, the physician should have been notified immediately when the nurse saw changes to the pin sites and for sure when his symptoms worsened with fever. A progress note dated 9/7/19, only indicated a request for R32 to be added to physician rounds.

During a subsequent interview on 10/2/19, at 3:03 p.m. RN- C stated the physician should have been made aware on 9/7/19, when the resident's shin was noted to be red and warm to touch. RN-C stated a request was made for the NP to see R32 on Monday 9/9/19. RN-C stated she had not been aware of the scratch noted on the hospital discharge summary that was a potential cause of the cellulitis. Further, RN-C stated any resident skin impairments were to be assessed, monitored and documented. RN-C reviewed R32's MAR and confirmed there was an antibiotic dose omitted. RN-C also stated when a resident was receiving antibiotics for skin issues, nurses were supposed to evaluate for effectiveness of the antibiotic, and document details of the resident's skin integrity. RN-C reviewed the physician order on the Clinic Referral form dated 9/26/19, RN-C stated the order should have been clarified because the order was to clean the pin sites twice a day, and not change the dressing twice a day. RN-C stated she would would seek order clarification.

R32's physician orders dated 10/2/19, indicated the dressing change to R32's left leg was

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changed from once a day to twice a day.

During an observation and interview 10/3/19, at 11:11 a.m. R32 was laying in bed and FM-D was sitting at the bedside. RN-B entered the room and explained to R32 she was going to complete his dressing change. RN-B informed R32 and FM-D the dressing change was changed to twice a day. FM-D stated he had been telling staff that since the order was written on 9/26/19, and stated those directions were on a piece of paper that came back from the doctor's office.

During an interview on 10/4/19, at 3:55 p.m. the director of nursing (DON) stated she expected staff were expected to implement physician orders within 24 hours of an appointment. The DON stated she further expected staff to document evaluation of antibiotic effectiveness, and stated if there had been a scratch with signs/symptoms of infection, that should also have been documented.

The facility's 10/2010 policy Wound Care, included: 1) Verify there is a physician's order for this procedure. Documentation: The following information should be recorded in the resident's medical record, 1) The type of wound care given 2) Date and time the wound care was given... 5) Any change in the resident's condition 6) All assessment date (wound bed color size, drainage) obtained when inspecting the wound... Reporting: 1) Notify the supervisor if the resident refuses wound care. 2) Report other information in accordance with facility policy and professional standards of care.

Edema

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During an observation and interview on 9/30/19, at 3:50 p.m. R151 sat in her wheelchair in her bed with her feet dependent (down). R151 had low stretch wraps on up to her knee; R151 legs were observed to be edematous. R151 stated when she was discharged from the hospital she had been wearing compression stockings that came up to her thigh, however her legs became more swollen, and the stockings become too tight and "they hurt so bad". R151 stated they "finally they got the wraps."

R151's facility Admission Record dated 10/4/19, indicated R151 was admitted to the facility on 9/13/19, with diagnoses that included displaced fracture of base of neck of left femur, hypertensive chronic kidney disease stage 1, and long term use of anticoagulants.

R151's hospital discharge summary dated 9/13/19, indicated on 9/12/19, included "No extremity edema"

R151's admission Nursing Assessment dated 9/14/19, included, "has significant amount of edema with noted pitting +1 on the top of her foot". In section 31. Venous, edema was checked and where the assessment asked to "Specify location/pitting ect:" response was "Bilateral legs from the knee down. Non-pitting."

R151's admission Minimum Data Set (MDS) dated 9/20/19, indicated R151 did not have cognitive impairment, required extensive assistance from one staff for dressing, and weighed 145 pounds. The MDS also indicated R151 did not use a diuretic medication.

R151's dehydration and fluid maintenance Care

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Area Assessment (CAA) dated 9/26/19, included "Resident also had redness and swelling noted to lower extremity so cellulitis could be a possibility. As well" and indicated at the time of the assessment R151 did not display symptoms of dehydration.

R151's care plan dated 9/30/19, included R151 had renal insufficiency with a goal of having no signs and symptoms of complications related to fluid overload. The care plan directed staff to monitor/document/report as need the following signs and symptoms: edema, weight gain of over 2 pounds. R151's cardiovascular care plan dated 9/20/19, included monitor/document/report as needed any changes in lung sounds on auscultation, edema, and changes in weight.

R151's physician orders included
-Compression stockings on in the morning to help with swelling off at night (start date 9/20/19)
-Bilateral lower extremity ace wraps to knees every morning and off at night every day to for edema (start date 9/25/19.)

R151's weight record was reviewed; the record indicated 8.9-pound weight gain.
-9/13/19, weight was 244.7 lbs. (pounds)
-9/23/19, weight was 253.6 lbs.

R151's record lacked evidence of physician notification of the weight gain and consistent monitoring/evaluation of edema.

R151's progress note indicated the first time edema was mentioned was on 9/18/19, note indicated R151 had 2+ pitting edema to both lower legs and feet.

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R151's progress note dated 9/20/19, indicated R151 was seen by orthopedic surgeon for follow up appointment; new orders included "compression stockings daily to help with swelling".

R151's progress note dated 9/21/19, indicated stockings were not applied because they needed to be ordered.

R151's progress note dated 9/22/19, included "non-pitting edema to bilateral lower extremities"

R151's progress note dated 9/23/19, included "no signs of edema"

R151's progress note dated 9/24/19, included "no edema" a subsequent note indicated compression stocking were no applied, "in Ace wraps until compression stockings come in, they have been ordered."

R151's progress note dated 9/29/19, indicated compression stockings were not applied. R151 declined them because "digs into her leg."

R151's progress note dated 10/2/19, included "edema noted to bilateral lower extremities" a subsequent progress note at 12:14 p.m. included, "declined compression stockings stated "they hurt my legs", the note also included, "bilateral legs swollen, non-pitting edema, therapy notified and will re measure and order bigger size, Ace wraps applied."

R151's progress note dated 10/4/19, indicated skin assessment had been completed on 10/3/19. Note indicated, bilateral chronic edema to right lower leg, firm, non-pitting edema to right lower

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leg up to knee/ankle, 2+ pitting edema to right lateral side of foot, no signs/symptoms of cellulitis, no weeping noted. Left leg chronic edema from just below knee to ankle 2+ pitting edema, left lateral foot 2+ pitting edema, no signs/symptoms of cellulitis. Per 151 she does have history of chronic edema also noted history of lymphedema. Refuses compression stockings because they are too tight, therapy measuring for a new pair. Ace wraps are applied however, she takes them off, encouraged to lay with legs elevated daily. Placed on daily weight monitoring for three days, weight down today at 237.2 pounds.

During an interview on 10/3/19, at 11:53 a.m. (RN)-B reviewed R151's record and verified R151 had an weight gain. RN stated the physician should have been notified with the weight increase, supposed to notify if over 3 pounds in one day, however would not know that because R151 was not on daily weights. RN-B stated R151 had a lot of edema right now. RN-B indicated she just talked to therapy today because R151 had pitting edema on the side of hip fracture and the right one is more swollen. RN-B indicated she had not notified the physician with the increase. RN-B stated edema was supposed to be assessed and documented daily; documentation needed to be thorough so there is something to compare to.

During an interview on 10/3/19, at 12:57 p.m. (RN)-C stated nursing staff were supposed to notify her when there were changes in a resident's condition. RN-C indicated she was not aware of the weight increase and staff should have first reweighed the resident and if it was accurate the physician should have been notified

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with the change. RN-C stated edema should be monitored and documentation should include location and extent of edema, and also evaluated for a change in the edema.

During an interview on 10/3/19, at 1:22 p.m. the NP indicated Senior Care encouraged short term residents to keep their own primary physician. NP indicated that Senior Care did not take call after hours or on weekends. NP indicated Senior Service physician's did not typically see short term residents on a routine basis but would if requested to do so. NP indicated she was not notified when R148 had an elevated temperature, and was not aware of R151's increase in weight or edema. NP indicated she was made aware of R32's changes to pin sites however, was not aware of how long he had been displaying symptoms. NP indicated if residents are showing signs/symptoms of a change in condition, nursing staff should notify a physician whether it be on-call service, primary care physician, or a physician with Senior Care.

During an interview on 10/4/19, at 3:54 p.m. the DON stated R151 saw the provider on 9/25/19. The DON stated it was expected the physician would be notified of weight gain related to edema, and that edema be monitored and evaluated consistently. The DON stated when R151 had a significant weight increase, there should have been further evaluation.
R40's Admission Record, indicated an admission date of 11/14/17 and diagnoses of chronic respiratory failure with hypoxia (lack of oxygen to the body tissues), pulmonary hypertension (causing shortness of breath, dizziness and chest pressure), chronic obstructive pulmonary disease (COPD), chronic diastolic congestive heart failure

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(CHF), lymphedema (swelling in an arm or leg caused by lymphatic system blockage), and major depressive disorder.

R40's After Visit Summary, dated 6/8/19, indicated, R40 was hospitalized from 6/4/19, to 6/8/19, with acute on chronic diastolic CHF, with new orders for daily weights, low sodium diet, 1500 ml fluid restriction, and to call provider for weight gain over 3 lbs. in one day, or more than 5 lbs. over baseline weight.

R40's Physician Progress Note, dated 6/21/19, indicated the reason for visit was a follow-up after recent hospitalization from 6/4/19 to 6/8/19 with increased dyspnea, secondary to CHF exacerbation. [R40] was diuresed in the hospital with 8 kilogram (kg) weight loss. (17.6 lbs.) Impression: CHF-weight is stable, continue present regimen, [R40] was changed from Lasix to bumetanide and spironolactone 1 week ago, weight has been stable since. Lymphedema not prominent while lying in bed with recent weight loss.

R40's annual, Minimum Data Set (MDS) assessment dated 9/10/19, indicated R40 to have intact cognition. R40 needed extensive assist with most activities of daily living (ADL'S), received diuretics and oxygen therapy.

R40's current, Physician Orders included the following:
-1500 milliliter (ml) fluid restriction daily
-oxygen via nasal cannula at 4 liters (L) per minute to keep oxygen saturations level 90 - 92% every shift, for shortness of breath (SOB) related to respiratory failure with hypoxia,
-Bumetanide (used to treat fluid retention and

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high blood pressure) 1 mg two times a day (BID) for diuretic therapy
-Lisinopril (used to treat high blood pressure and heart failure) 2.5 mg daily
-spironolactone (used to treat high blood pressure and fluid retention) 12.5 mg daily.

R40's care plan, revised 8/19/19, indicated a focus: The resident has nutritional problem ...related to diagnoses of polio, COPD, depression, hyperlipidemia, anemia, history of significant weight change, respiratory failure, and above ideal weight limits ...Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight within 227 - 237 pounds (lbs.), through review date. Interventions: no added sodium diet (NAS) with 1500 ml fluid restriction, weigh at the same time of day and record any weight over 3 lbs., in one day or 5 lbs. in 1 week, If weight increases or decreases by 5 lbs. call the provider. Review of R40's care plan lacked a focus, goals, and interventions for R40's diagnosis of CHF.

R40's medication administration record (MAR) for 10/2019, indicated R40 received bumetanide, Lisinopril, and spironolactone per provider order.

R40's treatment administration record (TAR) for 10/2019, indicated the following order was monitored for any weight over 3 lbs. in one day, 5 lbs. over baseline weight, or if weight increases or decreases by 5 lbs. to call the provider. Further indicated fluid intake was being documented each shift. 9/2019 TAR indicated the weight was not assessed on 9/24/19, as indicated the area to sign in was left blank.

Review of R40's progress notes indicated R40

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was exhibiting shortness of breath and lower extremity edema:

7/2/19, at 1:45 a.m. oxygen (O2) dependent at 4L NC, O2 sats 95%, dyspnea with exertion while transferring from wheelchair to EZ-stand to bed. Lower extremity edema.

7/14/19, O2 dependent on 4 L, 92%, 2+ lower extremity edema, dyspnea with any type of exertion, lung sounds wheezes, nebulizer treatment.

Review of R40's weights from 5/27/19, to current indicated R40 was not weighed daily per the provider order. Per review of nurses notes weights were not completed on 6/20/19, 7/12/19, 7/22/19, and 7/23/19 (no reason noted). On 7/15/19, no time to get R40's weight. On 7/31/19, R40 refused her weight.

R40's weights were not recorded on the following days:
-June: 15, 20, 21, 26, and 27
-July: 1, 11, 12, 15, 20, 22, 23, 30 and 31
-August: 20
-September: 4, 7, 9, 20, 23, 24, and 26

R40's documented weights:
5/27/19 243.1 lbs.
6/3/19 249.1 lbs.
6/8/19 237.7 lbs.
6/9/19 238.1 lbs.
6/10/19 241.4 lbs.
6/16/19 238.0 lbs.
6/17/19 241.7 lbs.
7/6/19 237.0 lbs.
7/7/19 240.8 lbs.
7/14/19 240.1 lbs.

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7/16/19 243.0 lbs.
7/21/19 239.6 lbs.
7/24/19 242.3 lbs.
7/28/19 238.9 lbs.
8/1/19 234.2 lbs.
8/2/19 243.3 lbs.
8/6/19 230.4 lbs.
8/7/19 233.2 lbs.
8/8/19 236.9 lbs.
8/12/19 232.1 lbs.
8/13/19 235.4 lbs.
9/16/19 232.0 lbs.
9/17/19 236.0 lbs.

R40's Skin Assessment, dated 7/28/19, identified +2 pitting edema to bilateral legs and enlarged abdomen.

R40's record indicated that R40 had fluctuations in weight over 3 lbs. daily on 10 different occasions since R40's hospitalization of CHF, on 6/4/19. The record lacked evidence that R40 was ever re-weighed with these increases in weight, and lacked evidence of ongoing edema assessment and monitoring. Further indicated that the physician was not notified related to the R40's weight increases.

During observation and interview on 10/1/19, at 11:25 a.m. R40 was seated up in her wheelchair in her room watching television. R40 was noted to have oxygen running at 2L/NC via concentrator. R40 stated, I was in the hospital in the intensive care unit in June, I had pneumonia.

During interview on 10/04/19, at 10:48 a.m. registered nurse (RN)-E stated, if there was a question of weight discrepancy, I would ask for a re-weight. RN-E verified R40 had no baseline

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weight, there were no reweighs completed, and there was an order to notify the physician with 3 lb. weight gain. RN-E stated whoever was in charge should have notified the provider of the weight gain for R40, and she should have been assessed to find where the fluid load was.

During phone interview on 10/04/19, at 11:04 a.m. family member (FM)-F stated, I usually visit [R40} every Sunday, Monday and Tuesday. FM-F stated, they do not have enough staff, the ones they have are good they just do not have enough of them. They used to have enough nurses, I don't know what happened, now the nurses have to run from wing to wing and it's very dangerous and anything could happen. [R40] had been having a lot of breathing problems, they gave her oxygen and neb treatments, but back in June she ended up with so much fluid and had labored breathing for weeks. Her O2 saturations were down to the 70's that was the third week, then they finally sent her to the ER. [R40] was in the ICU for 5 days with fluid overload and pneumonia. "I honestly didn't think she was going to make it." They need to have a nurse on every wing I think, it is just too dangerous and R40 doesn't like to complain, she will say, oh they are busy right now, I don't want to bother them.

During observation and interview on 10/04/19, at 5:16 p.m. R40 was seated in her wheelchair in her room watching television. R40 stated, I am on a fluid restriction, they weighed me this morning, right now my right leg is not swollen, just my left leg. My legs do feel heavy sometimes, when I feel SOB, I ask to have my oxygen turned up or do a nebulizer treatment.

During interview on 10/04/19, at 4:19 p.m. nurse

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practitioner (NP) stated if there is an order to notify the provider with an increase in 3 lbs., we should be notified. Edema monitoring should be completed every shift.

During interview on 10/04/19, at 6:46 p.m. the director of nursing (DON) verified there was no ongoing assessment or monitoring of edema and the physician was not notified per the order of R40's weight increases. DON stated, I would expect cardiovascular assessment and monitoring for a resident with a diagnosis of CHF to include: shortness of breath upon exertion, fatigue, weakness, edema monitoring, rapid heartbeat, and a persistent cough or wheezing with white or pink blood-tinged phlegm. DON further stated, a resident with a 3 lb. weight gain in one day, the physician should be notified, if there is an order for it.

R22's Admission Record indicated R22 had diagnoses of diabetes mellitus, chronic kidney disease, hyperlipidemia (excess fats such as cholesterol in the bloodstream which can result in arterial plaques) and an unspecified disorder of the circulatory system. In addition, a hospital summary dated 9/16/19 indicated R22 had additional diagnoses related to circulation of bradycardia sinus (abnormally slow heart rate), edema since 12/6/12, HTN and obesity.

A Significant Change Minimum Data Set (MDS) assessment dated 7/19/19 indicated R22 was totally dependent on staff to transfer and required extensive assistance from staff for repositioning. She did not walk or stand.

During an observation on 9/30/19, at 6:33 p.m. R22 was sitting in her wheelchair in her room

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noted to have an amputation of her left lower leg. Her right lower leg was dependent (hanging down) with swelling (edema) above her sock and extending up to her knee. R22 stated she did not notice she had swelling. R22 was wearing a padded boot on her lower leg but no compression stockings or wraps were noted.. R22 stated she did not remember if anyone had ever attended to her edema, but stated they did not wrap her leg.

R22's care plan read "CARDIOVASCULAR: chronic lower extremity edema with intervention to monitor edema as needed dated 5/15/18, but failed to include any other instruction on the monitoring, documentation or frequency of reporting of edema. Also, the interventions failed to include instructions for the reduction or control of edema.

R22's progress notes from 10/1/19 thru 10/3/19 failed to find any documentation related to edema monitoring.
R22's progress notes from 9/1/19 thru 9/30/19 indicated on 9/27/19 R22 had no edema or shortness of breath; however, record failed to show any other documentation on edema during that time period.

R22's Treatment administration record (TAR) had an order to elevate legs starting 10/31/18 and the order had been discontinued on 9/7/19. An order for "Ace wrap on during the day and off at HS (bedtime) dated 10/31/18 was discontinued 9/7/19. A review of medical provider visit notes did not include an order for discontinuation of the above orders.

According to an observation and interview, 10/02/19, 10:05 a.m. R22 went to a podiatry

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appointment in the facility and was seen by Medical Doctor (MD-A). R22's right leg was noted to be swollen and red. R22's legs had been dependent while she was sitting in her wheelchair. MD-A stated, "her edema is bad, it's doughy, plus four; I would say plus ten, but plus four is the maximum edema measurement indicating a finger impression will deeply indent the tissue and require 20 seconds or more for the indention to go away due to fluid accumulation in the interstitial tissue."

On 10/02/19, at 3:20 p.m. R22 was observed returning to her room from an activity. Her right leg remained dependent in the wheelchair. R22 stated she had not laid down and doesn't like to lay down.

According to an interview, 10/03/19, 7:37 a.m. registered nurse (RN)-A confirmed R22 had edema of her lower right leg. RN-A stated monitoring edema was not a requirement of care for R22, but said, "I guess, it's a mindful thing to do." RN-A stated R22's edema was "significant", but also stated "it's her normal amount." RN-A also confirmed she had not done any documentation related to edema monitoring for R22. RN-A said there were no compression wraps or stockings ordered for R22 because when she returned from the hospital there were no recommendations to do so. She said the hospital had recommended R22 lay down throughout the day, but stated R22 did not want to miss activities so would refuse to lay down.

During an interview on 10/03/19, at 7:57 a.m. RN-E stated an expectation for nurses to monitor residents with edema on a regular basis and document the onset of edema, the degree

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(measurement/severity) and if there was any pain, warmth or redness. RN-E stated an expectation for nurses to take actions to reduce edema, such as elevating the extremity or using standing orders (SO). RN-E said they could add a "nurse order" to their electronic medication administration record (EMAR) so nurses would know to monitor and care for edema. RN-E also stated an expectation for nurses to notify the physician even if that resident had recently been hospitalized. RN-E also confirmed that given R22's medical diagnoses and a recently resolved pressure area to that limb, the existence of edema was concerning.

During an interview on 10/03/19, at 1:32 p.m. the director of nursing (DON) stated an expectation for nurses to follow a resident care plan related to positioning residents. If a resident would refuse to be repositioned or to lay down, DON stated an expectation for nurses to educate the resident about the reasons for a position change, and to attempt to provide interventions in such a way that it would fit the personal preferences and needs of each resident. DON stated R22 was afraid of missing activities so it was important for staff to make sure they would get her up in time to attend those activities of interest to her. DON also stated an expectation for nurses to "look at the whole picture" when a resident has edema. DON stated physician orders should be followed, but nurses would be expected to elevate extremities, do daily weights, monitor cardiac and respiratory assessments to determine fluid overload and to document and report as needed. Should a resident continue to refuse planned intervention, the DON stated she expected nurses to continue with education and document the refusal of cares, as well as notify the

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physician.

According to a telephone interview on 10/04/19, at 4:19 p.m. nurse practitioner (NP) stated she remembered observing R22 to have had edema. NP stated an expectation for nurses to do regular monitoring and documentation of edema and weights and to notify the physician or NP of a significant change. NP stated she would expect nurses to do daily weights if they note a resident had significant edema and call the medical provider if a resident gained greater than three pound in one day or five pounds in a week. NP also stated she felt anyone in R22's condition should have edema monitored as often as every shift to determine her risk level.

The facility's 2/2014 policy, Heart Failure (HF)-Clinical Protocol included:
Treatment/Management: the physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin levels, etc.) To monitor, when to report findings to physician, etc. The physician will address related medical issues; for example, whether to adjust or stop medications that may be precipitating heart failure, whether to modify doses of diuretics, whether oxygen is needed etc. The physician will document information related to the individual's prognosis and current signs and symptoms; for example, whether there is end stage heart disease, the likelihood of the individual remaining stable or worsening in the near future, the presence of edema or lung finings, etc ...Monitoring/Follow-Up The physician will help monitor the progress of individuals with HF, including ongoing evaluation and

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documentation of signs, symptoms, and condition changes.

The facility's 12/2016 policy, Change in a Resident's Condition or Status included: Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. 1) The nurse will notify the resident's Attending Physician or physician on call when there has been a(an); d) significant change in the resident's physical/emotional/mental condition. e) need to alter the resident's treatment significantly g) need to transfer the resident to a hospital/treatment center. i) specific instruction to notify the physician of changes in the resident's condition. 5) Except in medical emergencies notifications will be made within twenty-four (24) hours of change occurring in the resident's medical/mental condition or status.

The facility's 12/2015 policy, Acute Condition Changed-Clinical Protocol included: 1) During the initial assessment, the physician will help identify individuals with a significant risk of having acute changes of condition during their stay. 2) The nurse shall assess and develop/report baseline information (vital signs, pain level, level of consciousness, active diagnosis). 3) Direct care staff including nursing assistance will be trained in recognizing subtle but significant changes in resident and how to communicate changes to the nurse. 4) The physician and nursing staff will identify any complications and/or problems that occurred during a recent hospital stay, which may include the risk for additional complications or instability. Cause Identification: 1) the nursing staff and physician will discuss possible causes of

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F 684	Continued From page 72 condition change based on factors including resident history, current symptoms, medication regimen and existing test results.	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 observation, interview, and document review, the facility failed to assess, develop and implement interventions consistently to reduce the risk of pressure ulcer development or decline for 3 of 3 residents (R22, R5 and R21) reviewed with pressure ulcers. R22 and R5 experienced harm, deterioration or persistence of pressure ulcers related to the facility's failures. Findings include: According to the National Pressure Ulcer Advisory Panel (NPUAP): Stage II (2) Pressure Injury includes: Partial thickness skin loss with exposed dermis. The	F 686	1. Corrective Action: Resident R5 was assessed for wound condition and need for intervention 10/3/2019. R5 evaluated by Provider on 10/7/2019, 10/14/2019, 10/24/2019, 10/28/2019. New orders were implemented along with facility interventions in place. IDT reviewed status of wound and interventions indicated 10/23/2019. IDT reviewed 10/30/2019, wound healed 10/28/2019 per provider. Nursing staff will continue to monitor for 2 weeks. IDT to review for 2 weeks in weekly wound meeting.	11/18/19

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F 686	Continued From page 73 wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage III (3) Pressure Injury includes: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage IV (4) Pressure Injury includes: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable Pressure Ulcer includes: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. R22 According to R22's electronic health record (EHR) Admission and Diagnoses list, R22 had an extensive list of co-morbidities including several effecting mobility, cardiovascular circulation, skin integrity and ability to heal including, but not limited to the following: Hemiplegia affecting left	F 686	Resident R21 Resident readmitted to facility 10/1/2019. Wound orders revised and implemented 10/4/2019 and 10/6/2019. Resident admitted to hospice 10/4/2019. Resident passed away on 10/10/2019. Resident R22 wound condition and need for intervention was assessed weekly including addition of wound vac treatment staff continued education to resident of the importance of repositioning. Resident wound progressing with wound vac treatments, nursing staff noted difference in wound 10/16/2019, notified provider. Provider recommended continuing current treatment and follow up at wound clinic. New air mattress placed 10/18/2019 by facility. Appointment at wound clinic 10/22/2019 where resident was directly admitted to Mayo Clinic as inpatient. Resident had debridement and piece of coccyx removed, started IV abx. Resident has had 3 seat mapping appointments scheduled at Mayo Clinic that have been cancelled. During this hospitalization, the seat mapping was again rescheduled to 11/7/2019. Resident returned from hospital 10/29/2019. OT evaluating seat cushion and additional cushion/wedges in bed. R22 returned with orders to be on bed rest except one hour during each meal. Previously R22 was noncompliant with laying in bed, R22 has been compliant since hospital return with bedrest. Activities providing alternative activities. R22 also has new collection bag placed over rectal stump that considerable fluid leaked out of and into	

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F 686	Continued From page 74 non-dominant side (paralysis or difficulty moving the left side of the body), amputation of left lower leg after recent history of heel ulcer and infection, myasthenia gravis (an autoimmune, neurological disease that causes muscle weakness), osteoarthritis, type 2 diabetes mellitus (DM2), chronic kidney disease stage 3 (reduced ability of kidneys to remove excess fluids and waste from the body), hyperlipidemia (excess fats such as cholesterol in the bloodstream which can result in arterial plaques), pressure ulcer of sacrum and an unspecified disorder of the circulatory system, coagulation and also anemia. In addition, a hospital summary of care document dated 9/16/19, indicated R22 had additional diagnoses of osteomyelitis of sacral decubitus ulcer, bradycardia sinus (abnormally slow heartrate), edema since 12/6/12, HTN (hypertension) and obesity. A Minimum Data Set (MDS) assessment dated 7/19/19, indicated R22 was totally dependent on staff to transfer and required extensive assistance from staff for repositioning. The MDS also indicated R22 was unable to stand, and did not walk. During an observation and interview at 6:28 p.m. on 9/30/19, R22 was seated in her wheelchair with a cushion under her however, she was also observed to be seated on a lift sling for a mechanical lift. The sling was observed to be wadded and tucked up between the resident's legs. R22's bed was noted to have a standard pressure reducing mattress. R22 stated she had a sore on her bottom and said the nurses were "watching it." She stated she thought they might put salve or medication on the sore and said she thought they did a dressing change every few	F 686	wound, affecting seal and cleanliness of wound. R22 continues on IV antibiotics, nursing staff monitoring for signs/sx of infection, IDT continuing to review weekly for effectiveness of interventions and indication for additional intervention. Resident care plans and TARs updated to reflect current orders and individualized interventions. Weekly skin observations added to resident records to be completed by licensed nurses weekly. Skin assessment (UDA) scheduled in resident records weekly. 2. Corrective Action as it applies to other Residents: All residents with skin issues will be assessed for wound condition and appropriate individualized interventions. Care plan, TAR and POC will be updated to reflect individualized interventions. Referral will be made to wound specialist for all ulcers and complex wounds. 3. Date of Completion: 11/18/19 4. Reoccurrence will be prevented by: Nurses will be educated at a mandatory meeting 11/7/19 and competency tested on Wound care. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information be competency tested and signed off by 11/15/19.	

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F 686	Continued From page 75 days. R22 said the nurses would look at the wound, but stated she could not remember a physician looking at her wound recently. R22 was unable to say how often she was repositioned in her chair but stated she thought it was quite often. At that time, R22 confirmed she had not had any assistance with repositioning since sometime prior to supper which she had at 5 p.m. R22 was unable to provide any further information about the size or severity of her wound, and stated she thought she had another wound, on her right heel, but could not provide any information about it. She was unable to recall why her left leg had recently been amputated. A review of R22's current care plan updated 7/12/19, included: "ADL (activities of daily living)/FUNCTIONAL STATUS: The resident has an ADL self-care performance deficit d/t (due to) impaired mobility r/t (related to) Dx (diagnosis) of multiple sclerosis, peripheral neuropathy, chronic lower extremity edema, Hx (history) of falls with subdural hematoma (bleed around brain). Hx of Foley catheter placement (a tube into bladder to drain urine). Hx of refusal to work with therapy. S/P (status post) Amputation of Leg Above Knee Status Post Left." The care plan interventions included: "BED MOBILITY/REPOSITIONING: The resident requires extensive AO1 (assist of one) for bed repositioning q2hr (every two hours) and PRN (as needed) through all shifts." "TRANSFER: The resident requires extensive assist by 2 staff with use of Hoyer lift to move between surfaces every 2 hours and as necessary." "Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function."	F 686	Licensed nurses will be educated on completing wound observation and skin assessments for all resident wounds. Nursing staff will be educated to follow clinical protocol for wound care, ensuring appropriate providers are made aware of changes in wound healing. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and be signed off by 11/15/19. DON or designee will audit wound observation and skin UDA□s for all residents with wound care to ensure appropriate assessment and wound care are being provided. Audits will be done every week for 1 month and then every month for 3 months. DON or designee will audit to ensure all changes in wound healing are communicated to the appropriate provider as they occur. Audits will be done every week for 1 months and then monthly for 3 months. Results will be communicated to the QAPI committee 5. Correction will be monitored by: DON or designee QAPI committee	

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R22's care plan had focus updated 9/20/19: "SKIN INTEGRITY: Impaired mobility r/t Dx multiple sclerosis,Dx peripheral neuropathy, gout, DM2, chronic lower extremity edema, Hx cellulitis to lower extremities ... tends to lean to the left. Hx and current MASD (moisture associated skin damage) ... refused alternating air mattress, frequently refuses interventions. Pressure injury to heel, left buttocks ..." Associated interventions included: "follow facility policies/protocols for the prevention/treatment of skin breakdown." " Inform the resident/family/caregivers of any new area of skin breakdown." "Recent surgical debridement of wound to left buttocks-follow orders and participate in follow up appointments. Requires frequent explaining and encouraging to follow through with skin interventions." "Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Staff assist with repositioning every 2 hours and PRN." The care plan did not include any interventions related to laying down between activities, or building trust by returning to get R22 up in time to attend activities of her choice.

According to a document in the EHR titled Weekly Ulcer/Complex Wound Observation Tool (WU/CWO Tool) dated 6/12/19, R22 had a pressure wound on her left buttock measuring 1.5 centimeters (cm) in length and 2.5cm in width and depth was marked as not applicable. At that time, R22 had a documented "unstageable" pressure ulcer on her right heel. The buttock wound was described as having 100% slough tissue and some clear yellow drainage. Additional information noted R22's buttocks had black/purple on the right side with some peeling skin and some maceration (moisture associated

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damage) from urine dribbling. A note within the document indicated as of 5/29/19, R22 was refusing pressure relieving interventions and was refusing to lay down. However, it noted R22 was on a turning and repositioning routine.

WU/CWO Tools dated 6/20 and 6/23/19, included the same description of the left buttock wounds as documentation 6/12/19.

A WU/CWO Tool dated 6/27/19, also included identical measurements as previous WU/CWO documentation that month, but also included: "left buttock/sacrum ulcer stage 2 with 50% slough, 2cm by 1.5 cm by 0.25 cm, no odor." In addition, an additional wound was mentioned "right buttock/inner thigh stage 2." Measurements for that wound were identified as "4.75 cm by 3 cm by 0.25 cm. 75% slough."

A WU/CWO Tool dated 7/3/19 included identical measurements to previous WU/CWO Tool with the depth of the wound identified as na (not applicable). An evaluation note indicated the following measurements; "left buttock sacrum ulcer stage 2, 50% slough, 2 cm by 1.5 cm by 0.5 cm" (increased depth) and "right inner thigh stage 2, 5cm by 3 cm by 0.5 cm, 100% slough." (increased length, depth and slough.)

According to a MDS discharge assessment, R22 was hospitalized on 7/3/19. An MDS tracking record showed R22 was re-admitted to the facility on 7/12/19.

A Skin Assessment (SA) document dated 7/12/19, indicated R22 had a stage 4 sacral ulcer with "tunneling present 1 cm deep." The SA did not indicate where the tunneling was located, and

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indicated the wound measured 1.25 cm wide and 1cm in length." In addition, the SA indicate an area of 5 cm by 6.5 cm of redness and irritation.

A WU/CWO Tool dated 7/15/19, included: "7/12/19: Hospital return left above knee amputation." No changes in interventions were documented on any of the WU/CWO Tools. Measurements in the evaluation portion of the document included: "left sacrum ulcer 1 cm by 1.25 cm by 1 cm with 5 cm by 6.5 cm red irritation surrounding tissue. 75% slough with tunneling." No further description of the tunneling was provided.

A WU/CWO Tool dated 7/30/19 contained new measurements "sacrum, pressure, 1.4cm length by 2.4cm width by 1.6cm depth, stage 3 (stage three is a full thickness with loss of tissue but bone, tendon or muscle are not visible.) The WU/CWO Tool stated the wound was "unchanged" and did not indicate any tunneling. No special equipment or preventative measures was listed, but read R22 was on a turning and repositioning program. Under current treatment plan indicated "resident often refuses to be in bed more and to turn from side to side" and under area to describe changes in the treatment plan indicated, "encouraged by staff to lie down for a short period after lunch." No further evaluation present. Although the tool indicated it was effective 7/30/19 it included documentation stating MD was updated 8/1/19 "during weekly rounds."

WU/CWO Tool dated 8/6/19, included the same pressure ulcer wound measurements with no additional interventions listed.

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WU/CWO Tool dated 8/13/19, also included the same wound measurements of the sacral area pressure ulcer, and also included the following: "left buttock, pressure, unstageable" with no measurements. The note also indicated the resident's family member was informed of changes on the resident's wound status and "noncompliance with treatment plan." WU/CWU tool also included documentation to indicate the MD was notified of her condition during weekly provider rounds 8/15/19." No update in treatment plan or interventions was documented except "Resident refuses majority of time." The director of nursing (DON) was notified of the worsening of the wound on the date of documentation.

WU/CWO Tool dated 8/23/19 indicated the sacral wound was the same size. No documentation was included regarding the "left buttock pressure area" as previously documented, but contained the following information about a wound, "site-left gluteal fold, type-pressure." No other measurements were included. No update to the treatment plan or interventions was listed even though the wound was marked as "worsening." The evaluation included: "sacral wound has worsened with increased drainage and odor noted." The document indicated the medical provider had been updated and an order received for a "snap-vac" wound drainage system.

A skin assessment dated 8/31/19, indicated R22 had a stage 2-3 pressure injury on her right buttock, a stage 3-4 pressure injury on her left buttock and a surgical incision on her left knee. Documentation included, "did not measure areas. Stage 3-4 pressure area has gotten bigger in diameter since last time author observed it. Large amount of foul smelling exudate present on

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dressing. Stringy slough coming out of wound with cleaning. Overall impression: worsening." No documentation included related to reporting to supervisor, medical provider or family. No documentation related to treatment, interventions or resident response to cares.

A physician's office visit note dated 9/4/19 stated R22's primary problem at the time was a sacral decubitus ulcer. The note indicated family member (FM)-C attended the visit and informed physician the wound vac was only placed over one wound, but R22 had two wounds. The note further indicated the physician was unable to look at the wound because R22 required a mechanical lift to lay her down, and no such lift was available at the clinic. The note indicated a referral had been made to Senior Services so R22 could be seen by the medical providers that make rounds at the facility. The following statement was included, "advised patient and the nursing home staff on frequent repositioning."

A skin assessment dated 9/20/19, indicated R22 had a slit in her abdominal fold, an excoriated area around her "whole buttocks area left and right" and a wound on her "left buttock" measuring 8 cm by 8.2 cm and 3 cm deep." Additionally, the left heel wound was identified as having a 32 [sic.] cm red area on the heel. This document stated her wound was "unchanged" but very tender to touch. There was no documentation related to treatment, interventions or resident response to cares. There was also no documentation related to reporting the condition of the wound to the medical provider or family identified.

A skin assessment dated 9/27/19, indicated R22

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had a stage 4 wound on left buttocks near coccyx with wound vac. No measurements or other description were included, but documentation indicated the wound was "improving." There was no documentation related to treatment or interventions found. There was also no documentation related to reporting the condition of the wound to the medical provider or family was included.

No additional WU/CWO Tool was found from 8/23/19 until one dated 10/2/19, which indicated R22 had a pressure wound on the coccyx measuring 9 cm in length, 5 cm wide and 6.4 cm deep, which was identified as a stage 4 pressure ulcer. The document indicated the physician had last been updated 9/23/19 during an appointment.

During interview on 10/2/19, at 3:28 p.m., registered nurse (RN)-A stated she had already completed R22's wound care for the day. RN-A described the wound as "really deep, you can see bone." RN-A stated she'd had to contact the equipment provider of the Snap-Vac wound vac system because the sponge was no longer filling the wound and the system wouldn't seal correctly. RN-A also said they needed to get larger vacuum canisters for the system "because it was draining so much." RN-A stated she had just learned that week, that she was supposed to do wound assessments and measurements on a weekly basis. However, RN-A said she had not done measurements because R22 had recently been to an appointment and the wound had been measured at the appointment. RN-A was unable to provide a copy of that report stating "I don't know where I put it. I left it here on the desk last night so I could get back to it when I came in today."

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During interview on 10/3/19, at 7:37 a.m., RN-A stated R22 had been in the hospital for about a week in September because of her sacral ulcer, and had returned without any new recommendations. RN-A stated the hospital had recommended R22 be encouraged to lay down, but RN-A said R22 "refuses to lay down because she doesn't want to miss any activities." RN-A said she had placed the new wound vac system yesterday, but had concerns because the suction tube came out very close to the wound. Finally, RN-A stated she had not checked R22's dressing yet that morning because R22 was "already dressed and was not patient to wait."

According to an interview 10/3/19 at 7:57 a.m., RN-E who was the nurse manager, stated it was expected the nurse would look at resident wounds every day. RN-E stated staff should educate residents about interventions that will help with healing, such as repositioning and laying down. RN-E also said they should refer patients to occupational therapy for further recommendations regarding use of cushions and special mattresses, and a nutritional consult should be conducted to see if any nutritional supplements should be added to promote improved healing.

During an interview on 10/3/19, at 11:16 a.m., R22 stated she couldn't remember what things she could do to help her bottom heal. She stated she could not remember if anyone had talked to her about the importance of pressure relief for her wound to heal. She did not think anyone had told her that continued pressure to her wound might be dangerous to her health. She did not remember having ever refused a pressure

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relieving mattress, stating, "I don't know why I wouldn't want that." R22 said she would probably be willing to lay down if they made sure to arrange it around the activities she wanted to attend. R22 was able to remember what activities were happening and the approximate time to attend.

A continuous observation for repositioning was initiated 10/3/19 at 11:16 a.m. R22 was taken to the dining room in her wheelchair at 11:20. At that time, nursing assistant (NA)-F stated she was a "float" staff so she was not exactly sure how often R22 should lay down. NA-F added, "they ask after lunch and breakfast, I'm pretty sure." However, NA-F said she had not asked R22 to lay down that day because she hardly ever worked with R22. NA-F stated she was on her way to take R22 to the dining room because R22 liked to go to lunch at that time. At 11:30 a.m. R22 was seated at the table waiting for her meal. At 11:45 a.m. she received her meal. R22 was noted to lean slightly to her left while sitting in the chair, sitting more heavily on her left buttock. At 12:00 p.m. R22 remained in the same position and had not made any attempts, or been reminded, to reposition herself or to shift her weight from her left side. At 12:14 p.m. R22 had finished drinking all of her fluids and had eaten about half of her meal. Her position remained unchanged. At 12:19 p.m. trained medication aid (TMA)-C approached R22 to see if she was done eating. TMA-C then took R22 to her room and parked her wheelchair in front of the television without repositioning or offering to assist R22 to lay down or off load. TMA-C left the room after telling R22 she would return "in a little bit." At 12:30 p.m. R22 remained in her room and had not changed position or shifted her weight. At 12:40 p.m. there was no

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change. At 12:47 p.m. TMA-B entered the room with medications. TMA-B chatted with R22 about his (TMA-B's) schooling and when he would be working again and left the room. TMA-B had not offered any repositioning and R22 remained in the same position. At 12:48 a therapist entered the room and chatted with R22 about crafts, dogs, R22's past work history and about R22's leg. The therapist left the room at 1:03 p.m. after asking R22 if she needed anything. R22 was not repositioned or asked if she would like to lay down. At 1:13 p.m. TMA-C returned to the room and said, "do you want to lay down?" R22 talked about activities. TMA-C said "it would be good for your bottom [to lay down]." R22 mumbled and TMA-C left the room at 1:14 p.m. R22 remained in her wheelchair in the same position. At 1:19 p.m. TMA-A was in the area passing meds. At that time, when questioned, TMA-A stated staff were to offer the resident repositioning "every two or four hours." TMA-A stated, "If the doctor would tell her she needs to lay down, I think it would help." TMA-A said it was the responsibility of the nursing assistants to offer repositioning and confirmed that he had not asked R22 about laying down or repositioning either. R22 at that time remained in her room with no change in position. At 1:23 p.m. TMA-C was interviewed and said she had asked R22 twice to lay down. TMA-C stated R22 was supposed to be repositioned every two hours, but added, "she refuses a lot." TMA-C stated at those times, she would normally return in five to ten minutes to lay her down. Then TMA-C added, "I just asked her and she agreed to lay down, but everyone is busy and I'm going on break." TMA-C said she had reported this to the director of nursing (DON), and then TMA-C left for her break. R22 remained sitting in the same position in her room.

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According to an interview 10/3/19 at 1:32 p.m., the DON stated staff were expected to follow a resident's care plan for repositioning. In the case of R22 who may be resistant to repositioning, the DON stated, "My expectation would be for staff to educate the resident on the importance of laying down or off-loading." The DON also stated she would expect staff to work with the resident to provide repositioning in a way that would best fit the resident needs and preferences. The DON said she was aware R22 was afraid she would miss activities if she laid down so she expected staff to make sure R22 would have a schedule allowing her to lay down, but be up for activities. The DON also stated nursing staff needed to continue to provide R22 and other residents like her with continuous education about risks/benefits. The DON said education and efforts should be documented, and if a resident continues to refuse, this should be adequately documented. The DON said the facility was revamping their pressure ulcer monitoring process, "The plan going forward is for the nurse manager to do follow-up assessments weekly." The DON described they had two different documentation tools for nurses to choose from, and stated the "Ulcer Observation Tool" should be completed weekly if a resident had a pressure ulcer. The DON also they had received an order to do "pressure mapping" so a new cushion could be developed for R22 to reduce pressure. However, the DON stated this had not yet occurred, but she thought it would be occurring soon.

According to a telephone interview on 10/4/19 at 10:54 a.m., the registered dietician (RD) stated she conducted remote nutritional assessments

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for the facility once a month. The RD said she had no way to run any reports from the EHRs and was therefore, reliant on the resident lists provided by the facility's certified dietary manager (CDM). The RD stated she'd get a list that generally included the names of persons with weight loss, or skin issues, and said when she was made aware of a problem, she would review the weekly skin assessments in the resident's chart. The RD said this was the only way she would know if a resident had any skin issues. The RD further stated, "I wouldn't be looking for anyone else [other than those on the list], I have to trust what they give me." When asked, the RD did not recall R22. However, after reviewing her notes the RD stated, "I did not assess her in August. In September I don't see her name on the list. July? Let me pull that up, nope, she is not on the list." RD confirmed that she had not done any assessments and had not written any notes on R22 in the last year. She stated any nutrition notes in R22's chart would have been completed by the CDM. When informed of R22's pressure ulcers, the RD stated R22's situation "definitely warrants a nutritional consult." The RD stated due to R22's stage 4 pressure ulcer, her case should have been reviewed. The RD stated she would look at R22's oral intake, use of vitamins, and evaluate calorie and protein needs in relation to her intake, and assess her blood sugars. RD stated healing would be poor if BS was high. She also felt it would be important to check to see if she had adequate micro-nutrients for healing, such as zinc and vitamin C. Additionally, she would want to make sure R22 wasn't suffering from edema.

During an interview 10/4/19 at 11:18 a.m., the CDM stated she used to get a list of facility

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residents with skin issues every Tuesday, a "risk management sheet." The CDM stated her protocol at that time had been to send those to the RD. However, the CDM said she was no longer getting such a list and said, "now we have a morning meeting and generally there is nothing mentioned about skin." The CDM said sometimes she would get an email from nurse managers about skin problems and she would let the RD know about those issues as they arose. The CDM confirmed she was aware of R22's skin issues and had "known for a long time." She was unable to remember how long it had been since R22's status had been reviewed by a dietician. CDM then stated, "[R22] is very non-complaint with diet and repositioning."

During a telephone interview 10/4/19 at 11:35 a.m., FM-C stated she'd been unaware R22 had a "bed sore" on her bottom until after R22 had been hospitalized to have her left leg amputated in July 2019. FM-C stated she believed the hospital had discovered the sore upon admission and had initiated treatment. FM-C stated she was told the wound was "looking good" at that time. Further, FM-C reported R22 continued to receive treatments to the wound on her bottom after she returned to the nursing home and stated, "It didn't seem to be getting better." FM-C said she felt the facility was slow to respond to changes and said she was NOT kept up on R22's status through routine reporting. FM-C stated, "The facility should have made me more aware of [R22's] condition without my having to question them as to her status. After some time, I noticed [R22] had developed an odor and when I asked the nurses about it, I was told the wound looked awful." FM-C said when she asked the facility what they were doing for R22 they reported they had started

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a treatment involving a wound vacuum, but had stated the vacuum wouldn't stay on the wound. FM-C said RN-A had reported the "wound did not look good at all" and had recommended R22 be seen by a provider. FM-C said this recommendation had not occurred until she had reported the odor. FM-C stated after R22 went to see the medical provider 9/11/19, it was determined R22 had an infection in the wound that had reached the bone. During the telephone interview, FM-C stated she was aware that R22 would at times, refuse preventative interventions, such as laying down. FM-C said, R22 wanted to attend activities and family was supportive of this as she used to be very isolative. FM-C said she felt there was a need for R22 to develop trust with the staff as there had been times R22 had agreed to lay down if they would get her up for the activity, only to be forgotten or left in bed. FM-C stated she had observed this to happen recently, and had to question the nursing staff on why R22 had not been gotten up as agreed. FM-C said she thought the director of nursing (DON) was aware of the plan to educate R22, lay her down and get her back up again in time for activities. FM-C said R22 would often be compliant for a few days, but then would start refusing again. FM-C stated she still expected staff to continue to attempt interventions and provide reminders and re-education as to the importance of laying down and repositioning. FM-C also stated she thought the plan to lay down between activities was supposed to be in R22's care plan, as well as instruction to turn and reposition every two hours, but was unsure whether this routinely occurred.

The facility's nurse practitioner (NP) reported during interview 10/4/19 at 4:19 p.m., she had not been following R22's case because R22 was

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being seen by her primary doctor at the clinic, so had not previously been seen on routine rounds by Senior Services. The NP futher stated Senior Services had recently been notified R22 had agreed to be seen by their service, but she herself had not seen R22's wound. The NP stated she remembered seeing a picture of the wound previously and had attempted to see R22 after being asked by primary physician, but R22 was unable to reposition herself and due to no staff assistance that day, the NP had been unable to see the wound. The NP stated staff were expected to keep medical providers updated with changes in wounds, but stated she had not been contacted immediately about R22 having a foul odor in her wound. The NP stated, "They told me the next time I got here, and [R22] had to be sent to the hospital shortly after that."

Additional record review included:

R22's behavior summary reports indicated the following rejection of care documentation:
Week Ending 10/3/19- one episode of rejecting care during a night shift only.
Week Ending 9/26/19-one episode of rejecting care during a night shift only.
Week Ending 9/12/19- no episodes of rejecting care
Week Ending 9/5/19- one episode of rejecting care during a night shift only.
Week Ending 8/29/19- no episodes of rejecting care
Week Ending 8/22/19- no episodes of rejecting care
Week Ending 8/15/19- no episodes of rejecting care
Week Ending 8/8/19- one episode of rejecting care during a night shift only.

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F 686	Continued From page 90 Week Ending 8/1/19- no episodes of rejecting care R22's July and August 2019 treatment administration records (TAR) R22 had an order to "reposition frequently, at least every 2 hours for excoriation to coccyx." The order start date was 3/7/19 and the stop date was 8/11/19. According to TAR documentation, in July 2019, R22 was in the hospital from 7/3-7/12/19. Of the remaining dates, 7 opportunities for repositioning were not documented, and the remaining opportunities had a check mark. There was no indication of refusal of care documented. In August 2019, 3 opportunities for repositioning were not documented, and for the remainder of the month there were no documented refusals of care. The July and August 2019 TARs also included: "Encourage to lay down after breakfast or in the afternoon, at least for a half an hour." The order start date was 4/8/19 and the stop date was 9/7/19. In July 2019, there were no documented refusals of care noted. Each opportunity was marked as having been done. In August 2019, there were 6 opportunities for laying down out of 62 documented as refused. R22's September 2019 TAR showed the order to lay down after breakfast or in afternoon was restarted 9/7/19, but was on hold during a hospitalization 9/11/19 to 9/16/19. Out of the remaining 36 opportunities, 8 were marked as refused and 20 were marked as "no." There was no indication as to whether "no" meant the opportunity was not offered, or whether it indicated R22 had refused. No additional documentation was included on the TAR to demonstrate if staff had provided education to R22 about the risks related to refusing repositioning or laying down, nor did the TAR documentation indicate whether staff had	F 686		

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re-approached R22 when she refused care. Finally, it was unable to be determined whether the resident's refusals of care had been communicated with the physician, staff leadership or to R22's family. The September 2019 TAR no longer included directions to reposition the resident every two hours.

A hospital discharge summary dated 7/12/19 stated an appointment had been made for seat mapping and wheelchair fitting.

R22's EHR progress note dated 9/9/19, indicated it was a "late entry" but reported NP had visited resident at facility. Note said, "Resident was in her wheelchair during the visit so provider was unable to examine the sacral decubitus."

A progress note dated 9/11/19 at 11:17 a.m., indicated staff had reported an increased odor, and continual discharge from the sore near R22's rectum. A call was placed to the physician to request evaluation at the emergency department.

According to a CT report dated 9/11/19- "FINDINGS: There is a sacral decubitus ulcer with gas within fistula (a tunnel between tissues) tracking to the S5 posterior elements. There is inflammatory edema from phlegmon (soft tissue swelling within the body) surrounding the posterior sacrum and coccyx. There is new osteolysis (pathological destruction of bone) of the coccyx, implying osteomyelitis (infection of the bone)."

According to a progress note dated 9/12/19 at 10:50 a.m., R22 was admitted to the hospital, was diagnosed with osteomyelitis, and required

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surgery to debride the wound on her coccyx.
R5

R5's undated Admission Record included diagnoses: peripheral vascular disease, venous insufficiency and unspecified fracture of shaft of right tibia.

R5's quarterly MDS assessment dated 7/5/19, included a brief interview for mental status (BIMS) score of 14 indicating R5 was cognitively intact. The MDS further indicated R5 required extensive assist of two with bed mobility and toileting and required total assist of two for transfers. The MDS also indicated R5 was at risk for pressure ulcers, utilized pressure-relieving devices in the bed and chair and was not on a turning and repositioning program.

R5's POTENTIAL FOR SKIN BREAKDOWN care plan last revised 7/17/19 included, "The resident has a Skin Tear/potential for skin tear of the r/t [related to] recurrent skin tears to extremities from bumping into objects into her environments/ PAD [peripheral artery disease]/ Bowel and bladder incontinence. Hx [history] Left 5Th toe Vascular Ulcer / Intermittent Loose stools. Braden scale of 18 or less. Long Splint in place to Right Lower extremity (splint and cam boot dc'd [discontinued] 7/9/19). Eliquis in use-resident is more easily bruised. Interventions included: Prompt and assist and assist resident with Q2 hours repo when in a sitting and laying position. Identify potential causative factors and eliminate/resolve when possible. Encourage frequent repositioning. Right leg in long cast, keep leg elevated on pillow blue boot on at all times, float both heels in bed. Repo [reposition] side to side every 2 hours with new limited

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mobility. Check and change every 2 hours and PRN while non-weight bearing."

R5's Nutrition Assessment-Short Form dated 9/24/19 included, "Resident continues to receive a NAS [no added salt] Diet. Resident consumes meals in MDR [main dining room] and appetite has remained stable over past 90 days. Resident has dentures and continues to deny any chewing or swallowing difficulties at this time. Resident is offered appropriate nourishments and substitutions daily. Resident continues to enjoy coffee and orange juice with her meals. Resident needs to be provided with adequate fluids daily and monitored for any S/s [signs and symptoms] of dehydration. Resident remains within ideal weight limits. Skin is intact. Care plan updated."

R5 was continuously observed on 10/2/19, from 8:39 a.m. until 11:01 a.m.
-At 8:39 a.m. R5 was in the dining room sitting in her wheelchair and was independently eating her breakfast. A unidentified staff member wheeled R5 out of the dining room, took her to a nursing station, put in her dentures and returned R5 has returned to the dining room. R5 was observed to have a blue foot protector on her right foot and legs were in a dependent position
-At 8:53 a.m. R5 remained in dining room eating her breakfast.
-At 9:06 a.m. R5 remained in dining room eating her breakfast
-At 9:08 a.m. a volunteer wheeled R5 from the dining room to her room.
-At 9:27 a.m. R5 was sitting in her room in her wheelchair. No staff has entered her room since she returned from the dining room.
-At 9:34 a.m. R5 was sitting in her room in her wheelchair.

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-At 9:41 a.m. R5 was sitting in her room in wheelchair.
-At 9:44 a.m. an unidentified staff member wheeled resident to get in line for the podiatrist. The unidentified staff member did not offer to toilet or reposition R5.
-At 9:48 a.m. R5 was placed in line for the podiatrist. There are eight residents in front of her waiting to be seen.
-At 10:00 a.m. an unidentified activity staff member holding a balloon moved R5's wheelchair to another spot in line and R5 she was now playing balloon ball with her and other residents.
-At 10:05 a.m. R5 was playing the balloon ball while she waited in line.
- At 10:10 a.m. R5 remained in line, sitting in her wheelchair waiting to see podiatrist.
-At 10:15 a.m. R5 continued to play games while she waited to be seen by the podiatrist.
-At 10:21 a.m. R5 continued to play games, while sitting in her wheelchair waiting to be seen by the podiatrist.
-At 10:22 a.m. R5 told an unidentified staff member she would like to go back to her room. The staff member took her back to her room. R5 was not toileted or repositioned. -At 10:29 a.m. R5 was in room, sitting in her wheelchair, with her feet in a dependent position.
-At 10:36 a.m. R5 was in room, sitting in her wheelchair, with her feet in a dependent position.
- At 10:46 a.m. nursing assistant (NA)-D wheeled R5 to another hall to get her weight while sitting in her wheelchair.
-At 10:49 a.m. NA-D returned R5 to her room, gave her the call light, asked if she would like the television on. NA-D did not offer to reposition or toilet R5. NA-D stated he offered to toilet her when he brought her to her room to her room

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about 20 minutes ago.
-At 10:56 a.m. R5 remained in her room sitting in her wheelchair with her legs in a dependent position.
-At 11:01 a.m. R5 remained in her room sitting in her wheelchair with her legs in a dependent position.
-At 11:11 a.m. R5 was toileted by nursing assistants (NA)-C and NA-E after surveyor intervened and requested R5 be toileted and repositioned. R5 was observed by nurse surveyor to have a red left inner thigh fold where clothing had been and a small bowel movement smear. R5 was observed to have red areas from folds of clothing, all fold areas pale pink but blanchable. R5 had no open areas or purple areas.

During the continuous observation period from 8:39 a.m. to 11:11 a.m. (2 hours, 35 minutes), R5 was not offered or provided assistance with cares related to repositioning needs.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 6/12/19 indicated R5 had a Stage III pressure ulcer to her right heel. Length (L) 3cm (centimeters), Width (W) 2cm and Depth .25cm. Details: Upon return from appointment to have Splint removed from right lower extremity. Fracture alignment stable PT. (patient) has stage 2 pressure ulcer on heel. Debrided in office today. Must keep all pressure off of heel. Upon assessment noting right heel stage 3 ulcer with slough present. Measuring 3cm x 2cm x .25cm. Cleanse area with normal saline, apply hydrogel gauze and 5inx5in (inch) Mepilex to heel and apply Mepilex to superior dorsal of foot for protection and reapply CAM boot. Cam boot to right lower extremity with pressure off of heel. Acquired pressure ulcer, first observation. Visible

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Tissue: Slough tissue present. Current treatment Plan: Cleanse area with normal saline, apply hydrogel gauze and 5in x 5in Mepilex to heel and apply Mepilex to superior dorsal of foot for protection and reapply CAM boot. Licensed Nurse Evaluation: Resident offers no c/o (complaints) of pain at this time. Wound was assessed, cleansed and new dressing tx (treatment) applied. Cam boot applied. Resident is a Hoyer assist and non-weight bearing to right lower extremity with repositioning q2hr (every two hours), Cam boot on at all times and pressure off of heel. AMT wound care contacted at this time."

R5's Weekly Ulcer/Complex Wound Observation Tool dated 6/20/19 indicated R5 had a Stage III pressure ulcer to her right heal. Length (L) 3cm (centimeters), Width (W) 2cm and Depth .25cm. Details: Upon return from appointment to have Splint removed from right lower extremity. Fracture alignment stable PT. (patient) has stage 2 pressure ulcer on heel. Debrided in office today. Must keep all pressure off of heel. Upon assessment noting right heel stage 3 ulcer with slough present. Measuring 3cm x 2cm x .25cm. Cleanse area with normal saline, apply hydrogel gauze and 5 in x 5in (inch) Mepilex to heel and apply Mepilex to superior dorsal of foot for protection and reapply CAM boot. Cam boot to right lower extremity with pressure off of heel. Acquired pressure ulcer, first observation. Visible Tissue: Slough tissue present. Current treatment Plan: Cleanse area with normal saline, apply hydrogel gauze and 5 in x5 in Mepilex to heel and apply Mepilex to superior dorsal of foot for protection and reapply CAM boot. Licensed Nurse Evaluation: Resident offers no c/o (complaints) of pain at this time. Wound was assessed, cleansed and new dressing tx (treatment) applied. Cam

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boot applied. Resident is a Hoyer assist and non-weight bearing to right lower extremity with repositioning q2hr (every two hours), Cam boot on at all times and pressure off of heel. AMT wound care contacted at this time. 2/20/19 no signs of infection noted. She tolerated the dressing change well.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 6/24/19 indicated R5 had a stage III/Stage II pressure ulcer. Length (L) 2cm (centimeters), Width (W) 1.25cm and Depth .25cm.
Details: Assessment of right heel stage 3 pressure ulcer, noting healing with measurements 2cm x1.25cm x.25cm, no drainage, odor or slough noted, stage 2 pressure ulcer at this time. Dressing updated from Hydrogel with foam dressing to cleanse heel with wound cleanser, pat dry and apply foam dressing every other day. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: healing. Visible Tissue: Epithelial Tissue present. Wound bed is pink with no slough noted. Surrounding tissue is pink and intact. Treatment Plan/Interventions: Cam boot to right lower extremity with pressure off of heel. Resident is on a turning and repositioning program. Current treatment plan: Right Heel: Stage 2 ulcer: 2cm x 1.25cm x .25cm. Cleanse area with normal saline, pat dry with gauze and apply 4 in x 4 in border foam dressing to heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. Licensed Nurse Evaluation: Resident offers no c/o pain at this time. Wound was assessed, cleansed and new dressing tx (treatment) applied. Cam boot applied. Resident is a Hoyer assist and non weight bearing to right lower

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extremity with repositioning q2hr (every two hours), Cam boot on at all times and pressure off of heel.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 7/3/19 indicated R5 had a stage III/Stage II pressure ulcer. Length (L) 2cm (centimeters), Width (W) 1.25cm and Depth .25cm. Details: Assessment of right heel stage 3 pressure ulcer, noting healing with measurements 2cm x1.25cm x.25cm, no drainage, odor or slough noted, stage 2 pressure ulcer at this time. 6/24/19 Dressing updated from Hydrogel with foam dressing to cleanse heel with wound cleanser, pat dry and apply foam dressing every other day. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: healing. Visible Tissue: Epithelial Tissue present. Wound bed is pink with no slough noted. Surrounding tissue is pink and intact. Treatment Plan/Interventions: Cam boot to right lower extremity with pressure off of heel. Resident is on a turning and repositioning program. Current treatment plan: 6/24/19 Right Heel: Stage 2 ulcer: 2cm x 1.25cm x .25cm. Cleanse area with normal saline, pat dry with gauze and apply 4 in x4 in border foam dressing to heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. 7/3/19: Stage 2 ulcer: 1.5cm x .75cm x .25cm Cleanse area with normal saline, pat dry with gauze and apply 4 in x 4 in border foam dressing to heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. Licensed Nurse Evaluation: Resident offers no c/o pain at this time. Wound was assessed, cleansed and new dressing tx (treatment) applied. Cam boot applied. Resident is a Hoyer

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assist and non weight bearing to right lower extremity with repositioning q2hr (every two hours), Cam boot on at all times and pressure off of heel.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 7/8/19 indicated R5 had a stage III/Stage II pressure ulcer. Length (L) 2cm (centimeters), Width (W) 1.25cm and Depth .25cm. Details: Assessment of right heel stage 3 pressure ulcer, noting healing with measurements 2cm x1.25cm x.25cm, no drainage, odor or slough noted, stage 2 pressure ulcer at this time. 6/24/19 Dressing updated from Hydrogel with foam dressing to cleanse heel with wound cleanser, pat dry and apply foam dressing every other day. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: healing. Visible Tissue: Epithelial Tissue present. Wound bed is pink with no slough noted. Surrounding tissue is pink and intact. Treatment Plan/Interventions: Cam boot to right lower extremity with pressure off of heel. Resident is on a turning and repositioning program. Current treatment plan: 6/24/19 Right Heel: Stage 2 ulcer: 2cm x 1.25cm x .25cm. Cleanse area with normal saline, pat dry with gauze and apply 4 in x 4 in border foam dressing to heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. 7/3/19: Stage 2 ulcer: 1.5cm x .75cm x .25cm Cleanse area with normal saline, pat dry with gauze and apply 4 in x 4 in border foam dressing to heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. 7/8/19: Right heel stage 2, 1 cm x .5cm x .5cm, continue with current treatment. Licensed Nurse Evaluation: Resident offers no c/o pain at this

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time. Wound was assessed, cleansed and new dressing tx (treatment) applied. Cam boot applied. Resident is a Hoyer assist and non weight bearing to right lower extremity with repositioning q2hr (every two hours), Cam boot on at all times and pressure off of heel.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 7/15/19 indicated R5 had a stage III/Stage II pressure ulcer. Length (L) 2cm (centimeters), Width (W) 1.25cm and Depth .25cm. Details: Assessment of right heel stage 3 pressure ulcer, noting healing with measurements 2cm x1.25cm x.25cm, no drainage, odor or slough noted, stage 2 pressure ulcer at this time. 6/24/19 Dressing updated from Hydrogel with foam dressing to cleanse heel with wound cleanser, pat dry and apply foam dressing every other day. 7/9/19: seen by ortho (orthopedics), continue with Meplix QOD 9every other day) and d/c (discontinue) CAM boot, float heels. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: healing. Visible Tissue: Epithelial Tissue present. Wound bed is pink with no slough noted. Surrounding tissue is pink and intact. Treatment Plan/Interventions: Cam boot to right lower extremity dc'd (discontinued) 7/9/19 continue to keep pressure off the heel. Resident is on a turning and repositioning program. Current treatment plan: 6/24/19 Right Heel: Stage 2 ulcer: 2cm x 1.25cm x .25cm. Cleanse area with normal saline, pat dry with gauze and apply 4 in x 4 in border foam dressing to heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. 7/3/19: Stage 2 ulcer: 1.5cm x.75cm x .25cm Cleanse area with normal saline, pat dry with gauze and apply 4 in x 4 in border foam dressing to

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heel/apply border foam dressing to superior dorsal of foot for protection and reapply CAM boot to be changed every other day. 7/8/19: Right heel stage 2, 1 cm x .5cm x .5cm, continue with current Tx. (treatment). 7/15/19: dc (discontinue) CAM boot, Right Heel .5cm, x .5cm x .25cm, Meplix dressing QOD (every other day). Licensed Nurse Evaluation: Resident offers no c/o pain at this time. Wound was assessed, cleansed and new dressing tx (treatment) applied. Cam boot applied. Resident is a Hoyer assist and non weight bearing to right lower extremity with repositioning q2hr (every two hours), pressure off of heel. PT/OT (physical therapy and occupational therapy) to eval (evaluate) and treat for ROM (range of motion) and strength.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 7/23/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.2 cm (centimeters), Width (W) 1.4 cm and Depth .2 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: worsening. Visible Tissue: Slough tissue present. 60% white slough, 20% tan slough, 20% beefy red tissue. Scant amount of serosang drainage on old dressing. No odor. Periwound pink blanchable. Wound edges rolled in, irregular in shape. Wound base firm, dry, indurated in center of wound. Treatment Plan/Interventions: Assessment of right stage 3 pressure ulcer, noting healing with measurements 1.2cm, x 1.4cm, x .2cm. 6/24/19 Dressing updated from Hydrogel with foam dressing to cleanse heel with wound cleanser, pat dry and apply foam dressing every other day. 7/9/19: seen by ortho (orthopedics), continue with Mepilex QOD (every other day) and d/c (discontinue) CAM boot, float heels. Resident is on a turning and repositioning program. Current

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treatment plan: Cleanse with NS (normal saline), pat dry, apply allevyn dressing, change daily. Licensed Nurse Evaluation: Resident c/o (complaint of) pain with cleansing the wound. Wound was measured, cleansed and new dressing applied. Resident is a mechanical lift for transfers and is non weight bearing to right lower extremity. Heels floated on pillow, repositioning q2hrs (every 2 hours).

R5's Weekly Ulcer/Complex Wound Observation Tool dated 7/30/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.2 cm (centimeters), Width (W) 1.4 cm and Depth .2 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: worsening. Visible Tissue: Slough tissue present. 60% white slough, 20% tan slough, 20% beefy red tissue. Scant amount of serosang drainage on old dressing. No odor. Periwound pink blanchable. Wound edges rolled in, irregular in shape. Wound base firm, dry, indurated in center of wound. Treatment Plan/Interventions: Assessment of right stage 3 pressure ulcer, noting healing with measurements 1.2cm, x 1.4cm, x .2cm. 6/24/19 Dressing updated from Hydrogel with foam dressing to cleanse heel with wound cleanser, pat dry and apply foam dressing every other day. 7/9/19: seen by ortho (orthopedics), continue with Mepilex QOD (every other day) and d/c (discontinue) CAM boot, float heels. Resident is on a turning and repositioning program. Current treatment plan: Cleanse with NS (normal saline), pat dry, apply allevyn dressing, change daily. Licensed Nurse Evaluation: Resident c/o (complaint of) pain with cleansing the wound. Wound was measured, cleansed and new dressing applied. Resident is a mechanical lift for transfers and is non weight bearing to right lower

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extremity. Heels floated on pillow, repositioning q2hrs (every 2 hours).

R5's Weekly Ulcer/Complex Wound Observation Tool dated 8/6/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.2 cm (centimeters), Width (W) 1.4 cm and Depth .3 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: unchanged. Visible Tissue: Slough tissue present. Drainage amount: scant. No odor. Peri-wound pink and blanchable. Treatment Plan/Interventions: Resident is on a turning and repositioning plan. Current treatment plan: unchanged. Licensed Nurse Evaluation: Wound care provided as ordered. No significant changes noted in healing process.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 8/6/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.2 cm (centimeters), Width (W) 1.4 cm and Depth .3 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: unchanged. Visible Tissue: Slough tissue present. Drainage amount: scant. No odor. Peri-wound pink and blanchable. Treatment Plan/Interventions: Resident is on a turning and repositioning plan. Current treatment plan: Unchanged treatment plan. Licensed Nurse Evaluation: Wound dressed by staff with measurements noted.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 8/13/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.2 cm (centimeters), Width (W) 1.4 cm and Depth .3 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: unchanged. Visible Tissue: Slough tissue present. Drainage amount: scant. No odor. Peri-wound reddened but blanchable. Treatment

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Plan/Interventions: Resident is on a turning and repositioning plan. Current treatment plan: Unchanged treatment plan. Licensed Nurse Evaluation: Wound dressed by staff with measurements noted.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 8/21/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.2 cm (centimeters), Width (W) 1.4 cm and Depth .2 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: unchanged. Visible Tissue: Slough tissue present. Drainage amount: scant. No odor. Heel reddened but blanches easily. Treatment Plan/Interventions: Resident is on a turning and repositioning plan. Current treatment plan: dressing unchanged. Licensed Nurse Evaluation: Resident complains of discomfort with cleansing and dressing of heel. Wound remains relatively unchanged. Staff continue dressing changes as ordered.

There were no additional Weekly Ulcer/ Complex Wound Observations completed from 8/21/19 until 10/2/19 when the lack of pressure ulcer documentation was brought to the facilities attention through the survey process.

R5's Weekly Ulcer/Complex Wound Observation Tool dated 10/2/19 indicated R5 had a stage III pressure ulcer. Length (L) 1.3 cm (centimeters), Width (W) .7 cm and Depth .2 cm. Acquired pressure ulcer, date acquired 6/12/19. Overall Impression: unchanged. Visible Tissue: Slough tissue present. Dry. The percentage of necrosis and/or slough in the wound bed was 80%. Drainage amount: N/A. No odor. Description of peri-wound (surrounding) tissue: Dry, intact, so s/s (signs or symptoms) of infection. Wound

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edges and shape: well defined. Treatment Plan/Interventions: Pressure relieving mattress, foam boot worn in bed and when up in w/c (wheelchair). Resident is on a turning and repositioning plan. Current treatment plan: Right Heel: Stage 2 ulcer: 2 cm x 1.25cm x .25 cm. Cleanse with normal saline, pat dry with gauze and apply 4 in x4 in (inch) foam dressing to heal. Will update MD (medical doctor) on rounds today-potential for different tx (treatment).
Licensed Nurse Evaluation: Res. (resident) has not c/o (complained of) pain to area. No pain w/ (with) dressing change. Res. is inc. (incontinent) of urine, wt. (weight) stable, good appetite and fluid intake. Risk fx. (fracture) immobility, incontinence.

On 10/02/19, at 10:51 a.m. nursing assistant (NA)-D stated he did not offer to toilet R5 before or after he took her to be weighed. NA-D stated he offered to toilet R5 about 20 minutes ago when he took her to her room. Surveyor had been completing a continuous observation of resident, since 8:39 a.m. NA-D was not observed to be with R5 until he took her to be weighed at 10:46 a.m.

On 10/02/19, at 11:34 a.m. NA-C and NA-E stated they just toileted her about 20 minutes ago. NA-C stated R5 was up this morning when she got here. Neither NA-C nor NA-E had assisted with toileting R5 until surveyor intervened and asked for R5 to be toileted about twenty minutes ago.

On 10/2/19, at 11:37 a.m. NA-C stated she was here at 6:00 a.m. and R5 was dressed and ready.

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On 10/2/19, at 11:42 a.m. NA-D stated he got R5 up took her to the dining room for breakfast. NA-D stated he got her up around 7:00 and 7:30 a.m. NA-D stated he changed her in bed at this time. NA-D stated he was a float on both 400 and 500 wings and I got busy. NA-D verified the last time he toileted and reposition R5 was when he got her up in the morning between 7:00 and 7:30 a.m. NA-D stated he was the one that got her ready for the day. NA-D verified R5 was not toileted or repositioned by him since he got her up in the morning. NA-D stated he did not toilet her or reposition R5 since he got her up and stated he did not know if anybody else had.

On 10/2/19, at 1:30 p.m. registered nurse (RN)-E stated the nurse that had been doing the weekly wound assessments was a pool nurse and she had a death in the family. RN-E stated when the nurse came back from the funeral leave we thought she was going to start doing the weekly wound assessment again and that did not happen. RN-E stated she was reassigned to the TCU (transitional care unit) and nobody else took over doing the weekly wound assessments. RN-E stated that was probably about three weeks ago. RN-E stated she was aware the weekly wound assessments was not being done. RN-E stated the wound care clipboard was turned over to me the week of September 19th from the pathways nurse, but I had not had the chance to start doing weekly wound assessments yet. RN-E stated there was no documentation for R5 that the pathway nurse had completed any wound assessments for this resident. RN-E stated R5's current measurements of the pressure ulcer were Length (L) 1.3cm, Width (W) .7cm and .2 cm depth (D). RN-E stated the pressure ulcer was last measure/assessed 8/21/19. RN-E stated the

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measurements at that time were (L) 1.2 cm (W) 1.4 cm and (D) .2cm. RN-E stated the expectation was measurements were to be done on a weekly basis.

On 10/2/19, at 11:59 a.m. the DON stated her expectation would be for R5 to toileted or checked every two hours in accordance with the resident's care plan. The DON verified the last Weekly Ulcer/Complex Wound form in R5's record was dated 8/21/19.

On 10/3/19, at 1:22 p.m. NA-C stated R5 was supposed to be toileted and repositioned every two hours. NA-C stated R5 gets up by the staff member that started work at 4:00 a.m. and she did not go back to bed until after lunch. NA-C Stated this was a problem for the residents for toileting and repositioning. NA-C stated on my shift we are getting them (residents) up then it is breakfast, then it is our breaks and answering call lights for the residents that are more with it. NA-C stated with R5 she was getting up between 4:00 and 6:00 a.m. and was ready for the day. NA-C stated the next time R5 was toileted and repositioned would be after lunch, when we are doing our next rounds because we do not have adequate time to do the cares. NA-C stated even then it can be a conflict because we have to go to activities and we have to hunt them down.

On 10/4/19, at 11:12 a.m. the registered dietician (RD) stated she was not aware of R5's stage 3 pressure ulcer and stated the last time she reviewed R5 was in June 2018. The RD stated she should have been informed of the stage 3 pressure ulcer and stated it was pretty standard to have an RD review for a stage 3 pressure ulcer. The RD stated she completed

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assessments once a month of residents that were identified for her review by the certified dietary manager.

R21

R21's Admission Record undated identified diagnoses that included chronic kidney disease stage 4 (severe), weakness and heart failure.

R21's admission Minimum Data Set (MDS) assessment dated 8/9/19 included a brief interview for mental status (BIMS) with a score of 12 indicating R21 had moderate cognitive impairment. The MDS further indicated R21 required extensive assist of two with bed mobility, transfers and toileting. The MDS also indicated R21 was at risk for pressure ulcers and utilized pressure-relieving device in the chair and was not on a turning and repositioning program.

R21's Braden Scale for Predicting Pressure Sore Risk dated 8/9/19 had a score of 14 indicating R21 was at moderate risk for developing pressure ulcers.

R21's care plan dated 8/15/19 included, "The resident has potential/actual impairment to skin integrity r/t [related to] fragile skin, decreased mobility, f/c [foley catheter] use. Interventions included: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible. Keep skin clean and dry. Use lotion on dry skin as needed."

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R21's Skin Assessment dated 9/18/19 included Skin issues: MASD (Moisture Related Skin Damage) and other open area/scratch. Site: Right buttock 1cm round open area. Right buttock 2 cm x 0.5 scratch area and Left buttock 1 cm x 0.5cm scratch area. Skin Issue Notes: no pain when asked. Licensed Nurse Analysis: was left blank. Overall Impression was marked first observation, no reference.

R21's hospital discharge summary dated 9/30/19 indicated R21 was admitted to the hospital with two stage 2 pressure ulcers on 9/26/19. Pressure injury stage 2, 7 mm (millimeters) x 7 mm buttocks right medial. Left medial buttock stage 2, 1 cm (centimeter) x 1 cm.

R21's medical was reviewed and revealed no hospital re-admission assessments had been completed on R21's return from the hospital.

On 10/02/19, at 1:41 p.m. registered nurse (RN)-E stated she was unware R21 had current pressure ulcers.

On 10/02/19, at 2:26 p.m. RN-E stated they (the pressure ulcers) were reported on his transfer information. RN-E stated the pressure ulcers got put in as orders from the hospital discharge summary. RN-E stated the aide that took care of him today stated she did not notice anything.

On 10/02/19, at 2:35 p.m. RN-E stated R21 was refusing to allow staff to look at his bottom to assess pressure ulcers at this time.

R21 was observed during wound care measurements on 10/03/19, at 7:31 a.m. with

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registered nurse (RN)-E and nursing assistant (NA)-C. RN-E pulled R21's brief pulled back, no dressing noted. RN-E measured his left buttock open area, round 0.5 cm x 0.5 cm stage 1, right buttock open area, round 1cm x 0.5 cm stage 2, noted to have a spot of blood on the brief from the left buttock and had catheter in place.

On 10/03/19, at 7:35 a.m. RN-E stated these areas started as superficial scratches before he went to the hospital, he got back from the hospital on Monday and they have gotten worse. RN-E stated we should have initially (upon return from the hospital) done a skin assessment on him, but we did not. RN-E verified a skin assessment has not been done when R21 got back from the hospital on 9/30/19. When asked what the current treatment was RN-E stated, that's what we are assessing now to get a treatment plan in place.

On 10/03/19, at 7:51 a.m. RN-E verified the pressure ulcer on the left buttock was open, so it would be a stage 2 pressure ulcer.

R21's Weekly Ulcer / Complex Wound Observation Tool dated 10/3/19 included, Stage 2 pressure ulcer. Right buttock L (Length) 1.5, W (width) .5 and D .1 stage II. Acquired Pressure ulcer. Date acquired 10/2/19. First Observation, no reference. Visible Tissue: Epithelial Tissue present (pink: Only present with Stage II partial thickness skin loss) and Moist. Drainage type: Bloody. Drainage amount: small, no odor, scant blood on pad. Description of peri-wound (surrounding) tissue: intact, good borders. Describe wound edges and shape: defined, oblong wound. Treatment Plan/Interventions: cushioned pad to recliner/wheelchair,

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pressure-relieving mattress, roll res. (resident) to side while in bed. Current Treatment Plan: Standing orders for Stage 2 ulcer. Cleanse and foam dressing. Initiated today. Licensed Nurse Evaluation:
Res. (resident) has braden score of 13-risk fx (factors) poor appetite, refusal to reposition, inc. (incontinent) of bowel, declining overall health. Anticipate hospice admission.

R21's Weekly Ulcer / Complex Wound Observation Tool dated 10/3/19 included, Stage 2 pressure ulcer. Left buttock L (Length) .5, W (width) .5 and D .1 stage II. Acquired Pressure ulcer. Date acquired 10/2/19. First Observation, no reference. Visible Tissue: Epithelial Tissue present (pink: Only present with Stage II partial thickness skin loss). Drainage type: none. No odor. Description of peri-wound (surrounding) tissue: intact. Describe wound edges and shape: well defined. Treatment Plan/Interventions: Pressure relieving cushion for chair, pressure-relieving mattress. Resident is on a turning and repositioning program. Current Treatment Plan: Repositioning, as res. will allow, educated and encourage res. (resident) to lie in bed turning from side to side. Cleanse and apply foam dressing per standing orders. Licensed Nurse Evaluation: Braden score of 13 w/risk (with risk) fx (factors) of res. (resident) refusal to repostion, poor appetite, overall failing health, inc. (incontinent) of BM (bowel movement). Stage 5-kidney disease.

On 10/3/19, at 9:32 a.m. the DON stated the nurse working the unit would be responsible to complete a skin assessment and I would expect it to be done with in the first 24 hours but we have discussed it was important for this to be done

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within the first 2 hours of a hospital return. The DON stated if the hospital had identified these pressure ulcers I would expect the hospital to provide orders for interventions and wound care. The DON stated the expectation would be to call the hospital to clarify why there was no orders or to obtain orders for the wounds that were identified. The DON stated the nurse on the unit would be responsible to follow up and call first and or the nurse manager or myself if the floor nurse did not have time. The DON stated she expected staff to document if resident was refusing to allow skin assessment and repositioning.

On 10/3/19, at 9:58 a.m. the DON stated, "Since my arrival has been educated on PCC (point click care) and how to utilize and how to fill out assessments. The DON stated they (nurses) have been educated on when to complete what assessments and they have been given checklist to help ensure they complete the correct assessments for whatever the case was. The DON stated they (nurses) have had one to one education on assessments and documentation. The DON Verified by looking at R21's assessment the assessments on the re-admission checklist were not completed. The DON stated it looks like the nurse manager completed the only assessments completed today.

The facility provided policy titled Prevention of Pressure Ulcers, revised September 2013 included:
"1. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow)

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to that area and subsequent destruction of tissue ...
3 ...if pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected.
5.Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious condition for the resident."
The policy also included the following interventions and preventive measures:
"1. Identify risk factors for pressure ulcer development.
2. For a person in bed:
a. change position at least every two hours or more frequently if needed.
b. determine if resident needs a special mattress per bed selection algorithm (not provided) ...
3. For a person in a chair:
a. change position at least every hour ...
8. Ensure that the resident drinks plenty of fluids and eats a well-balanced diet.
9. Routinely asses and document the condition of the residents skin per Weekly Skin Integrity form for any signs and symptoms of irritation or breakdown
10. Report any signs of a developing pressure ulcer to the physician.
11. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate."
The policy also included the following related to nutrition:
"7.a. Dietitian will assess nutrition and hydration and make recommendations based on the individual resident's assessment ....
d. encourage proper dietary and fluid intake.
e. If a normal diet is not possible, request

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supplements to physician.
f. Administer vitamins, mineral and protein supplements in accordance with physician orders and dietitian recommendations. "
And the policy provided the following in relation to additional risk factors:
"1.Impaired/decreased functional ability
2. Co-morbid conditions, such as end stage renal disease, terminal cancer or diabetes mellitus ...
5. Resident refusal of some aspects of care and treatment;
6. Cognitive impairment."

The facility policy Pressure Ulcer Treatment, revised September 2013 included:
1. The Pressure ulcer treatment program should focus on the following strategies:
a. assessing the resident and the current status of the pressure ulcer(s).
b. Current support surfaces.
c. Pressure ulcer care.
d. Managing bacterial colonization and infection
e. Education and quality imporvement ..."
This policy included the following list of "interventions/care strategies-Pressure ulcer treatment requries a comprehensive approach, including:
1. Debridement.
2. Managing infections.
3. Managing systemic issues (edema, venous insufficiency etc.)
4. Maximizing the potential for healing.
5. Pain control ..."
The policy provided the following direction for documentation:
"The following information should be recorded in the resident's medical record, treatment sheet or designated wound form:
1. the date and time the dressing was changed.

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F 686	Continued From page 115 2. Wound appearance, including wound bed, edges, presence of dreainage. 3. The name and title of the individual changing the dressing, or initials. 4. The type of dressing used and wound care given. 5. All assessment date(ie. Wound bed color, size, drainage, etc.) obtained when inspecting the wound. 6. How the resident tolerated the procedure. 7. Any problems or complaints (e.g. pain or discomfort) made by the resident related to the procedure 8. If the resident refused the treatment and the reasons(s) why ..." Additionally, the policy provided the following directions for reporting: "1. Notify the supervisor if the resident refuses the procedure or interventions. 2. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure the benefits of accepting and available alternatives. Document family and physician notification of refusal. 3. Report other information in accordance with facility policy and professional standards of practice."	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		11/18/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 116 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement therapy recommendations and routinely provide restorative nursing services to maintain function for 1 of 1 residents (R10) reviewed for restorative program. Findings include: During observation and interview on 9/30/19, at 4:42 p.m. R10 was seated in her recliner in her room and stated, I used to get walked 190 feet with the walker every day. The nurse manager that used to work here came in my room one day and told me I wouldn't have any more walks because they cut the staffing, so I didn't get any more walks and I got weaker. Now they will walk to me to the bathroom, at least it's something then. R10's quarterly Minimum Data Set (MDS) assessment dated 7/14/19, indicated R10 was cognitively intact and required one person extensive physical assist with most activities of daily living (ADLs).	F 688	1. Corrective Action: R10 was referred to therapy on 10/30/2019 to determine individualized restorative programming. Staff educated on the requirement to complete the programming as ordered. 2. Corrective Action as it applies to other Residents: All residents not receiving therapy will be evaluated for limited ROM or mobility. Referrals to therapy will be made where deemed appropriate for those to ensure all residents have an individualized restorative program in place. Residents with current restorative programs will be evaluated by nursing to determine whether the program is effective and refer to therapy as indicated. 3. Date of Completion: 11/18/19. 4. Reoccurrence will be prevented by:	

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F 688	Continued From page 117 R10's Admission Record, identified diagnoses of heart failure, anxiety disorder and weakness. R10's Therapy recommendations, dated 3/1/19, indicated the please ambulate [R10] to and from the bathroom and in halls. Please ambulate in the hall 1 time per day. [R10] needed 4 wheeled walker, gait belt, and assist of 1 person with wheelchair to follow. R10's care plan revised 7/24/19, A restorative goal is to maintain leg strength and range of motion (ROM) to be able to ambulate with stand by assist (SBA) and front wheeled walker (FWW) on a daily basis. Interventions include ambulation with SBA, FWW, wheelchair to follow the end of the hall and back twice daily. Review of R10's restorative charting sheets identified R10 was not walked daily, per therapy recommendations. During interview on 10/03/19, at 11:50 a.m. R10 stated, they don't walk me in the hall anymore because they don't have time to. If they had the time, I would go out in the hall and walk every day. The last time I walked in the hall is when they had all the changes, I really can't remember when, there are so many things to remember, I quit writing it all down. When I used to walk in the hall they take the wheelchair with them, and they use that gait belt, I would sure try and see how far I can go if they had the time, R10 smiled. During interview on 10/03/19, at 11:58 a.m. trained medication aide (TMA)-A stated, we used to have a restorative aide. They had cut staffing to 2 aides in May they used to have 3. TMA-A added they really have no time to walk residents.	F 688	Nursing Assistants will be educated on the requirement to complete resident restorative programming as ordered at a mandatory meeting on 11/12/2019. Nursing assistant hours will be added to schedule starting 11/18/2019 to facilitate the ability to perform restorative and ADL tasks safely for each resident. Licensed Nurses will be educated on the need to ensure the restorative programming for residents is completed as ordered and to evaluate for the need of therapy referral when the program becomes no longer appropriate or residents display a decline in ROM or mobility. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and be signed off by 11/15/19. Activities director and IDT will meet to adapt activities schedule 11/18/2019 to incorporate restorative needs for residents indicated in weekly activities calendar starting 12/1/2019. Nurse Managers will be educated on developing and monitoring restorative programming for all residents with decline in ROM or mobility. Monthly Restorative Meeting will be implemented starting one month after interventions implemented. Designated IDT will review restorative programs for appropriateness, activities involvement and calendar, nursing assistant performance with restorative services,	

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F 688	Continued From page 118 TMA-A said they have 8 of the 23 residents who need 2 person assist with toileting and transfers and do not have enough staff to do everything safely. TMA-A said some residents do not get walked, because of short staff. TMA-A said R10 is slow to walk, we just don't have time to do it. Before May we had the staff to walk R10 and she could probably do about 87 feet, but it has probably been since May since we have walked R10 in the hallway. During interview on 10/03/19, at 12:15 p.m. physical therapist assistant (PTA)-A stated, R10 had a restorative program for walking R10 on 3/1/19, at that time she was able to walk 100 feet. Once we have recommendations it goes to aides on the floor, then the cart nurse and the nurse manager. They used to have a restorative program with an aide. PTA-A stated, we hear from the residents a lot about them being short of staff, probably since about May, 2019. During observation on 10/03/19, at 1:58 p.m. registered nurse (RN)-A assisted R10 to ambulate in the hallway, at 2:05 p.m. R10 stated she needed to stop and rest. R10 started to ambulate again and stated to RN-A, I haven't done this for a long time you know because ever since they made the cuts, they haven't had time to walk me out here in the hall, R10 was ambulating to the edge of the hall and stated, "Hey, I'm going to make it to the edge of the carpet." R10 further stated, I think I need to rest for a little bit, R10 sat down in her wheelchair, and stated, I have never had to rest like this before, but I guess I have to now, at 2:11 p.m. R10 continued to walk and stated, I don't think I will be able to make it back but I will sure try. R10 stopped to rest 2 more times and made it back to	F 688	and any ongoing education indicated for nursing staff . Therapy referrals will be made as indicated. DON or designee will audit 1 restorative program weekly for 1 month and then all programs monthly at the facility□s Restorative Meeting ongoing. 5. Correction will be monitored by: DON or designee QAPI Committee	

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F 688	Continued From page 119	F 688		

her room at 2:17 p.m.

During interview on 10/03/19 2:17p.m. Nursing assistant (NA)-K stated, I have worked here for about a year and work the evening shift. We haven't been able to walk R10 in the hallway since they cut our staff in May, we just don't have time anymore. R10 walked really slowly and it takes a long time. I am surprised R10 can still walk that far.

During interview on 10/04/19, at 11:39 a.m. the director of nursing (DON) stated, they changed the staffing model in March due to low census, they used to have 3 aides on wing 4/5 for the day and the evening. They changed it in March because of the census. Last night we did a staffing analysis, this one is based on acuity versus census which I find more appropriate. We just got approved for a restorative aide and we just posted it. At 11:52 a.m. the DON verified R10 had therapy recommendations on 3/1/19, for an ambulating program with a goal to ambulate daily. DON stated, I am not seeing her being walked daily. My expectation would be for therapy recommendations to be followed, and to make sure the care plans are updated.

Facility policy, Goals and Objectives, Restorative Services, revised April, 2013, indicated, Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. Goals may include, but are not limited to: assisting the resident in adjusting to his/her abilities; assisting the resident in developing and strengthening his/her physiological and psychological resources; encouraging the resident to maintain his/her independence and self-esteem;

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F 688	Continued From page 120 encouraging the resident to participate in the development and implementation of his/her plan of care ...	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, develop and implement appropriate patient-centered interventions, to prevent and/or reduce the likelihood of future falls for 1of 3 residents (R23) reviewed for falls. This resulted in actual harm for R23 who experienced falls and sustained a right hip and sacrum fracture; In addition, the facility failed to develop and implement interventions to prevent accidents related to smoking for 1 of 1 resident (R152) reviewed for smoking. Findings include: R23's Admission Record identified an admit date of 7/21/15, and included diagnoses of dementia, personal history of urinary tract infection (UTIs) and history of falls. R23's care plan revised 2/5/19, included: Fall/Safety Risk-History of left pubic fracture secondary to a fall. Impaired cognition/dementia,	F 689	1. Corrective Action: R23 was provided with 1:1 staffing beginning 10-3-2019. Staff positioned to ensure resident□s toileting and repositioning programs were being completed and that falls did not occur. During 1:1 staffing, staff evaluated resident bowel and bladder patterns, behaviors and activity involvement. IDT reviewed past falls, interventions implemented and their effectiveness. IDT, hospice and resident family met to review data collected and develop customized plan of care. 1:1 staffing discontinued on 10/14/2019 with interventions implemented to sufficiently keep resident safe from falls. R23□s falls were reviewed for patterns and root cause. Her care plan was revised and updated to reflect	11/18/19

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F 689	Continued From page 121 known to self-transfer, macular degeneration, and cataracts. Does not remember to use the call light for assistance. History of using the over bed table as a walker. The goals for the resident included: will be free of falls through the review date. Interventions included: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, every 2 hour assist to the bathroom and PRN (as needed), anticipate needs as able, follow facility fall protocol, lay down in bed in afternoon as resident requests, bed in lowest position, routine safety checks with increased restlessness, auto lock brakes to the wheelchair, no over the bed side table in room, gripper socks on while in bed, contoured mattress, assist to the bathroom at 4 am, do not leave resident alone in room when up in chair, encourage resident to be up in wheelchair in common area per therapy for safety. R23's Morse Fall Scale dated 5/20/19, identified a score of 80, indicating the resident was at high risk for falls. The following risk factors were identified: has fallen before, more than one diagnoses, ambulatory aide used walker, weak gait-stooped but able to lift head without losing balance and steps are short and resident may shuffle. Mental status-over estimates or forgets limits. This assessment identified risk factors, but failed to identify interventions to reduce fall risks. No further fall risk assessments were received	F 689	interventions put into place to prevent falls. Hospice revised staff schedule in addition to adding staff hours to complement resident□s needs. Life enrichment collaborated to provide resident activity engagement during hours of increased falls beginning 10/14/2019. Care plan and POC updated to reflect the interventions. IDT reviewed revised plan of care with resident family 10/25/2019 to ensure all appropriate and necessary interventions are in place. R152 had a smoking assessment completed on 9/30/2019. Per facility policy, resident was to store lighter and cigarettes at nurses station. Resident was to sign self out with nurses and get cigarettes when wanting to smoke. Resident capable and deemed safe to transfer self in wheelchair off facility grounds when she chooses to smoke. Facility offered to provide smoking cessation program. Resident refused, staff to continue to educate and encourage smoking cessation. Resident discharged on 10/2/2019 2. Corrective Action as it applies to other Residents: All residents who are at risk for falls will be assessed via the Fall Risk Assessment and have all falls evaluated for root cause. All care plans will be revised to reflect appropriate individualized interventions	

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F 689	Continued From page 122 when requested. R23's quarterly minimum data set (MDS) assessment dated 8/13/19, indicated R23 had severe cognitive impairment, was frequently incontinent of urine, required 2 person extensive assist with toileting, had experienced 2 or more falls with no injury, had experienced 1 fall with an injury, and had experienced no falls with major injury. R23's Incident Reports, Nursing progress notes, and Emergency Record from 7/20 to 8/4/19, included: On 7/20/19, at 7:00 a.m. R23 was found on the floor in the dining room. R23 stated a need to use the toilet. On 7/21/19, at 3:00 p.m. R23 was observed by a visitor to get up from bed and stand up next to the night stand by the bed. R23's left foot seemed to slide when she noticed the visitor, and R23 lowered herself down, sliding from the walker to the floor. When nurse entered the room, R23 was lying on her left side with a pillow under her head. R23 denied hitting her head, was continent of bowel and bladder, denied having to go to the bathroom, and had gripper socks on her feet. After the fall, staff documented R23 had a slightly reddened area noted on her spine that was blanchable, and documented the resident had sustained "No injury noted, no pain noted." According to the incident report, immediate action taken included: examined head, arms, back, hips and legs. Vital signs completed and recorded. No new interventions were identified, and the care plan was not updated.	F 689	put into place to prevent reoccurrence. Therapy evaluations will be completed as indicated. Facility Smoking Policy reviewed with Nurse Managers, DON and Interdisciplinary Team. 3. Date of Completion:11/18/19 4. Reoccurrence will be prevented by: Licensed nurses will be educated on the Incident reporting process and fall risk management and Fall Risk assessment at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. All falls will be immediately evaluated for root cause and an interventions will be put into place to prevent reoccurrence. An Incident Report will be completed and interventions will be entered into the resident care plan and POC. Nurse Manager will review all incidents daily during business days. Incident reports will be reviewed at daily stand-up by the IDT to ensure root cause analysis has been completed and appropriate interventions are in place for each resident fall. Therapy will be referred as indicated. All residents will be assessed for fall risk on admission, quarterly and with change of condition.	

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F 689	Continued From page 123 On 7/22/19, at 4:22 a.m. R23 complained of right hip pain and was given Tylenol. On 7/23/19 at 8:13 a.m., R23 was seated on the toilet complaining of pain to right hip/posterior pelvic area. Two staff assisted R23 to stand with gait belt, R23 unable to bear weight to right leg without significant pain, so staff assisted R23 to bed. The notes indicated R23's right leg did not appear shortened or rotated, so Tylenol was administered and the MD was notified. On 7/23/19, at 8:19 a.m. the case manager from [name]Hospice was notified of the resident's fall and complaints of right hip/pelvic pain. The hospice case manager stated they only provide comfort care, so if the family wanted an X-ray it would be up to them. At 8:32 a.m., family member (FM)-C was called and notified of R23's pain, and inability to bear weight. FM-C requested R23 be sent in for an X-ray. At 8:41 a.m., an ambulance was called for transfer to the local hospital, due to no mobile x-ray available. R23's Emergency Department (ED) Provider Notes dated 7/23/19, at 9:23 a.m. included: Reason for visit: hip pain Patient presents to the ED via ambulance with complaints of inability to bear weight to ambulate after a fall 2 days ago. Patient is on hospice, but family is requesting an X-ray of right hip as patient has been unable to bear weight to ambulate. Assessment /Plan: X-ray reveals an inferior and superior rami (bottom most portion of the pelvis) fracture, with questionable right femoral neck (just below the ball of the ball-and-socket hip joint) fracture ...will obtain a CT scan to further evaluate this. CT scan revealed no acute femoral neck fracture, but there is a superior inferior rami fracture and with	F 689	DON or designee will audit 1 fall weekly for 1 month and then 3 falls monthly for root cause analysis, appropriate interventions and follow-up. 5. Correction will be monitored by: DON or designee QAPI committee	

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F 689	Continued From page 124	F 689		

this a non-displaced sacral (area above the tailbone) fracture. I have discussed this case with the orthopedic on-call and advised that the patient does not want surgery as she is on hospice. I did call them for recommendations on weight bearing and instructions at home. They recommend toe-touch weight bearing as tolerated, pain control, and stated they would like follow up in 2-3 weeks if the family desired ...I advised the family and the nursing home to contact hospice services if she has breakthrough pain, at this time R23 is pain free.

R23's CT Pelvis without IV Contrast results dated 7/23/19, included: Impression: 1. Acute, comminuted (producing multiple bone splinters) fractures of the right superior and inferior pubic rami extending into the pubic body and pubic symphysis. 2. No proximal femoral fracture. 3. Small non-displaced fracture of the right sacral ala should be acute.

On 7/23/19, at 10:22 p.m. the ED papers/instructions with follow up included: follow up with ortho in 2 weeks, continue to give extra strength Tylenol, if R23 requires something more please contact hospice services for recommendations. Pelvic fracture information attached. Hospice recommends Hoyer lift for transfers.

On 7/24/19 at 1:14 a.m. new orders were identified by hospice: discontinue current scheduled and PRN Tylenol orders. Start the following: extra strength Tylenol 500 (milligrams) mg give 2 tabs twice a day for pain/fever. An additional 1000 mg daily prn for pain/fever. Fall intervention-wear gripper socks at all times to help in preventing falls. New hospice orders on

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7/23/19: Morphine concentrate 20mg/ml (milliliter), give 5 mg every 3 hours prn pain/shortness of breath. Tramadol 50 mg, give 1 tablet twice a day and every 4 hours for fracture pain.

On 7/24/19, at 5:11 a.m. Tylenol 1000 mg given at 12:40 a.m., R23 did not want staff to leave the room. R23 was talking about wanting to die due to pain. Tramadol and morphine not here yet. R23 seemed to calm and go back to sleep.

On 8/3/19, at 2:40 p.m. R23 was found by staff in bathroom on her knees with wheelchair behind her, was attempting to stand and get onto the commode. R23 had slid down to her knees and was facing the commode. She had some slight redness on her knees. According to the note, R23 stated she had wanted to go to the bathroom. No new intervention put in place at this time.

On 8/4/19 at 4:10 p.m. R23 was seated in her wheelchair with the foot rests up next to the table in the dining area on Unit 4/5. R23 had previously been assisted with bowel care prior to going to the dining room. The notes indicate R23 was observed to constantly move in her wheelchair stating she wanted to go to the bathroom. Then R23 pushed herself from the table, and had a pillow under her legs on the leg rests. R23 pushed the pillow between the leg rests and attempted to scoot self onto the leg rests to try and stand. At that time, the wheelchair pedals tipped forward and R23 slid from the seat of the wheelchair to the foot rests, and slid onto her right arm. R23 sustained a 2 centimeter (cm) x 1 cm open area to the outside of her right elbow. Vital signs taken and R23 was assisted to the bathroom to have her brief changed.

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F 689	Continued From page 126	F 689		

Following this fall, R23's wheelchair was taken away and a Broda-chair (tilt in space wheelchair) was initiated.

According to document review, including nursing notes and incident reports, R23 sustained falls: 12/14/18, 1/3/19, 1/10/19, 2/5/19, 4/5/19, 6/10/19, 6/19/19, 7/10/19, 7/13/19, 7/20/19, 7/21/19, 8/3/19, 8/4/19, 8/24/19, and 9/28/19. Eight of the 15 falls were related to toileting, others were related to rolling out of bed or just being found on the floor. Many falls lacked interventions developed after the fall, and the care plan was not always updated or followed.

During continuous observations on 10/3/19, it was identified the facility did not implement the care plan for R23 to include: every 2 hour toileting, and toileting after meals as fall prevention interventions.

At 7:07 a.m. R23 was seated in a Broda chair in her room, nursing assistant (NA)-E was observed leaving R23's room carrying a clear garbage bag containing a disposable incontinence brief, and disposed of it in the soiled utility room.
At 7:11 a.m. NA-E wheeled R23 from her room and pushed her up to the dining table on the 4/5 Unit, in the common area outside her room.
At 7:28 a.m. R23 continued to be seated up to the table in her Broda chair with her eyes closed. At 7:38 a.m. R23 continued to be seated up to the table in her Broda chair with her eyes closed. At 7:43 a.m. R23 continued to be seated up to the table in the Broda chair.
At 7:54 a.m. R23 continued to be seated up to the table in the Broda chair, with her eyes opened, and had a Kleenex in her right hand.
At 7:56 a.m. NA-C walked by and stated to R23,

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"Well you look wide awake today." R23 stated, "Ya."
At 8:06 a.m. R23 continued to be seated up to the table in her Broda chair.
At 8:12 a.m. R23 was wheeled to the main dining room and brought to the table where 3 other residents were being assisted with eating.
At 8:20 a.m. R23 remained seated at the dining room table.
At 8:25 a.m. R23 remained seated in her Broda chair up to the table in the main dining room, looking around.
At 8:36 a.m. R23 was served breakfast. R23 was independently eating her jellied toast. At 8:46 a.m. R23 ate all of her toast, took a drink of her thickened water, remaining beverages at the table remain untouched.
At 8:56 a.m. NA-C walked up to R23 and asked, "Are you working on your drinks?" R23 stated, "Ya." NA-C walked away and began removing the other residents from the table as they were done eating. R23 remained seated at the table with food to eat.
At 9:04 a.m. NA-C wheeled R23 from the main dining room and back up to the table on the 4/5 Unit. NA-C brought R23 a glass of cranberry juice, set it in front of R23 at the table, and walked away.
At 9:10 a.m. NA-C told NA-E she was going to take a break. NA-C then left the floor. NA-E was seated at the table where R23 was.
At 9:18 a.m. R23 continued to be seated up to the table in her Broda chair, with her eyes closed.
At 9:26 a.m. R23 remained in the same position.
At 9:27 a.m. NA-C was back from her break, NA-E told NA-C she was going to take a break.
At 9:32 a.m. when R23 was asked what she was going to do for fun today, R23 stated, "Sleep" and then started laughing.

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At 9:37 a.m. trained medication aide (TMA)-A brought R23 her morning medications and gave her a glass of water.
At 9:46 a.m. NA-E was back on the floor from break, R23 continued to be seated in her Broda chair up to the table.

During interview on 10/3/19, at 9:57 a.m. NA-C was asked the last time R23 had been offered help to the toilet. NA-C replied, "I am not sure, I didn't get [R23] up today."

During interview on 10/3/19, at 9:58 a.m. NA-E was asked the last time R23 was offered to be toileted and NA-E stated, "I haven't had a chance to toilet [R23] yet, she is supposed to be offered every 2 hours. I last toileted her around 7 a.m. when I got her up this morning."

During interview on 10/3/19, at 2:03 p.m. NA-C and NA-E stated, "We usually have time to toilet [R23] when we first get her up before and after lunch. We don't have time to take her every 2 hours, we just don't have enough staff, and it has been this way since May when they cut our staffing."

During Interview on 10/3/19, at 2:53 p.m. family member (FM)-C stated, "I think it was at the end of July, that [R23] fell and was unable to bear any weight on her right leg. A couple days later they called me and asked me what to do about it, so they sent her via ambulance, because they didn't have portable X-ray services. The X-ray wasn't clear, so they did a CT scan and found 2 fractures in the pelvis and a fractured sacrum."

During interview on 10/3/19, at 2:54 p.m. FM-B stated, "Why can't they just bring her to the

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bathroom when they are supposed to, then she won't keep falling."

During interview on 10/4/19, at 12:05 p.m. the director of nursing (DON) stated, "My expectation is residents should be truly evaluated for their toileting needs. [R23's] toileting plan was not personalized. The staff were not following the care plan. I am going to make a personalized care plan for her toileting."

During interview on 10/4/19, at 12:42 p.m. with the administrator and director of nursing (DON), they verified R23's falls were not always evaluated for root cause, and verified new interventions were not always identified or put in place.

On 10/4/19 at 1:20 p.m. the DON stated, "I feel that staff members were attempting to provide the root cause analysis for most of the falls, and after doing the time line, there were quite a few interventions that were put into place. However, I feel like R23 has had a decline, and we have had to reassess the interventions as we go."

A facility policy for Falls was requested but not received.

Smoking

During on interview on 10/2/19, at 11:29 a.m. R152 indicated she smoked cigarettes, and was aware the facility was a non-smoking facility. R152 stated she would sneak out and go smoke and would smoke 20 feet from the door and the nurses would come outside and get her. R152 stated facility nursing staff had not watched her smoke since admission. R152 stated she was capable of wheeling herself outside, opening the

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door, light and manage her own cigarette without burning herself, would flick her cigarettes into the parking lot, and while residing at the facility had not sustained any burns.

R152 facility Admission Record indicated R152 was admitted to the facility on 9/19/19.

R152's adminision Minimum Data Set (MDS) dated 9/26/19, indicated R152 did not have cognitive impairment. The MDS also indicated R152 required extensive assistance from one staff member for transfers and supervision for locomotion on and off the unit.

R152's base line care plan dated 9/19/19, or partially completed comprehensive care plan dated 9/30/19, did not identify history of smoking or nicotine dependence.

R152's record lacked evidence of a safe smoking assessment.

R152's skilled nursing note dated 9/27/19, at 9:43 p.m. included resident, "has been sneaking outside and asking residents family members to buy her cigarettes and asking them if she can smoke with them, did speak to her about this she did become angry and did say yes she has been doing that but will stop, explained that she is aware we are a non smoking facility and that she till chose to come here, did give this writer 4 cigarettes she had in possession from another resident."

R152's skilled nursing note dated 9/28/19, at 1:08 p.m. included "res [resident] went outside without supervision-found her on side door smoking. Res was cooperative and come in. reminded res of

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not able to be outside unattended and too close to facility.

R152's communication nursing note dated 9/30/19, included "This writer also reinforced the non-smoking policy to resident by explaining there is no smoking on the facility grounds with no exceptions. Nursing has reported that resident was seen smoking outside the front and side doors. Resident was notified of non-smoking policy by the SW [social worker] before admission at the acute care hospital and upon admission to the facility here. She verbally agreed to this however she has not been compliant with the non-smoking rules. Will continue to monitor."

R152's behavior note dated 10/2/19, included "resident has been offered nicotine patches and sum to help quit smoking but resident refuses. Resident has also been talked to by the unit manager who explained St. Mark Livings policy." The note indicated the interventions were not effective.

During an interview on 10/1/19, at 9:32 a.m. registered nurse (RN)-B, indicated the facility was a non-smoking. RN-B stated R152 would sneak outside and smoke cigarettes, would not sign herself out or alert nursing staff, and has been provided education.

During an interview on 10/4/19, at 3:14 p.m. director of nursing (DON) stated the facility was a non-smoking facility and R152 was aware of that prior to admission. DON confirmed a safe smoking assessment was not completed. DON confirmed R152's baseline care plan did not address smoking and should have. DON indicated R152 was capable of signing herself out

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F 689	Continued From page 132 of the facility and leave the property to smoke. Adminstrator indicated the admission paperwork included the rules of the facility which included that the facility was non-smoking. During a subsequent interview on 10/4/19, at 8:28 p.m. DON indicated currently the facility did not have a policy for non-smoking, the only policy Ecumen had was for smoking.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		11/18/19

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F 690	Continued From page 133 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely toileting services were provided for 2 of 2 residents (R5 and R23) reviewed for incontinence care. In addition, the facility failed to assess and implement urinary orders for 1 of 1 residents (R148) reviewed for urine retention. Findings include: R5's Admission Record undated identified diagnoses that included peripheral vascular disease, venous insufficiency and unspecified fracture of shaft of right tibia. R5's quarterly Minimum Data Set (MDS) assessment dated 7/5/19 included a brief interview for mental status (BIMS) with a score of 14 indicating R5 was cognitively intact. The MDS indicated R5 required extensive assist of two with bed mobility and toileting and total dependence of two for transfers. The MDS further indicated R5 was frequently incontinent of bowl and bladder and was not on a toileting program. R5's POTENTIAL FOR SKIN BREAKDOWN care plan last revised 7/17/19 included, "The resident has a Skin Tear/potential for skin tear of the r/t [related to] recurrent skin tears to extremities	F 690	1. Corrective Action: R5 and R23 Care plans were reviewed to ensure that their toileting programs were developed and individualized to meet their needs. Care plan and POC updated to reflect the interventions and toileting plan. R148□s bladder functioning was assessed on 10/9/2019 to determine appropriate interventions were in place to prevent incontinence and prevent urinary retention. MD provided comprehensive evaluation and clarification of orders on 10/18/2019. Facility bladder scanner was assessed and nursing staff were advised on indications and use of bladder scanner. 2. Corrective Action as it applies to other Residents: All residents will have toileting needs assessed to determine individualized toileting plans by 11/18/2019. Provider and therapy referrals will be made as indicated. Care plans and POC will be updated to reflect individualized	

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F 690	Continued From page 134 from bumping into objects into her environments/ PAD [peripheral artery disease]/ Bowel and bladder incontinence. Hx [history] Left 5th toe Vascular Ulcer / Intermittent Loose stools. Braden scale of 18 or less. Long Splint in place to Right Lower extremity (splint and cam boot dc' d [discontinued] 7/9/19). Eliquis in use-resident is more easily bruised. Interventions included: Prompt and assist and assist resident with Q2 hours repo when in a sitting and laying position. Identify potential causative factors and eliminate/resolve when possible. Encourage frequent repositioning. Right leg in long cast, keep leg elevated on pillow blue boot on at all times, float both heels in bed. Repo [reposition] side to side every 2 hours with new limited mobility. Check and change every 2 hours and PRN while non-weight bearing." R5 was continuously observed on 10/2/19, from 8:39 a.m. until 11:01 a.m. -At 8:39 a.m. R5 was in the dining room sitting in her wheelchair and was independently eating her breakfast. A unidentified staff member wheeled R5 out of the dining room, took her to a nursing station, put in her dentures and returned R5 has returned to the dining room. R5 was observed to have a blue foot protector on her right foot and legs were in a dependent position -At 8:53 a.m. R5 remained in dining room eating her breakfast. -At 9:06 a.m. R5 remained in dining room eating her breakfast -At 9:08 a.m. a volunteer wheeled R5 from the dining room to her room. -At 9:27 a.m. R5 was sitting in her room in her wheelchair. No staff has entered her room since she returned from the dining room. -At 9:34 a.m. R5 was sitting in her room in her	F 690	interventions. All residents with diagnosis of incontinence will have their orders reviewed to ensure all provider orders are accurate and in place. 3. Date of Completion: 11/18/2019 4. Reoccurrence will be prevented by: Nursing Assistants will educated on adhering to individual toileting plans for residents and documenting the care in POC at a mandatory meeting on 11/12/2019. Nurses will be educated on ensuring staff are performing toileting assistance according to plan of care for each resident and to monitor residents for changes. Nurses will also be educated on appropriate Nursing Assessment, Physician Notification, order implementation and processing, Urinary Incontinence and Retention, and Bladder Scanning at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. All residents will have bowel and bladder functioning assessed on admission, quarterly and with significant change of condition to determine individualized toileting needs. Provider and therapy referral made as indicated. Toileting plans will be reflected in the Care Plan and POC.	

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F 690	Continued From page 135 wheelchair. -At 9:41 a.m. R5 was sitting in her room in wheelchair. -At 9:44 a.m. an unidentified staff member wheeled resident to get in line for the podiatrist. The unidentified staff member did not offer to toilet or reposition R5. -At 9:48 a.m. R5 was placed in line for the podiatrist. There are eight residents in front of her waiting to be seen. -At 10:00 a.m. an unidentified activity staff member holding a balloon moved R5's wheelchair to another spot in line and R5 she was now playing balloon ball with her and other residents. -At 10:05 a.m. R5 was playing the balloon ball while she waited in line. - At 10:10 a.m. R5 remained in line, sitting in her wheelchair waiting to see podiatrist. -At 10:15 a.m. R5 continued to play games while she waited to be seen by the podiatrist. -At 10:21 a.m. R5 continued to play games, while sitting in her wheelchair waiting to be seen by the podiatrist. -At 10:22 a.m. R5 told an unidentified staff member she would like to go back to her room. The staff member took her back to her room. R5 was not toileted or repositioned. -At 10:29 a.m. R5 was in room, sitting in her wheelchair, with her feet in a dependent position. -At 10:36 a.m. R5 was in room, sitting in her wheelchair, with her feet in a dependent position. - At 10:46 a.m. nursing assistant (NA)-D wheeled R5 to another hall to get her weight while sitting in her wheelchair. -At 10:49 a.m. NA-D returned R5 to her room, gave her the call light, asked if she would like the television on. NA-D did not offer to reposition or toilet R5. NA-D stated he offered to toilet her	F 690	Licensed Nurses and HUC will review the double check system for order entry beginning 11/15/2019 after mandatory education is completed. Nurse Managers will review all admissions for assessment of toileting assistance needs. DON or designee will audit one resident per week for 1 month, then one per month for 3 months to ensure appropriate interventions are in place. 5. Correction will be monitored by: DON or designee QAPI committee	

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when he brought her to her room to her room about 20 minutes ago.
-At 10:56 a.m. R5 remained in her room sitting in her wheelchair with her legs in a dependent position.
-At 11:01 a.m. R5 remained in her room sitting in her wheelchair with her legs in a dependent position.
-At 11:11 a.m. R5 was toileted by nursing assistants (NA)-C and NA-E after surveyor intervened and requested R5 be toileted and repositioned. R5 was observed by nurse surveyor to have a red left inner thigh fold where clothing had been and a small bowel movement smear. R5 was observed to have red areas from folds of clothing, all fold areas pale pink but blanchable. R5 had no open areas or purple areas.

During the continuous observation period from 8:39 a.m. to 11:11 a.m. (2 hours, 35 minutes), R5 was not provided nor offered cares related to toileting needs.

On 10/02/19, at 10:51 a.m. nursing assistant (NA)-D stated he did not offer to toilet R5 before or after he took her to be weighed. NA-D stated he offered to toilet R5 about 20 minutes ago when he took her to her room. Surveyor had been completing a continuous observation of resident, since 8:39 a.m. NA-D was not observed to be with R5 until he took her to be weighed at 10:46 a.m.

On 10/02/19, at 11:34 a.m. NA-C and NA-E stated they just toileted her about 20 minutes ago. NA-C stated R5 was up this morning when she got here. Neither NA-C nor NA-E had assisted with toileting R5 until surveyor intervened and asked for R5 to be toileted about

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twenty minutes ago.

On 10/02/19, at 11:37 a.m. NA-C stated she was here at 6:00 a.m. and R5 was dressed and ready.

On 10/02/19, at 11:42 a.m. NA-D stated he got R5 up took her to the dining room for breakfast. NA-D stated he got her up around 7:00 and 7:30 a.m. NA-D stated he changed her in bed at this time. NA-D stated he was a float on both 400 and 500 wings and I got busy. NA-D verified the last time he toileted and reposition R5 was when he got her up in the morning between 7:00 and 7:30 a.m. NA-D stated he was the one that got her ready for the day. NA-D verified R5 was not toileted or repositioned by him since he got her up in the morning. NA-D stated he did not toilet her or reposition R5 since he got her up and stated he did not know if anybody else had.

On 10/02/19, at 11:59 a.m. the director of nursing (DON) stated my expectation would be for R5 to toileted or checked every two hours and to follow the care plan.

On 10/03/19, at 1:22 p.m. NA-C stated R5 was supposed to be toileted and repositioned every two hours. NA-C stated R5 gets up by the staff member that started work at 4:00 a.m. and she did not go back to bed until after lunch. NA-C Stated this was a problem for the residents for toileting and repositioning. NA-C stated on my shift we are getting them (residents) up then it is breakfast, then it is our breaks and answering call lights for the residents that are more with it. NA-C stated with R5 she was getting up between 4:00 and 6:00 a.m. and was ready for the day. NA-C stated the next time R5 was toileted and repositioned would be after lunch, when we are

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doing our next rounds because we do not have adequate time to do the cares. NA-C stated even then it can be a conflict because we have to go to activities and we have to hunt them down.
R23

R23's Admission Record identified diagnoses of dementia, personal history of urinary tract infections (UTI'S), history of falls, fracture of superior rim of right pubis and fracture of sacrum.

R23's quarterly minimum data set (MDS), dated 8/13/19, and identified R23 to have severe cognitive impairment, frequently incontinent of urine, and required 2 person extensive assist with toileting.

R23's care plan, revised 8/14/19, included a focus: ADL (activity of daily living) function-history of pubic fracture (pelvis), depression, dementia, macular degeneration, cataracts, chronic pain, osteoporosis, DJD (degenerative joint disease). Often declining to ambulate. Goal: Will continue to participate in ADL's as able through next review. Intervention: toileting extensive assist of 1. Assist to the toilet every 2 hours while awake and PRN (as needed), assist to toilet after meals, assist to get up at 4 am and use the bathroom. Incontinent product in use (pull ups). Staff complete peri cares.

R23's Bowel and Bladder Assessment dated, 8/20/19, identified R23 to be occasionally incontinent and had a trial of a toileting program with a response of decreased wetness. A toileting program not currently being used to manage incontinence. R23 was immobile/ or needed 2 person assist for the ability to get to the bathroom/transfer to toilet, adjust clothing and

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wipe, mental status was confused and needed prompting. Usually aware of the need to toilet. Type of bladder incontinence was functional: cognitive or physical impairment. Analysis identified R23 is occasionally incontinent of blabber/bowels, assist of 2 with transfers for toileting, during the night offer the bed pan, and offer every 2 hours toileting. Bladder interventions are prompted voiding and dignity program.

During an interview on 10/02/19, at 2:50 p.m. in R23's room, family member (FM)-B stated, I come visit R23 every morning, my primary concerns are R23's falls, and she never gets to the bathroom. They have her sitting up to that table, FM-B pointed to the dining table on 4/5 unit in the common area, right outside of R23's room. R23 will tell me she has to go to the bathroom, so I will tell the aides and they always say, well you have to wait because we need 2 to take her to the bathroom. For a while they were using the bedpan on her and even the doctor said she needed to be taken to the toilet. Well then the aides acted mad that they had to bring her to the toilet. She cracked her hip, this last summer because they aren't checking on her to ask if she wants to go to the bathroom. I am usually here every day from 9:00 am until around noon. I guess my biggest concern was that they are not getting her to the bathroom, and then R23 will try to do it herself and she will fall, that makes me very upset. I do not think there is enough staff, all of a sudden they all just disappear, and then you see one with a pop in their hand. I am here every day like clockwork and this is how it is. We have made this complaint to administration, it must have went in one ear and out the other, and nothing changes.

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F 690	Continued From page 140 Continuous Observation on 10/03/19, At 7:07 a.m. R23 was seated in a Broda chair in her room, nursing assistant (NA)-E observed leaving R23's room carrying a clear garbage bag containing a brief, and disposed of it in the soiled utility room. At 7:11 a.m. NA-E wheeled R23 from her room and pushed her up to the dining table on the 4/5 Unit, in the common area outside her room. At 7:28 to 7:43 a.m. R23 continued to be seated up to the table in her Broda chair with her eyes closed. At 7:54 a.m. R23 continued to be seated up to the table in the Broda chair, with her eyes opened, and had a Kleenex in her right hand. At 7:56 a.m. NA-C walked by and stated to R23, well you look wide awake today. R23 stated, "Ya." At 8:06 a.m. R23 continued to be seated up to the table in her Broda chair. At 8:12 a.m. R23 was wheeled to the main dining room and brought to the table where 3 other residents are assisted with eating. At 8:20 a.m. R23 remained seated at the dining room table. At 8:25 a.m. R23 remained seated in her Broda chair up to the table in the main dining room, looking around. At 8:36 a.m. R23 was served breakfast. R23 was independently eating her jellied toast. At 8:46 a.m. R23 ate all of her toast, took a drink of her thickened water, remaining beverages at the table remain untouched. At 8:56 a.m. NA-C walked up to R23 and asked, are you working on your drinks? R23 stated, "Ya." NA-C walked away and began removing the other residents from the table, as they were done eating. R23 seated at the table, had fried egg and all beverages left to eat and drink.	F 690		

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At 9:04 a.m. NA-C wheeled R23 from the main dining room and back up to the table on the 4/5 Unit, brings her cranberry juice and sets it in front of R23 at the table and walked away.
At 9:10 a.m. NA-C told NA-E that she was going to take a break. NA-C then left the floor. NA-E was seated at the table where R23 was. 2 other unknown residents were noted to be eating their breakfast.
At 9:18 a.m. R23 continued to be seated up to the table in her Broda chair, with her eyes closed. At 9:26 a.m. R23 noted to have drank half of her glass of cranberry juice.
At 9:27 a.m. NA-C was back on the floor from her break, NA-E told NA-C she was going to take a break now.
At 9:32 a.m. when R23 was asked what she is going to do for fun today R23 stated, sleep, and then started laughing. R23 started talking about a yellow canary that she had when she was little that she really enjoyed.
At 9:37 a.m. trained medication aide (TMA)-A brought R23 her morning medications and gave her a glass of water with it.
At 9:46 a.m. NA-E was back on the floor from break, R23 continued to be seated in her Broda chair up to the table. During interview on 10/3/19, at 9:57 a.m. NA-C was asked the last time R23 was offered to be toileted. NA-C replied, I am not sure, I didn't get R23 up today.

During interview on 10/3/19, at 9:58 a.m. NA-E was asked the last time R23 was offered to be toileted and NA-E stated, I haven't had a chance to toilet R23 yet, she is supposed to be offered every 2 hours. I last toileted her around 7am when I got her up this morning.

During interview on 10/03/19, at 2:03 p.m. NA-C

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and NA-E stated, we usually have time to toilet R23 when we first get her up before and after lunch. We don't have time to take her every 2 hours, we just don't have enough staff, and it has been this way since May when they cut our staffing.

During interview on 10/03/19, at 2:54 p.m. FM-A stated, why can't they just bring her to the bathroom when they are supposed to, then she won't keep falling.

10/04/19, at 12:05 p.m. the director of nursing (DON) stated, my expectation is be sure residents are truly evaluated for their toileting needs, R23's toileting plan was not personalized. The staff were not following the care plan. I am going to make a personalized care plan for her toileting.

R148 urinary retention

During an interview on 10/4/19, at 11:43 a.m. R148 sat in his wheelchair in his room. R148 stated he required urinary catheterization in the hospital for urine retention and it was discontinued prior to admission to the facility. R148 stated since he was admitted to the facility he has had urinary urgency, had a little bit of incontinence, and when he urinated not a lot of urine came out. R148 also stated he felt like he was not completely emptying his bladder when he voided and questioned if he has some retention. R148 indicated that the facility has not scanned his bladder or attempted to assess his bladder for fullness. R148 stated a medication for urinary urgency has been on hold since discharged from the hospital, did not recall the name, and

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indicated an unawareness why the medication was on hold and/or when the medication would be restarted.

R148's hospital summary dated 9/19/19, indicated Trospium (medication for urinary retention)was on hold and indicated for primary care physician to reassess the need. The summary instructions included; Urinary retention: the patient continued to have high PVRs (post void residuals) and should have bladder scans and intermittent catheterization per facility protocol.

R148's facility Admission Record dated 10/4/19, indicated R148 was admitted to the facility on 9/19/19, with diagnosis that included benign prostatic hyperplasia without lower urinary tract infection.

R148's scheduled Minimum Data Set dated 9/30/19, indicated R148 did not have cognitive impairment. The MDS indicated R148 required extensive assistance from two or more staff members for transfers and toileting, was occasionally incontinent of urine and was not on a toileting program.

R148's physician orders included
-Trospium Chloride Tablet 20 milligrams (mg) by mouth two times a day related to benign prostatic hyperplasia; HOLD due to urinary retention.

R148's baseline care plan dated 9/19/19, did not address urinary retention.

R148's progress note dated 9/21/19, indicated R148 was continent; occasional incontinence due to urgency and not getting to the restroom in time.

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The note also indicated R148 having symptoms of urinary tract infection and was placed on a 3 day voiding diary.

Progress note dated 9/22/19, indicated R148 was sent to the hospital and had been admitted for bladder infection. A subsequent progress note dated 9/27/19, indicated R148 had returned to the facility with a diagnosis of urosepsis.

R148's progress notes dated 9/28, 9/29, 9/30, 10/1/2019 indicated R148 was continent of urine.

R148's progress note dated 10/3/19, included R148 was occasionally incontinent of urine.

R148's record lacked evidence evaluations and/or monitoring for urinary retention per the hospital discharge summary.

R148's bowel and bladder assessment dated 9/30/19, indicated R148 was occasionally incontinent of urine was not on a trial toileting program, always aware of the need toilet, and was taking medications that affected urinary continence. The assessment indicated R148 had stress incontinence defined as urine leaking. The section for Licensed Nurse Analysis of Bowel and Bladder Functioning indicated the analysis was not completed until 10/4/19, the note included "Resident has a history of urinary retention with PVR [post void residual]. He also is occasionally incontinent but that has improved since admission. 72 hour bladder assessment initiated on 10/4. New orders in PCC [Point Click Care-electronic health record] for output to be documented every shift and prn [as needed] Tasks triggered for CNA's to record output QS [every shift] but prn on night shift. He had to be

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placed on toilet and urinal to be offered. 72 hour urinary output monitoring to be completed on 10/7/19. Results will be reported to PCP [primary care provider]."

During an interview on 10/3/19, at 12:02 p.m. registered nurse (RN)-B stated she was not aware of the hospital instruction to complete post void residuals and was not sure of how that would have dropped off physician orders. RN-B indicated she had not assessed R148 for urinary retention.

During an interview on 10/3/19, at 12:23 p.m. registered nurse (RN)-C indicated she tried to go over the hospital discharge summary's when the residents were admitted. RN-C reviewed R148's record and verified there was not evidence of completed assessments and/or monitoring for urinary retention. RN-C indicated that the facility had a bladder scanner however, was not used because there was a concern it was not accurate. RN-C indicated in place of performing bladder scans; intake and output should have been completed, questioning the resident, and palpation of the bladder to determine if it was full. RN-C indicated she would start something today. RN-C stated the last bladder assessment that was completed; indicated that R148 was occasionally incontinent of urine, always aware of having to go to the bathroom, has some stress incontinence. RN-C then reviewed the previous bladder assessment and stated the first assessment indicated R148 was always continent of urine.

During an interview on 10/4/19, at 2:52 p.m. director of nursing (DON) stated she would have expected nursing to reach out to the hospital for

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clear instruction what assessments be completed. DON indicated that she also expected a 72 hour voiding diary be started upon admission per the admission checklist and would expect nurses to use nursing judgement in relation to pertinent diagnosis to complete the appropriate assessments and interventions. DON indicated that urinary retention should have been identified on the baseline care plan.

Facility policy Urinary Continence and Incontinence-Assessment and Management dated 9/2010, included The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary incontinence. Examples of sources of such information may include the resident, family, or hospital discharge summary describing placement of indwelling urinary catheter during a recent hospitalization. AS part of it's assessment, nursing staff will seek and document details related to continence. Relevant details include: voiding patterns, associated pain or discomfort, and types of incontinence. nursing staff will identify risk factors for becoming incontinent or worsening of current incontinence, including; a) prostate cancer/BPH. For individuals with persistent or recurrent urinary retention despite interventions , the staff and physician will seek treatable causes and consider intermittent catheterization, if feasible, before placing indwelling catheter. The staff and practitioner will appropriately screen for, and

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F 690	Continued From page 147 manage, individuals with urinary incontinence. Management of incontinence will follow relevant clinical guidelines. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. Identification and management of urinary tract infections will follow clinical guidelines. Antibiotics will be used appropriately.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		11/18/19

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F 725	Continued From page 148 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to provide timely assistance with personal cares according to the residents' assessed need and as directed by the care plan. This practice had the potential to affect all 55 residents who resided in the facility. Findings include: See 565-On 10/2/19, at 12:57 p.m. a resident council meeting was held with R11, R3, R2, R43, R31 with surveyors. The resident's shared they have had multiple concerns with staffing issues, call light response time was described as ridiculous. During an observation on 10/4/19, at 9:16 a.m. R43 sat in her recliner chair in her room with pajama's on; R43 put her call light on. At 9:22 a.m. activity director (AD) entered R43's room, R43 indicated to AD she wanted someone to help her get ready for the day. At 9:23 a.m. registered nurse (RN)-E entered R43's room, R43 told RN-E she wanted to get ready for the day, RN-E told R43 she could not get her dressed and would find someone to help her. At 9:28 a.m. R43 stated her normal routine was she "gets up"(referring to being toileted, washed up in the bathroom). R43 stated she had to go to the bathroom pretty bad. R43 indicated she has had to wait for a long time to go the bathroom that caused her to be incontinent. At 9:38 a.m., 22 minutes after R43 had initially put her call light on nursing assistant (NA)-I entered R43's room. R43 stated she needed to go to the bathroom, and needed the sit	F 725	1. Corrective Action: Nursing staff patterns were reviewed and additional staff added to be able to provide necessary care and meet residents needs safely. Facility added an additional 16 hours of C.N.A. time daily (8 hours for day shift, and 8 hours for evening shift). 2. Corrective Action as it applies to other Residents: Facility will review resident acuity and staffing levels on-going in order to provide necessary care and meet resident needs safely. 3. Date of Completion: 11/18/2019 4. Reoccurrence will be prevented by: Resident acuity will be reviewed daily at IDT Standup beginning 11/15/19. Staffing patterns will be adjusted according to resident needs and ensure resident safety. DON or designee will audit call light response daily beginning 11/4/2019 for 5 days and then weekly for 3 months. Results will be shared with the QAPI Committee 5. Correction will be monitored by:	

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F 725	Continued From page 149 to stand lift today because she felt weak. NA-I left the room and returned with a lift and NA-J. The calf strap malfunctioned, a different lift was obtained, at 9:45 a.m. R43 was transferred to the toilet and voided a large amount of urine. During an interview on 10/4/19, at 10:41 a.m. RN-E stated she had responded R43's call light and communicated to an aide R43 wanted to get up. RN-E stated 20 minutes was too long to wait, and ideally it would be half that time. "I wouldn't want to wait that long." See F677- Activities of daily living cares for dependent resident: the facility failed to provide facial hair removal hygiene services for 1 of 1 residents (R5) observed with facial hair and was dependent on staff. See F686- Pressure ulcers: the facility failed to ensure Weekly Ulcer/Complex Wound Observation Tool documentation was completed for 2 of 3 residents (R5 and R22) for residents with stage three or greater pressure ulcers. See F688-ROM/Mobility: The facility failed to provide ambulation according to therapy recommendations for 1 of 1 residents (R10) reviewed for restorative program. During interview on 10/03/19 2:17p.m. Nursing assistant (NA)-K stated, I have worked here for about a year and work the evening shift. We haven't been able to walk R10 in the hallway since they cut our staff in May, we just don't have time anymore. R10 walked really slowly and it takes a long time. I am surprised R10 can still walk that far.	F 725	DON or designee QAPI committee	

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See F689-Falls: the facility failed to implement, monitor and/or revise interventions to ensure efficacy for 1 of 1 residents (R23) reviewed for accidents.

See F690 - Bowel/Bladder incontinence/catheter: the facility failed to provide timely assistance with incontinence cares for 2 of 2 residents (R5, R23) observe for incontinence cares.

On 10/03/19, at 1:22 p.m. nursing assistant (NA)-C stated we provide shaving assistance to female residents when we have time. NA-C stated if they [staff] see a resident with facial hair they will try to complete the shaving real fast. NA-C stated R5 was supposed to be toileted and repositioned every two hours. NA-C stated R5 gets up by the staff member that started work at 4:00 a.m. and R5 does not go back to bed until after lunch. NA-C stated this was a problem for the residents for toileting and repositioning. NA-C stated on their shift, they get residents up for breakfast, and then it is our breaks and answering call lights for the residents that are more with it. NA-C stated with R5 she was getting up between 4:00 and 6:00 a.m. and was ready for the day. NA-C stated the next time R5 was toileted and repositioned would be after lunch, when we are doing our next rounds because we do not have adequate time to do the cares. NA-C stated staffing had been cut to one nursing assistant on the transitional care unit (TCU), and two nursing assistants on the other two units. NA-C stated now on the TCU if there are more than 10 residents there are two nursing assistants. NA-C stated oral cares, shaving, applying lotion, repositioning, toileting and walking residents was not getting done. NA-C stated quick showers are given instead of whirlpools.

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F 725	Continued From page 151 During interview on 10/03/19, at 2:03 p.m. NA-C and NA-E stated, we usually have time to toilet R23 when we first get her up before and after lunch. We don't have time to take her every 2 hours, we just don't have enough staff, and it has been this way since May when they cut our staffing. During an interview on 10/4/19, at 9:55 a.m. administrator indicated on 10/3/19, she completed a staffing analysis that was based on acuity and not resident census. Administrator indicated staffing levels were changed a few months ago because we were way over on our staffing hours. Administrator stated the last staffing analysis that was completed a few months ago was only based on the resident census and did not take resident acuity into consideration. Administrator indicated the new staff model based on the new analysis was pending approval from cooperate.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		11/18/19

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F 755	Continued From page 152 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure proper disposal of fentanyl patches (an opioid patch delivery system), to prevent potential diversion. This had the potential to affect 55 residents who resided in the facility. In addition, based on observation, interview, and document review the facility failed to have a system in place for the disposition of all medications and biologicals this had the potential to affect 55 residents who resided in the facility. Findings include: Fentanyl patch destruction During an interview on 10/4/19, at 7:15 a.m. trained medication assistant (TMA)-A indicated she personally had a nurse verify when she removed a patch from a resident. TMA-A then	F 755	1. Corrective Action: Licensed Nurses and Trained Medication Aides provided written education on Fentanyl Patch disposal procedure on 10/4/2019 via written policy placed at each nurses station. 2. Corrective Action as it applies to other Residents: Licensed Nurses and Trained Medication Aides will re-educated on Fentanyl Patch disposal procedure as well as Medication Disposal Policy and Procedure at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and	

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F 755	Continued From page 153 stated she would fold the patch in half and dispose of it in a sharps container. During an interview on 10/4/19, at 7:50 a.m. registered nurse (RN)-D indicated the facility policy for fentanyl patch destruction was to throw the patches in the garbage. During an interview on 10/4/19, at 4:33 p.m. director of nursing (DON) stated fentanyl patches where supposed to be folded in half, or placed on a tissue and flushed into the sewer system or disposed of in a proper disposal container. DON stated the patches cannot be put in a sharps container or thrown in the garbage. Facility policy Disposal of Fentanyl (Duragesic) Patches dated 8/2019, Proper disposal of fentanyl patches involves tow separate scenarios: The fentanyl patch should be folded or placed onto a tissue paper. If allowed by facility publicly owned treatment works, the patch may be immediately flushed into the sewer system per manufacturer recommendation in the presence of a licensed nurse. Or facility will dispose of the fentanyl patch in compliance with federal and state rules for the disposal of unused controlled pharmaceuticals by rendering "non-retrievable" based on DEA guidance. Placing the patches in sharps containers or other biohazard disposal containers in not acceptable as a used patch is not considered infectious waste. Using a medication waste hauler to dispose of fentanyl patches is not an option. disposal and witness of disposal must be documented on the medication administration record or other appropriate documentation record in order to provide the facility with appropriate tracking of the patch disposal in the patient record.	F 755	sign off by 11/15/19. Medications other than Fentanyl Patches will be disposed via Medsafe per facility policy and documented in the resident record. 3. Date of Completion: 11/18/2019 4. Reoccurrence will be prevented by: DON or designee will audit disposal of Fentanyl Patches and all medications once weekly for 1 month and then monthly for 3 months. Results will be shared with the QAPI Committee. 5. Correction will be monitored by: DON or designee QAPI Committee	

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F 755	Continued From page 154 Disposition of medications On 10/4/19, at 7:15 a.m. a medication room tour was completed with trained medication assistant (TMA)-A. On the counter in a clear plastic bag were medication cards, bottles, inhalers with doses of medications remaining. TMA-A indicated the pharmacy would then pick up the medications, however was not aware of a recording system. During an interview on 10/4/19, at 7:36 a.m. registered nurse (RN)-E stated she was the unit manager. RN-E confirmed the presence of the medications in the medication room. RN-E indicated the discontinued medications were placed in the container in the medication room, and the pharmacy driver would pick them up in the afternoon. RN-E stated to her knowledge there was not a current process for the accounting for dispositioned medications; medications were logged on any form of tracking sheet. During an interview on 10/4/19, at 4:33 p.m. director of nursing (DON) stated the facility was currently only recording the destruction and disposition of narcotic medications with the MedSafe Containers however, was not placing the record in the resident record. DON indicated the facility did not have a process in place for accounting for all medications and biologicals. Facility policy Medications: Disposal MedSafe Containers dated 7/2017, the policy did not include direction for medications returned to the facility pharmacy. The policy directed staff to count and log all medication to be dispositioned	F 755		

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F 755	Continued From page 155 of with two people per individual site policy. Place all discontinued medications into the Medsafe with a 2nd person as a witness. The policy indicated when the container was to be shipped out of the facility for destruction record the required data on the log form and keep the log in the DON's office. The policy did not address maintaining dispositioned medications as part of the resident records.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to offer/attempt non-pharmacological	F 757	1. Corrective Action:	11/18/19

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F 757	Continued From page 156 interventions prior to administration of narcotic pain medications and failed to consistently evaluate the effectiveness of the pain medication for 1 of 1 residents (R148) reviewed for pain management Findings include: During an interview on 9/30/19, at 6:27 p.m. R148 indicated he had surgery on his right hip and was not having a lot of pain. R148 indicated when he had pain, he reported to the nursing staff and they administered pain medications and sometimes he used an ice pack. R148's facility Admission Record dated 10/4/19, included diagnosis of aftercare following joint replacement surgery, unsteadiness on feet, and pain in left hip. R148's physician pain medication orders included: -Ultram 50 mg every six hours as needed for pain level rated 1-3 out of 10. -Hydromorphone 2 mg every four hours as needed for pain: give 0.5 tab (1 mg) every four hours as needed for pain level rated 4-6 out of 10; 10 being worst pain (start date 9/19/19). R148's baseline care plan dated 9/19/19, indicated R148 was at risk for alteration in comfort/pain related to recent left hip arthroplasty and arthritis. The care plan directed staff to "Prior to analgesic: attempt non-medication interventions and document effectiveness. Interventions for pain relief include: Ice, Heat, Elevation, Repositioning for comfort, gentle massage, Simple exercise, Rest periods, Quiet, Calm environment to facilitate relief, Deep	F 757	R148 had a pain assessment on 10/9/2019 including preferred non-pharmacological pain management strategies. His medication orders and care plan were reviewed and non-pharmacological interventions were added to the care plan, eMAR and POC. Provider was contacted to review resident□s pain management on 10/18/2019. 2. Corrective Action as it applies to other Residents: All residents care plans and medication orders will be reviewed to determine individualized interventions including non-pharmacological pain strategies are in place for each resident having pain. Providers will be contacted for any resident with inadequate pain management for guidance. 3. Date of Completion: 11/18//2019 4. Reoccurrence will be prevented by: All residents will have pain assessed on admission, quarterly and with significant change of condition. Individualized pain management plans will be developed to meet individualized resident needs including non-pharmacological strategies. These interventions will be reflected in the residents care plan, eMAR, and POC. Licensed Nurses will be educated on the use of non-pharmacological pain	

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F 757	Continued From page 157 breathing exercises, provide distraction/diversion Aromatherapy" The care plan further directed staff to Evaluate effectiveness of pain interventions, review for compliance, alleviating symptoms, dosing schedules, impact on functional ability and impact on cognition. In addition, the care plan directed staff to use Ice or heat/ heated blanket for comfort as needed, Ice on for 20 minutes at a time, offer prior to administration of narcotic pain medication. R148's September 2019, medication administration record (MAR), identified administration of medication, that included time of administration, numeric pain levels, staff initials, effectiveness of medication. The MAR identified administration of Ultram on 9/21 for pain level rated a 5. The MAR identified Hydromorphone was administered once on 9/19, 9/21, 9/22, 9/27, and 9/30. R148's October 2019, MAR identified Hydromorphone was administered twice on 10/1/19, one dose on 10/2, one dose on 10/3/19. R148's progress notes were reviewed and compared to the MAR's, R148's notes consistently lacked evidence of non-pharmacological interventions attempted or offered prior to the administration of an opioid pain medication, failed to identify the location of pain, did not identify the dose of hydromorphone administered, and failed to consistently evaluate the effectiveness of the administered doses. -Order Note dated 9/19/19, at 6:05 p.m. indicated R148 was administered Ultram 50 mg. Order Note at 6:27 p.m. indicated R148 was administered Hydromorphone. A subsequent note	F 757	management strategies at a mandatory meeting on 11/7/2019. Nursing Assistants will be educated on the use of non-pharmacological pain management strategies as well as documented results and follow-up at a mandatory meeting on 11/12/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19 . DON or designee will audit on record weekly for appropriate pain interventions and utilization of non-pharmacological strategies for 1 month and then one record monthly for 3 months. 5. Correction will be monitored by: DON or designee QAPI Committee	

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F 757	Continued From page 158	F 757		

at 6:58 p.m. indicated a dose of Hydromorphone was administered; record indicated pain was not reassessed until 10:20 p.m., and indicated the 2nd dose was effective.
-Order note dated 9/21/19, at 5:53 a.m. indicated Hydromorphone was administered. A follow-up note at 6:50 a.m. indicated the dose was effective, however, did not identify a pain rating.
-Order note 9/21/19, at 1:29 p.m. indicated Ultram was administered; subsequent progress note at 2:36 p.m. indicated the administration was effective; pain rated zero.
-Order note dated 9/22/19, at 10:55 a.m. indicated Hydromorphone was administered for "Resident has complaints of general pain and states he feels achy. A subsequent progress note at 12:52 p.m. indicated the dose was effective; pain rated 2/10.
-Order note dated 9/27/19, at 9:27 p.m. indicated dose of hydromorphone was administered; subsequent note at 12:30 a.m. indicated the administered dose was effective; pain rated 2/10.
-Order note dated 9/30/19, at 5:44 p.m. indicated dose of hydromorphone was administered; subsequent note at 8:45 p.m. indicated the administered dose was effective; pain rated 0/10.
- Order note dated 10/1/19, at 9:24 a.m. indicated dose of hydromorphone was administered; subsequent note at 9:42 a.m. indicated the administered dose was effective, however did not identify a pain rating.
-Order note dated 10/1/19, at 10:57 p.m. indicated dose of hydromorphone was administered: subsequent note at 3:07 a.m. indicated the administered dose was effective; pain rated 0/10.
-Order note dated 10/2/19, at 11:26 a.m. indicated dose of hydromorphone was administered; subsequent note at 12:31 indicated

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F 757	Continued From page 159 dose was effective; pain rated 0/10. -Order note dated 10/3/19, at 8:43 a.m. indicated dose of hydromorphone was administered; subsequent note at 10:22 a.m. indicated the dose was effective; no pain rating was included. During an interview on 10/3/19, at 1:13 p.m. registered nurse (RN)-C reviewed R148's record and confirmed the documentation did not identify the location of pain, or if non-pharmacological interventions were attempted or offered prior to the administration. RN-C indicated the location of pain should be documented, non-pharmacological interventions should be offered/attempted prior to administration, and documentation should include the effectiveness of the interventions or the effectiveness of the medication. During an interview on 10/4/19, at 2:52 p.m. director of nursing (DON) stated an expectation non-pharmacological interventions be attempted prior to the administration and would expect nurses to document attempts and effectiveness. DON indicated refusals of offers of non-medication interventions also be documented. DON further indicated that documentation should identify the location of the pain and the extent of effectiveness of the administered pain medication dose using the pain scale. Facility policy was requested pertaining to administration of as needed medications and was not received.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		11/18/19

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F 758	Continued From page 160 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 161 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to discontinue a medication within the designated time frame for 1 of 5 residents (R30) reviewed for psychotropic drug use. Findings include: According to R30's Admission Record and Diagnosis list indicated generalized anxiety, major depressive disorder, and dementia with behavioral disturbance. R30's Physician Orders included the following order: Lorazepam Concentrate (an antianxiety medication) 2 MG/ML, give 0.25 ml by mouth every 2 hours as needed (PRN) for anxiety. The start date for this order was 7/11/19. Within the order was the following statement, "Received stop date for 60 days 9/11/19." A handwritten original of this order was found in R30's hard chart on the Physician's Order sheet. According to R30's medication administration record (MAR), R30 received a PRN dose of Lorazepam on 9/12/19, 3:43 p.m., 9/24/19, 2:43 p.m., 9/30/19, 4:12 p.m. and 10/2/19, 10:19 a.m. According to an interview on 10/04/19, at 10:31 a.m. registered nurse (RN-A) reviewed R30's	F 758	1. Corrective Action: R30□s Lorazepam was discontinued on 10/4/2019. Resident□s care plan reviewed and revised to reflect individualized interventions to address anxiety. 2. Corrective Action as it applies to other Residents: All records for residents receiving PRN psychoactive medications will be reviewed to ensure stop dates are in place for the medications. In addition, individualized non-pharmacological interventions will be added to the care plan, eMAR and POC as appropriate to each resident□s plan of care. 3. Date of Completion: 11/18/19. 4. Reoccurrence will be prevented by: Licensed Nurses will be educated on the Policy and use of PRN Psychoactive medications at a mandatory meeting on 111/7/2019. Staff who are unable to attend the meetings will be required to	

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F 758	Continued From page 162 MAR and confirmed the four PRN doses after the order stop date of 9/11/19 would be considered medication errors and the Lorazepam should have been discontinued as written. During an interview on 10/04/19, at 4:41 p.m. the director of nursing (DON) confirmed the four PRN doses of Lorazepam should not have been administered. DON stated an expectation for nurses to report medication errors, fill out a risk management document and notify the family and physician. DON stated she had not received notification of the error. A request was made for a policy related to the use of psychotropic medication use. The facility provided a document titled, Antipsychotic Medication Use, dated as revised December 2016. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders for psychotropic medication beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order."	F 758	meet with the DON or designee to review the information and sign off by 11/15/19. DON or designee will audit one record weekly for 1 month and then one monthly for 3 months to ensure that all PRN Psychoactive medications have an appropriate stop date in place. 5. Correction will be monitored by: DON or designee QAPI Committee	
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 observation, interview and document review the facility failed to have physician ordered Urea powder (medication used to treat	F 760	1. Corrective Action: R152□s medication orders were reviewed	11/18/19

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F 760	Continued From page 163 Hyponatremia) available for administration for 1 of 1 residents (R152) reviewed who had a diagnosis of hyponatremia (low sodium). Additionally, facility failed to provide pain medication as ordered, or to report and monitor the resident's condition related to the missed doses for 1 of 1 Residents (R46) reviewed for pain control for a terminal illness. Findings include During an interview on 10/1/19, at 10:46 a.m. R152 stated she was admitted to the facility after a hospitalization related to hyponatremia that caused serious heart complications. R152 stated she was concerned she had not been given her sodium powder since admission, and had been told by facility staff that she could not have the medication because her insurance would not cover it. R152 indicated she use to take the powder once per day. R152 stated she planned to discharge to home on 10/2/19. R152's hospital Discharge Summary dated 9/19/19, indicated R152 was admitted to the hospital on 9/6/19, following a cardiac arrest. The discharge summary including diagnosis of inappropriate antidiuretic hormone syndrome and congestive heart failure. The summary indicated on 9/6/19, R152 was found to be in cardiac arrest and was transferred to the emergency department where R152's cardiac abnormalities were due to metabolic abnormalities. Bloods tests revealed her sodium level was 127 and had significant urine output (over 500 milliliters an hour). The discharge summary indicated after treatment in the intensive care unit, R152 was stabilized transferred "floor" where "sodium's remained stable on the diuretic and urea	F 760	on 10/2/2019 by provider with new medication orders, follow up labs and appointments. R152 chose to leave facility AMA later that day. R152 had appointment 10/3/2019 with PCP for follow up evaluation and labs. Facility notified PCP of R152 treatments & condition while at the facility as well as provider recommendations. R 46 was discharged from the facility on 7/9/2019. Medication orders were reviewed to determine if any further doses of pain medication had been missed while a resident at the facility. Medication Error entries were completed for the errors and staff members responsible for the errors were counseled and re-educated on Medication Order Transcription and MAR use for medication pass on 11/6/2019. 2. Corrective Action as it applies to other Residents: All resident Medication Orders will be reviewed from paper to eMAR to ensure all orders are correct and in place. All Licensed Nurses will be educated on Medication Order Processing and MAR use for medication pass at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19.	

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F 760	Continued From page 164 regimen." Patient was discharged in stable condition to skilled nursing facility. The summary indicated on 9/19/19, R152's blood sodium level was low at 131 (normal sodium levels are 135-145). The discharge summary included orders for Urea 15 grams powder packet (commonly known as URE-NA) twice per day; order indicated that this was a dose change since previous order. R152's facility Admission Record dated 10/4/19, indicated R152 was admitted to the facility on 9/19/19, with diagnoses that included history of sudden cardiac arrest, inappropriate secretion of antidiuretic hormone, hypo-osmolality and hyponatremia, congestive heart failure, atrial fibrillation, hypertensive heart disease, hypokalemia (low potassium), and hypocalcemia (low calcium). R152' BIMS (Brief Interview of Mental Status) Resident Interview dated 9/19/19, indicated R152 did not have cognitive impairment. R152's physician orders included, -"Urea Powder give 15 grams by mouth two times a day related to URGE INCONTINENCE" (start date 9/19/19.) On 10/2/19, the indication for the order was changed to "PERSONAL HISTORY OF SUDDEN CARDIAC ARREST" R152's medication administration record (MAR) for September and October were reviewed. The MARS identified the order for Urea with the start date of 9/19/19, however indicated the order was put on hold from 9/29/19 through 10/1/19 (R152's record lacked evidence of a physician order to hold urea). The boxes on the MARS were marked	F 760	3. Date of Completion:11/18/19. 4. Reoccurrence will be prevented by: Nurse Managers and DON will audit the medication dashboard daily to monitor for medication errors. Staff who commit medication errors will be counseled and re-educated on Medication Pass or Transcription as indicated. DON or designee will audit one record weekly for 1 month to evaluate medication order transcription and for errors. DON or designee will then audit one record monthly for 3 months. Medication Errors will be shared at the facility QAPI Meeting. 5. Correction will be monitored by: DON or designee QAPI Committee	

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with a "9", which the MAR chart codes did not identify with. The MAR indicated on 9/22/19, both doses were administered as well as one dose on 9/25/19. Boxes from 9/29/19 through 10/2/19, were marked with "H", indicating the doses were held.

R152's record was reviewed from 9/19/19 through 10/2/19, nursing progress note documentation indicated urea was not available and did not indicate why the medication was not available. The record lacked evidence of a plan to obtain and/or substitute medication, lacked evidence of increased monitoring interventions. In addition, the record lacked evidence the physician was notified of the unavailable medication.

R152's record only included the following progress notes pertaining to the missed doses of urea powder.
-Order administration notes dated 9/20/19, at 8:23 a.m. and 6:16 p.m. indicated urea powder was not administered; "not available"
-Order administration note dated 9/21/19, at 8:24 a.m. indicated urea powder was not administered; "not available" Order administration note at 6:08 p.m. indicated urea powder was not administered and did not identify a reason why.
-On 9/22/19, progress notes did not mention urea powder
-Order administration notes dated 9/23/19, at 7:36 a.m. and 9:41 a.m. indicated urea powder was not administered and did not indicate a reason why.
-Order administration note dated 9/24/19, at 6:44 a.m. indicated urea powder was not administered; "Med [medication] not available. Order administration note at 6:11 p.m. indicated urea powder was not administered and did not indicate

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a reason why.
-Order administration note dated 9/25/19, at 8:36 a.m. indicated urea powder was not administered; "not available". Progress notes did not address the second dose of the urea powder for 9/25/19.
-Order administration note dated 9/26/9, at 6:33 a.m. indicated urea powder was not administered; "Med not available". Order administration note at 5:12 p.m. indicated urea powder was not administered; "unavailable".
-Order administration note dated 9/27/19, at 8:56 a.m. indicated urea powder was not administered; "unavailable". Order administration note at 5:35 p.m. indicated urea powder was not administered and included, "unavailable will be dispensed Monday from pharmacy."
-Order administration note dated 9/28/19, at 9:38 a.m. indicated urea powder was not administered, "no med here". Order administration note at 5:06 p.m. indicated urea powder was not administered and included, "Resident states medication not paid by insurance. Medication not available to nurse."

R152's progress notes did not address urea powder from 9/29/19 and 9/30/19.

Late entry orders administration note dated 10/2/19, for 10/1/19, included "Urea powder stated "on hold" 5 boxes did arrive in facility, and offered to resident in am [morning] she stated, "I don't want it, doesn't matter at this point"

During an interview on 10/2/19, at 8:44 a.m. R152 and family member (FM)-F, sat in R152's room. FM-F stated she was R152's emergency contact and health care power of attorney. FM-F stated she was very concerned and upset that R152 had not received her urea powder since admission

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because R152 had chronically low sodium levels and has ended up in the intensive care unit as a result. FM-F stated she had contacted the facility about the urea powder and was told that R152's insurance would not cover the medication. FM-F indicated she did not understand what R152's insurance company had to do with covering the medication because R152 was at the facility under a skilled Medicare A stay.

-At 8:51 a.m. registered nurse (RN)-B entered the room with facility totes that contained medications and small clear plastic bags with a number of boxes and indicated she was going to go through the discharge paperwork with FM-F and R152. RN-B went through R152's medication list with R152 and FM-F; RN-B stated to R152, the urea powder for your rash came in yesterday. FM-F stated the powder is not for rash, it is for her sodium; FM-F stated she was very concerned that R152 had not received the medication because it was the medication that was going to keep her out of the intensive care unit. RN-B then indicated an unawareness of what the urea powder was for and did not know where the indication came from that was part of the physician orders. R152 stated she was not familiar with the name of the medication, and only knew she was supposed to take powder to help her sodium. RN indicated when she presented the medication to R152 yesterday, she told R152 it was for her dermatitis, and R152 refused the medication. R152 indicated had she known that the urea was for her sodium she would have taken it because there was nothing wrong with her skin. When FM-B asked if a physician been notified or labs drawn to check R152's sodium level, RN-B stated no labs had been drawn since R152 was admitted and had not been seen by a

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physician. RN-B stated she called the pharmacy last week; pharmacy told her that the medication was not covered under R152's insurance. RN-B indicated she then told the pharmacy R152 was at the facility under a Medicare A, and that was when the pharmacy told her they would send out the medication. RN-B stated she had not made the physician aware the medication had not been administered since admission.

-At 9:18 a.m. RN-C entered R152's room. RN-C indicated she was completely unaware that the urea was not available for administration. When FM-F asked RN-C if a physician was going to see R152 today before discharge or have labs drawn. RN-C indicated there was not a physician available, wasn't aware if labs could be obtained prior to discharge but would find out. FM-F again stated she was very concerned about R152 discharging to home without knowing if her labs were stable. RN-C indicated she would attempt to call R152's primary care physician or physician on-call.

-At 11:29 a.m. R152 sat in her room. R152 indicated the facility had arranged a physician visit later this afternoon. R152 stated she was very irritated and just wanted to be discharged. FM-F indicated the urea powder had not been given yet because she had instructed staff not to give it, wasn't sure what her blood levels were doing, and it was important to know what the lab was doing, because the urea dose may need to be changed based off the lab levels. R152 stated historically she has not had signs or symptoms of hyponatremia until her sodium was "super low"; by that time, she has to go to the hospital.

-During an interview at 12:21 p.m. RN-C stated

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she was not aware of where the indication for urinary incontinence came from, stated the health unit coordinator enters the orders and then the orders were reviewed and signed by a nurse. RN-C again indicated she had not been aware the medication was not available, nurses should have notified her, the physician should have been contacted. RN-C stated she had reviewed R152's progress notes; there was no documentation of any follow-up related to the medication, no physician order to put the medication on hold, and no documentation of R152 refusing the medication. RN-C stated a doctor would be evaluating R152 prior to discharge this afternoon.

-During an interview at 1:40 p.m. [clinic name] doctor (MD)-A indicated he was not familiar with R152 hospital course and the medical team that treated R152 during her hospitalization was not available. MD-A reviewed R152's record and indicated R152's urea had been increased from 15 grams once a day to 15 grams twice a day, and her sodium level at the time of discharge was 131. MD-A stated basically the urea helped control hyponatremia, but was hard to give a medical opinion on what effect urea would have on sodium levels because that medication was not a standardized treatment or not often used. MD-A indicated if treatments were missed, the physician should have been notified and lab work completed to ascertain how the urea was working and/or if the urea was needed to maintain sodium levels.

-During an interview on 10/2/19, at 2:24 p.m. MD-B stated he was not going to recommend R152 be discharged until labs were obtained because it was unknown if sodium levels were within safe ranges. MD-B indicated that urea was

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not widely used, and it was not known how critical that medication was to R152 until labs were completed. MD-B stated if R152 chose to leave it would be against medical advice. MD-B stated "it would have been ideal that the physician be aware of the medication that was not given."

-At 2:42 p.m. R152 and FM-F walked up to the nurses station; R152 stated she was going to leave the facility. RN-B provided a discharge against medical advice form. R152 signed the form and left the facility.

During an interview on 10/4/19, at 3:14 p.m. director of nursing (DON) indicated she thought there was a breakdown of communication starting with hospital and should have provided more information about the medication. DON indicated she had looked into why the pharmacy had not sent the medication; stated that the pharmacy did not provide the appropriate follow-up and communication and were supposed to follow-up in one day, however the pharmacy did not and there was not any subsequent follow-up. DON indicated the nursing staff should have communicated with the provider and would expected R152 be monitored and assessed to make sure there were no signs and symptoms of an electrolyte imbalance.

Facility policy Administering Medications dated 12/2012, included 3) Medications must be administered in accordance with the orders, including any required time frame.

Facility policy Medication Utilization and Prescribing-Clinical Protocol dated 9/2012, included: when a medication is prescribed in response to an identified problem, condition, or

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risk, the physician and staff will identify the indications (condition or problem for which it is being given, or what the medication is supposed to do or prevent). The physician and staff will review the rationale for existing medications that lack a clear indication or are being used intermittently on a PRN (as needed) basis. Monitoring: The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medication to ensure that the mediation an dosage are still relevant an dare not causing undesired complications.

R46's Admission Record and Diagnosis list indicated R46 had a terminal diagnosis of gangrene of the foot (gangrene is the death of body tissue related to a serious bacterial infection and/or lack of circulation to the tissue) and cellulitis (infection of soft tissue).

According to a report filed 7/5/19 to the state agency indicated "a pain medication was not given with dressing change ..." The results of the facility investigation indicated a licensed practical nurse (LPN-B) had not given R46 "morphine on 7/5/19 during day shift that is scheduled 4 times a day with dressing changes as she documented that the medication was not available and pharmacy to bring."

According to a telephone interview on 10/03/19, at 4:58 p.m. a family member (FM-E) stated she had gone to the facility on 7/5/19 and found R46 to be "not herself" and "acting weirder and weirder" as the day went on. FM-E said a trained medication aide (TMA-D) had told her R46 had not received two doses of her pain medication because LPN-B could not find the medication.

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R46's orders related to pain control: "Offer pain medication before dressing change two times a day related Gangrene. Order date 5/1/19. R46's medications administration record (MAR) indicated LPN-B had signed this order as having been completed. Additionally, the following order was found, "Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 1 ML by mouth four times a day for dressing changes ...order date 7/2/19." Along with the medication order, the MAR indicated a pain level should be documented. On 7/4/19 LPN-B had documented a pain level of "0" and documented she had given the morphine dose at 8:00 a.m. and documented the same for a 12:00 p.m. dose. The MAR indicated R46 received two more doses on 7/4/19 with associated pain levels of 3 and 4. On the morning of 7/5/19 LPN-B failed to document a pain level and instead of documenting the dose as having been given the MAR documentation was "other/see progress notes." Documentation by LPN-B for the 12:00 p.m. dose on 7/5/19 was the same. A review of R46's progress note included "med not available". According to R46's MAR, TMA-D administered R46's ordered dose of morphine at 4:00 p.m. with a corresponding pain level of "5" and again at 8:00 p.m. with a pain rating of "4". R46's MAR also included an order for "Morphine Sulfate Solution 20 MG/5ML. Give 1 ML by mouth every 1 hours as needed for pain related to encounter for palliative care ...Order date-6/13/19." MAR indicated no "as needed dose" was given on 7/5/19.

R46's progress notes included the following: 7/5/19, 10:15 a.m. "Morphine Sulfate ...meds not available, pharmacy will send out today," and 13:18 p.m. "Morphine Sulfate ...meds not

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available."

According to the facility Narcotic book page 91, facility had received a bottle of 30 ML of Morphine Sulfate 20 MG/ML on 6/11/19. No doses were signed out as being administered, meaning, 30 ML of Morphine was available on 7/5/19.

R46's progress notes failed to indicate that the physician had been notified of the missed morphine doses.

According to a telephone interview on 10/04/19, at 6:15 p.m. LPN-B stated she had no recollection of the incident or facility providing feedback or education related to use of a medication emergency kit.

According to an interview on 10/04/19, at 4:41 p.m. the director of nursing (DON) stated a person missing two ordered doses of ordered Morphine was likely to suffer increased pain and distress. DON stated an expectation for nurses to do an assessment of the resident, fill out a risk management form, report missed doses and notify family and physician of any missed doses of medications. DON confirmed missed medication doses would be considered a medication error.

Facility provided a requested list for six months of reported medication errors in the facility. The list contained six items, none of which was R46's missed Morphine doses.

A policy related to medication errors was requested. Facility provided a document titled Adverse Consequences and Medication Errors dated as revised April 2014. The policy included

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F 760	Continued From page 174 the following as an example of a medication error: "Omission-a drug is ordered but not administered." Additionally, the policy provided the following instructions: In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare ... The Attending Physician is notified promptly of any significant error or adverse consequence. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours as directed. The incident is described on the shift change report to alert staff on the need to monitor the resident. The following information is documented in an incident report and in the resident's clinical record: Factual description of the error or adverse consequence. Name of physician and time notified. Physician's subsequent orders. Resident's condition for 24 to 72 hours or as directed ..."	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		11/18/19

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F 761	Continued From page 175 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to dispose of expired tuberculin (TB) solution in one of three medication rooms. Findings include: During observation of the unit 4/5 medication storage room on 10/4/19 at 7:36 a.m. with registered nurse (RN)-E, an opened vial of expired TB solution was observed; the TB solutions' box had an open date of 6/29/19. RN-E indicated the solution is good for 30 days after open date and should have been disposed of. During an interview on 10/4/19, at 4:33 p.m. director of nursing (DON) stated the TB solution should have been disposed of. DON indicated that staff use to be administered the solution from that unit however, that had been changed. DON stated no residents and/or staff have been administered the solution after 7/29/19. Aplisol package insert included the direction; "Vials in use more than 30 days should be	F 761	1. Corrective Action: TB solution vial that was outdated was disposed of on 10/4/2019. 2. Corrective Action as it applies to all Residents: All TB solution vials were observed for date opened. TB solution vials moved to be centrally located in a single medication refrigerator to reduce opportunity for vials to become outdated and create a more efficient means of monitoring the dated vials. 3. Date of Completion: 11/18/19. 4. Reoccurrence will be prevented by: Licensed Nurses will be educated on dating opened vials and ensuring that outdated vials are discarded at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or	

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F 761	Continued From page 176 discarded due to possible oxidation and degradation which may affect potency."	F 761	designee to review the information and sign off by 11/15/19. Night Shift Nurses will be responsible as to audit opened vials for expiration and disposal on a nightly basis. 5. Correction will be monitored by: DON or designee QAPI Committee	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the fans located in the kitchen in the clean side of the dishwasher	F 812	1. Corrective Action: Dirty fan was cleaned on 10/4/19	11/18/19

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F 812	Continued From page 177 room and by the three-compartment sink were clean. This had the potential to affect all 55 residents that resided in the facility. Findings include: During a tour of the kitchen on 10/4/19, at 10:56 a.m. the certified dietary manager (CDM) stated the maintenance department was responsible to clean the fans in the kitchen and stated she was not sure of the schedule for cleaning the fans. The CDM verified there was a fan blowing with visible dust in the corner where the three-compartment sink was. The CDM verified the fan was blowing over the top of the area where clean items would sit. The CMD verified there was a fan blowing with clumping dust where the clean items come off the dishwasher. On 10/4/19, at 10:59 a.m. The CDM stated the concern was the dirty fans blowing on clean items could cause contamination of the items being washed. The CDM stated this was not a new concern. On 10/4/19, at 2:00 p.m. the CDM stated maintenance did not have a cleaning schedule for the fans in the kitchen and stated maintenance was unaware when the fans were last cleaned. A cleaning schedule for maintenance staff included, "Monday and Friday- No extra duties to do. So this is a good time to do the fans in the kitchen..." On 10/04/19, at 2:49 p.m. the administrator stated every night there was a maintenance staff that was assigned to clean in the kitchen from 3:00 p.m. to 11:00 p.m. and my expectation was	F 812	2. Corrective Action as it applies to other Residents: Maintenance cleaning tasks were revised and updated 10/22/20119. Maintenance staff were provided education on updated cleaning tasks on 10/25/2019, and signed off acknowledgment. Updated task list was also printed & hung in cleaning closet for review. 3. Date of Completion: 10/18/2019 4. Reoccurrence will be prevented by: Cleaning schedule for the fans placed in TELS system to ensure that routine cleaning will take place moving forward. Environmental Services Director or Designee will audit fans one time weekly for 1 month and then monthly for 3 months to ensure cleaning is being completed. Ongoing monitoring will occur by Environmental Service Director or Designee. 5. Correction will be monitored by: Environmental Services Director or Designee QAPI Committee	

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F 812	Continued From page 178 the fans would be cleaned at that time. A policy and procedure for cleaning of the fans in the kitchen was requested and not provided.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		11/18/19

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F 880	Continued From page 179 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop an infection control program and ensure surveillance logs were completed which included prevention measures, failed to complete investigations of infections	F 880	F880 1. Corrective Action: Nurse responsible for the improper	

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F 880	Continued From page 180 and/or infectious trends, and failed to perform and document infection prevention measures based on infectious trends. This had the potential to effect all residents, visitors, and staff. In addition, based on interview and observation the facility failed to perform standard hand hygiene and clean equipment for 1 of 1 residents (R44) observed for wound care and glove use. Finding include During an interview on 10/4/19, at 7:20 p.m. with director of nursing (DON) and registered nurse (RN)-G, RN-G stated she used to be the acting infection preventionist. DON and RN-G indicated that no one since then had been designated for that position. RN-G stated she stopped doing infection surveillance in June, and was not sure who was doing it after her. DON stated infection surveillance, tracking and trending of infections/illnesses, and completing prevention measures had not been assigned and has not been completed since RN-G stopped in June. DON stated that the facility was looking at the antibiotic usage that was displayed on the "dashboard" of their electronic health record system. DON indicated that the dashboard did not display resident's with signs and symptoms of illness/infections, however, nurse managers and interdisciplinary team reviewed the 24 hour progress note reports. DON indicated the infections/illnesses were brought up at IDT meeting every morning, however, stated she did not keep minutes of the discussions. DON and RN-G indicated infection control audits like handwashing and peri-care were not being completed. DON stated there were currently residents with signs and symptoms of respiratory illness in the facility that had started over the last	F 880	technique counseled and educated on appropriate Infection Control Technique on 11/7/19. 2. Corrective Action as it applies to other Residents: All Licensed Nurses will be educated on appropriate Infection Control Technique as well appropriate disinfecting technique and competency tested on Wound Care at a mandatory meeting on 11/7/2019. Staff who are unable to attend the meetings will be required to meet with the DON or designee to review the information and sign off by 11/15/19. 3. Date of Completion: 11/18/19. 4. Reoccurrence will be prevented by: Facility will be implementing the use of ABX Tracker software on 11/14/2019 to establish and maintain an Infection Control Program. The software establishes protocols and a system to monitor antibiotic use, aide in prevention of infection, create a mode of documentation, investigation, outbreak management and surveillance of infections and communicable diseases. In addition the facility will be implementing policies for Infection Control and Prevention, Standard Precautions, Hand Hygiene, Infection Monitoring, Isolation and Transmission Based Precautions, and Antibiotic Stewardship.	

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F 880	Continued From page 181 weekend, however, had not started a log and had not performed any investigation activities. DON indicated there was a staff meeting last week on 9/25/19, where we discussed how we were going to implement the infection control program. DON indicated at that time; tracking employee illnesses was designated and up to date, tuberculosis skin test for employee's audits were designated and up to date. Review of antibiotic usage since 7/1/19, included residents who were prescribed antibiotics to treat illnesses related to bacterial infections. -July antibiotic usage indicated 2 residents were prescribed antibiotics; 1 for pneumonia and the other for cellulitis. -August antibiotic usage indicated, 5 residents were prescribed antibiotics. Antibiotics were prescribed for 1 resident who had urinary tract infections, 1 resident who had cellulitis, and 3 residents who had respiratory infections. -September antibiotic usage indicated, 8 residents were prescribed antibiotics. Antibiotics were prescribed for 1 urinary tract infection, 1 prophylaxis (was not specified), 3 cellulitis infections, 1 intra-abdominal infection, 1 respiratory, and 1 not specified infection. -October antibiotic usage indicated, 2 residents were prescribed antibiotics for cellulitis; one of those infections was MRSA (methicillin resistant staphylococcus aureus.) Upon request of the facility's Infection Control Program policy, the facility provided a policy Infection Control Guidelines for All Nursing Procedures dated 8/14/19, the policy did not include protocols for surveillance, infection outbreaks, investigation, prevention of infections aside from the utilization of standard precautions.	F 880	Facility is actively seeking an Infection Control Nurse to fill the open position. In the interim, DON or designee will be assigned the duties of the Infection Preventionist. DON or designee will audit wound care once weekly for 1 month and then once monthly for 3 months. Audit results will be shared with the QAPI Committee. DON or designee will audit the use of ABX Tracker for completion once weekly for 1 month and then monthly for 3 months. Results will be shared with the QAPI Committee. 5. Correction will be monitored by: DON or designee QAPI Committee	

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According to R44's Admission Record and Diagnosis list indicated R44 had a primary diagnosis of heart failure and cellulitis (an infection of the skin/soft tissues).

During an observation on 9/30/19, at 7:06 p.m. R44 was noted to have a bandage encircling her lower right leg. R44 said she had a wound of some sort, and had pain in that area at times.

R44's treatment record indicated a physician's order dated 9/23/19 read "Wound care: Cleanse ulcer daily, apply Xeroform (an antibacterial gauze) & gauze wrap. Sure press wrap to leg, May remove at HS (bedtime) one time a day for Leg Ulcer related to Cellulitis." An updated order dated 10/2/19 read to utilize Aquacel-Ag Extra Hydrofiber Pad (a wound dressing impregnated with silver for its antibacterial activity) instead of the Xeroform.

During an observation of wound care, on 10/03/19, at 7:17 a.m. registered nurse (RN-A) gathered supplies in the room for the dressing change. R44 was seated in her wheelchair next to the bed and nightstand. RN-A went across the room, picked up a trash can, lined with a plastic bag, and carried it back to R44's side of the room, placing it next to R44. Without performing hand washing or sanitizing, RN-A put on a pair of gloves. She then removed a pair of scissors from her pocket. Without cleansing the scissors, RN-A proceeded to cut the bandage from R44's lower right leg and then threw the soiled dressing in the trash can. RN-A laid the scissor on R44's bed. The wound care supplies were in a plastic box sitting on R44's bedside stand. RN-A went to the stand and without removing her soiled gloves, picked up the box, attempting to carry it between

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her forearms and set it on the bed. RN-A took a piece of gauze from the box of supplies and a bottle of wound cleansing agent. She sprayed the wound and blotted it off with the gauze. She then removed her soiled gloves and disposed of them. No hand washing or sanitizing was observed at that time. RN-A took an alcohol swab from her pocket, opened it and wiped off the scissors. She then removed an already opened Aquacel-Ag dressing from a zip lock back and cut a small piece to fit the wound. RN-A then replaced the remainder of the Aquacel-Ag dressing in the zip lock bag, in the process, RN-A did touch the dressing with her unclean hands. RN-A then applied a pair of gloves and placed the cut piece of dressing into the base of the wound. RN-A felt the temperature of R44's calf with her wrist and then wrapped the leg with a gauze wrap and then a compression wrap. RN-A then removed her gloves, put the scissor in her pocket and put the wound care supplies back in the cupboard. RN-A then left the room and no handwashing or sanitizing was observed.

During an interview on 10/03/19, at 7:26 a.m. RN-A stated she had only worked at the facility for a few months, but had received training related to infection control when she started. Reflecting on the care she had given R44, RN-A stated, "I did wash my hands before going in and I suppose you should wash before putting gloves on." RN-A said her practice was to "go from dirty to clean gloves" without hand hygiene between. RN-A said she was not aware of the proper product to use for cleaning equipment, but confirmed a pair of scissors kept in a pocket would be considered contaminated. Later she identified the facility had a disinfecting wipe available in their nurses' station for cleaning equipment.

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According to an interview on 10/03/19, at 7:57 a.m. RN-E, stated an expectation for handwashing to "occur as frequently as possible." RN-E stated hand hygiene should occur before gloves were applied and after they were removed. RN-E also stated scissors should remain with a resident's wound care supplies, but should be cleansed with the facility provided disinfecting "Sani-wipes or bleach wipes" before and after use. RN-E said, "scissors should not go back into a pocket."

According to an interview on 10/03/19, at 1:41 p.m. the director of nursing (DON) stated proper handwashing was an important infection control practice during wound care. DON identified proper handwashing as including washing hands prior to providing care and before the application of gloves. DON indicated hand washing should occur again after gloves were removed. DON said she had only worked at the facility for a few months and had not gone over how to sanitize scissors, but stated an expectation of using standard nursing protocol for cleansing equipment and for hand hygiene. DON confirmed the facility provided cleaning products for equipment.

According to the Centers of Disease Control (CDC): Alcohols are not recommended for sterilizing/disinfecting medical and surgical materials principally because they lack sporicidal action and they cannot penetrate protein-rich materials. The CDC recommends health professionals practice hand hygiene before and after direct contact with a patient's skin, after contact with blood or body fluids, after contact with the patient's environment and after glove

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removal.

A policy related to infection control and wound care was requested. Facility provided a policy titled Handwashing/Hand Hygiene dated as revised August 2015. This policy included the following:
All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors...,Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:..., Before and after direct contact with residents; Before performing an non-surgical invasive procedures; before donning sterile gloves', Before handling clean or soiled dressings, gauze pads, etc.; After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; After contact with objects(e.g. medical equipment) in the immediate vicinity of the resident; After removing gloves ...,The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infection."

Facility provided a policy titled Wound Care and dated as revised October 2010. The policy indicated all wound care supplies to be used during a procedure should be placed on a clean field on the resident's over bed table. The policy instructed nurse to wash and dry hand thoroughly prior to providing care and to put on exam gloves before removing a soiled dressing. After removal of the dressing, the policy stated the nurse should pull a glove over the soiled dressing and dispose

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F 880	Continued From page 186 of the gloves and dressing, followed by hand washing. The policy instructed nurse to use a no-touch technique related to supplies and ointments, to use forceps, swabs and gloves. After care has been provided, the policy instructed the nurse to dispose of all items and clean reusable supplies and wash and dry hands. The policy does indicate alcohol could be used for scissors but indicated such supplies should be kept in the resident's room and not shared.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop and implement an antibiotic stewardship program with antibiotic protocols and systems to monitor and analyze antibiotic use and effectiveness to prevent antibiotic resistance. The deficient practice had the potential to effect all residents who resided in the facility Findings include: During an interview on 10/4/19, at 7:20 p.m. with director of nursing (DON) and registered nurse (RN)-G, RN-G stated she used to be the acting	F 881	1. Corrective Action: Facility will be implementing the use software ABX Tracker on 11/14/2019 to establish and maintain an Antibiotic Stewardship Program. The software is designed to establish protocols and a system to monitor antibiotic use, create a mode of documentation, investigation, outbreak management and surveillance of infections and antibiotic use. It establishes protocols and a system to monitor antibiotic use and surveillance.	11/18/19

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	245369	A. BUILDING _____ B. WING _____	C 10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

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F 881	Continued From page 187 infection preventionist until June 2019. DON and RN-G indicated no one had been designated that position since then. RN-G indicated when she used to be responsible for the facilities antibiotic stewardship program and would review the antibiotics for appropriateness as well as tracked/trended and analyzed. DON indicated infection control surveillance and antibiotic stewardship program had not been continued since RN-G stopped, however the facility had a meeting on 9/25/19, to discuss and re-implement the infection and antibiotic stewardship programs. The DON indicated that the interdisciplinary team would be aware of who had been administered antibiotics by referencing the "dashboard" of the EHR (electronic health record) system. The facility provided a report of residents with prescribed antibiotics between July and October. -In July 2019, 2 antibiotics were prescribed. -In August 2019, 7 antibiotics were prescribed. -In September 2019, 17 antibiotics were prescribed -In October 2019, 7, antibiotics were prescribed The facility provided Minnesota Sample Antibiotic Stewardship Policy For Long-Term Care Facilities dated 9/13/17. The policy had sections to be filled in to individualize the policy to the facility however, these sections were left blank. The Minnesota Sample Policy included the description, components, and requirements for an antibiotic stewardship program: leadership commitment, accountability, Drug expertise, Action, Tracking, Reporting, Education.	F 881	2. Corrective Action as it applies to all Residents: Facility is actively seeking an Infection Control Nurse to fill the open position. In the interim, DON or designee will be assigned the duties of the Infection Preventionist. All antibiotic use will be entered into ABX Tracker to ensure appropriate stewardship and surveillance. Nurse Managers will be responsible for auditing antibiotic entry and follow-up by using ABX Tracker daily. Infections will be reviewed and discussed at daily standup meeting with the IDT to ensure appropriate interventions and follow up are in place. 3. Date of Completion: 11/18/2019 4. Reoccurrence will be prevented by: Nurse Managers will be responsible for auditing antibiotic entry and follow-up by using ABX Tracker daily. Infections will be reviewed and discussed at daily standup meeting with the IDT to ensure appropriate interventions are in place. DON or designee will audit the use of ABX Tracker for completion and accuracy once weekly for 1 month and then monthly for 3 months. Results will be shared with the QAPI Committee. 5. Correction will be monitored by: DON or designee	

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F 881	Continued From page 188	F 881	QAPI Committee	

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	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/02/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**400 - 15TH AVENUE SOUTHWEST** **AUSTIN, MN 55912**

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K 000	INITIAL COMMENTS UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (St.Mark's Lutheran Home) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as one building per new 2012 Life Safety Code. St. Mark's Lutheran Home is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1967, addition was constructed to the East Wing that was determined to be of Type II(111) construction. In 1981, another addition was added to the East Wing and was determined to be Type V(111). In 1991, an addition was added to the North Wing and was determined to be Type II (111) construction. In 2013 another addition was a 1-story building with no basement. The 2013 addition was also determined to be of Type V (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101	K 291		11/11/19

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K 291	Continued From page 2 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 54 out of 54 residents. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 10/02/2019, during inspection and documentation review, the battery emergency light in the generator transfer switch room did not function when tested and there was no documentation available to show that a 30 second monthly test and the 90 minute annual test had occurred. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	1. Facility completed 30 second testing on emergency light described. 2. Testing of emergency light every month for 30 seconds, as well as annual 90 minute testing has been added to facility's TELS program. 3. Environmental Service Director will complete monthly auditing to ensure compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712		11/11/19

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K 712	Continued From page 3 with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 55 of 55 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. Findings include: On facility tour between 10:00 AM and 1:00 PM on 10/02/2019, during documentation review, it was revealed that there was no documentation available to review that showed that a 2nd shift fire drill and a 3rd shift fire drill had occurred during the 4th quarter.	K 712	1. Facility maintenance staff was re-educated on the fire drill process on 10/7/19. 2. All completed fire drill forms will be given directly to Facility's Environmental Service Director to ensure monthly completion and continued compliance going forward. 3. Environmental Service Director will complete monthly auditing to ensure compliance.	

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K 712	Continued From page 4 This deficient practice was verified by the Facility Maintenance Director.	K 712		