STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	02/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 10, 11, 12, 13, 14, and 17, 2020 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 7 Medicaid: 54 Other: 4 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 26, 2020.	F 0000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Golden Living Centers – Richmond admits or denies the validity of the allegation and citation listed on the following pages of this Statement of Deficiency. Golden Living Centers – Richmond maintains that the alleged deficiency does not jeopardize the health and safety of the residents, nor is of such character as to limit our capability to render adequate care. Please accept this plan of correction as the facility's written credible allegation of compliance such that the alleged deficiency cited has been or will be corrected by 3/17/2020. **We respectfully request that you consider paper compliance for this survey.**	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such			

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

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	allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review the facility failed to immediately report an allegation of abuse to the Administrator for 1 of 2 residents reviewed for abuse (Resident 25). Findings include: During an interview with Resident 25 on 2/10/2020 at 1:26 p.m., she indicated she had been physically abused by a staff person and "it just happened". Two female staff were trying to force her to go to bed and the tall female staff picked her up and threw her in the bed. The resident did not know the female staff members names. When the staff had lifted her up, it hurt her under her right arm. She yelled and the nurse came into her room. She reported the abuse to the nurse. The resident indicated "I am fearful to stay here." During an interview with the Administrator on 2/10/2020 at 1:57 p.m., she indicated there had not been any allegations of abuse reported to her or any type of incident reported to her related to Resident 25. During an interview with the Administrator on 2/10/2020 at 2:46 p.m., she indicated the nurse had reported the allegation of abuse to the Director Of Nursing (DON) and not to the Administrator. CNA (Certified Nurse Aide) 5 who was the alleged perpetrator was now suspended and an investigation was initiated. During an interview with the Administrator on 2/11/2020 at 9:39 a.m., the staff involved with the allegation of abuse was LPN 4 , CNA 5, and CNA	F 0607	1. The incident involving Resident 25 was reported and investigated. Social Services Director followed up with Resident 25. 2. Social Services Director/designee will conduct an audit of all current residents with a BIMS of 10 or greater to screen for abuse/neglect. Residents with a BIMS less than 10 will have a skin assessment performed to screen for signs of abuse/neglect. 3. The facility's Director of Clinical Education/ Designee will educate all staff on identifying and reporting allegations of abuse/neglect to the Health Facility Administrator (identified as Executive Director in Facility's Policy). Education will be completed by 3/17/20. Health Facility Administrator/ designee will complete an audit daily of Nursing Notes to ensure that all reportable incidents are reported and investigated x4 weeks and then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled	03/17/2020

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	6. LPN 4 was educated to report allegations of abuse to the Administrator. CNA 5 and CNA 6 was educated to honor residents wishes if they did not want to do something. The allegation had been investigated and was unsubstantiated. The clinical record for Resident 25 was reviewed, on 2/18/2020 at 2:00 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, edema, Cererbrovascular disease, major depression disorder, diabetes mellitus, pain, and age related osteoporosis without current pathological fracture. The Admission Minimum Data Set (MDS) assessment, dated 11/22/19, indicated the resident was moderately impaired for daily decision making. The resident had no psychosis or behaviors. The resident required extensive assistance of two staff members for bed mobility, transfers, and toileting needs. The resident did not ambulate. During an interview with LPN 4 on 2/14/2020 at 11:24 a.m., she indicated she was caring for Resident 25 during the incident on 2/10/2020. She was standing at the nursing station and the resident was sitting in her wheelchair at her bedroom doorway. The resident was being loud. CNA 5 and CNA 6 came and assisted the resident to bed, after the CNA's left the room the resident was yelling and the nurse went into her room. The resident reported that CNA 5 had put her hands around the resident's throat and held her down in the bed. LPN 4 indicated she couldn't see either CNA doing something like that and she attempted to calm the resident down. LPN 4 reported to the DON the resident reported CNA 5 had held the resident down, but was unsure if she reported that		monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	the resident also reported she put her hands around her neck. The DON did not give any direction for her to do a skin assessment or document anything about the incident. During an interview with CNA 5 on 2/14/2020 at 11:55 a.m., she indicated herself and CNA 6 was caring for Resident 25 on 1/10/2020. The CNA's assisted the resident to bed. When they got her into bed the resident started trying to hit and kick her. The resident then told CNA 6 that she was going to report that CNA 5 had threw her in bed and put her hands on her. Both CNA's went out of the resident's bedroom and immediately reported the allegation of abuse to LPN 4. During an interview with the DON on 2/14/2020 at 12:09 p.m., she indicated the first time she had heard about the allegation of abuse related to Resident 25 was when the Administrator told her. LPN 4 never reported abuse to the DON. LPN 4 had reported that the CNA's were having a hard time with the resident and the resident was accusing them of things. The DON did not recall exactly what the CNA's were being accused of doing but it was not holding her down or choking her. The DON did not remember if she directed LPN 4 to do anything. The DON indicated she went down and asked CNA 5 and CNA 6 if they were ok. CNA 5 and CNA 6 did not report to the DON of the allegation of abuse. During an interview with CNA 6 on 2/14/2020 at 2:42 p.m., she indicated on 2/10/2020 herself and CNA 5 assisted the resident to bed. The resident started hitting and kicking CNA 5. The resident was saying "why are you guys hitting me". CNA 6 indicated they left the resident's room and immediately reported to LPN 4 that the resident was accusing them of being abusive to her and			

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	hitting her. The abuse policy provided by the Administrator on 2/14/2020 at 10:25 a.m., "It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property are reported immediately to the Executive Director". 3.1-28(a)			
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.			

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	(xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to complete a timely Minimum Data Set (MDS) assessment for 2 of 20 residents reviewed for assessments. (Residents 5 and 212) Findings include:	F 0636	1. Resident 5's Annual MDS was completed. Resident 212's Medicare 5 day MDS assessment was completed. Resident 212's MDS Admission Assessment was completed.	03/17/2020

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	1. Resident 5's clinical record was reviewed on 2/12/20 at 11:30 a.m. Her diagnoses included, but were not limited to, gastro-esophageal reflux disease, high blood fats, high blood pressure, postmenopausal bleeding, diabetes mellitus, heart disease, early onset Alzheimer's disease, depression, and anxiety. The resident's Quarterly MDS assessment was dated 10/26/19. An Annual MDS assessment, dated 1/22/20, was still in progress and had not been completed. During an interview, on 2/17/20 at 10:52 a.m., the MDS Coordinator indicated she had 14 days after the date to complete the MDS. The Annual MDS was completed on 2/14/20. The Annual MDS should have been completed with in the first week of February. 2. The clinical record for Resident 212 was reviewed on 2/11/20 at 2:06 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, peripheral vascular disease, urinary tract infection, major depressive disorder, and insomnia. The resident was admitted to the facility on 1/22/20. The resident's clinical record lacked the MDS assessments for the Medicare 5 day assessment and the Admission assessment. During an interview on 2/14/20 at 11:56 a.m., with the MDS coordinator she indicated she was aware the MDS's were not completed for this resident. "...I had to be off, I was told that the facility had someone to cover for me, but when I returned this week, not much was done, so I'm spending this week trying to play catch-up. This is also, why her		2. The Director of Nursing/designee completed an audit of current residents to ensure that all residents' MDS Assessments were current. 3. The facility's Health Facility Administrator will educate MDS Coordinator that all MDS assessments need to be completed within required timeframes. Education will be completed by 3/17/20. Director of Nursing/designee will audit MDS assessments due weekly x4 weeks and then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020.QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	care plans were put into place late." During an interview, on 2/17/20 at 9:14 a.m., the Administrator indicated the facility did not have a policy and procedure related to the MDS, they used the Resident Assessment Instrument manual. 3.1-31(d)(2)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §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			

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	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.			
	Based on record review and interview, the facility failed to develop care plans related to resident medications for 3 of 20 residents reviewed for care plans. (Residents 5, 33, and 212) Findings include: 1. Resident 5's clinical record was reviewed on 2/12/20 at 11:30 a.m. Her diagnoses included, but were not limited to, gastro-esophageal reflux disease, high blood fats, high blood pressure, anemia, postmenopausal bleeding, diabetes mellitus, heart disease, early onset Alzheimer's disease, depression, and anxiety. The current physician's medication orders included, but were not limited to: - Atorvastatin Calcium (lowers blood fats/cholesterol) Tablet 10 mg (milligrams), give 1 tablet by mouth at bedtime for hyperlipidemia (high blood fats), with a start date of 3/6/2019. - Ferrous Sulfate (iron supplement) Tablet 325 mg, give 1 tablet by mouth two times a day for	F 0656	1. Resident 5's Care Plan was updated to include medications related to current diagnoses. Resident 212's Care Plan was updated to include medications related to current diagnoses. 2. The Director of Nursing/designee completed an audit of current residents to ensure that all residents' Care Plans include medications related to current diagnoses. 3. The Regional Nurse Consultant will educate Director of Nursing and MDS Coordinator that Care Plans need to include medications related to current diagnoses. Education will be completed by 3/17/20. DON/ designee will randomly select ten (10) residents to audit for Care Plan for medications related to current diagnoses x4 weeks and then monthly x 3 months then randomly as determined through	03/17/2020

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	Anemia, with a start date of 3/7/2019. - Omeprazole (blocks stomach acid) Capsule Delayed Release 10 mg, give 10 mg by mouth one time a day for gastro-esophageal reflux disease, started 10/23/2015. The clinical record lacked care plans related to the resident's medications. On 2/17/19, at 10:52 a.m., the MDS Coordinator indicated there were no care plans in place for the resident's atorvastatin, ferrous sulfate, or Omeprazole. 2. Resident 33's clinical record was reviewed on 2/11/20 at 1:55 p.m. The resident's diagnoses included, but were not limited to, high blood pressure and gastro-esophageal reflux disease. The current physician's orders included, but were not limited to: - Famotidine 2 mg, give 20 mg by mouth in the morning for gastro-esophageal reflux disease started 11/29/19. - Omeprazole delayed release tablet, 20 mg two times a day for gastro-esophageal reflux disease started 11/6/19. - Lisinopril 5 mg, give in the morning for essential hypertension (high blood pressure) started 11/5/19. - Bystolic table, 10 mg, give 1 tablet by mouth one time a day for essential hypertension, started 11/5/19. - Amlodipine besylate tablet 10 mg, give 1 tablet by mouth in the morning for essential		QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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hypertension, hold if systolic blood pressure is less than 110, started 11/5/19.

- Aspirin, give 81 mg by mouth in the morning for essential hypertension, started 11/5/19.

The clinical record lacked care plans related to the resident's medications.

During an interview, on 2/17/20 at 11:00 a.m., the MDS (minimum data set) Coordinator indicated he did not have a care plan for high blood pressure or gastro-esophageal reflux disease and they would normally care plan these.

2. Resident 212's clinical record was reviewed on 2/11/20 at 2:06 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease, peripheral vascular disease, longstanding persistent atrial fibrillation, urinary tract infection, major depressive disorder, supraventricular tachycardia, enterocolitis due to clostridium difficle, and insomnia.

The current physician's orders indicated the resident was prescribed the following medications:

- vancocin (antibiotic) HCl capsule 125 mg give 125 mg by mouth two times a day

- cymbalta (antidepressant) capsule 60 mg give 1 capsule orally at bedtime

- ambien (hyponotic) tablet 5 mg give 1 tablet by mouth at bedtime

- trazodone (antidepressant) HCl Tablet 50 mg give 1 tablet by mouth at bedtime

- xarelto (anticoagulant) Tablet 15 mg give 1 tablet

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	orally one time a day - lasix (diuretic) tablet 20 mg give 1 tablet orally one time a day every other day - seroquel (antipsychotic) tablet 25 mg give 1 tablet by mouth at bedtime On 2/11/20 at 2:15 p.m., Resident 212's care plans were reviewed. The resident had care plans for an anti-biotic, antipsychotic, and antidepressant. The clinical record lacked care plans for a hypnotic, diuretic, or anticoagulant medication. During an interview on 2/14/20 at 11:56 a.m., with the MDS Coordinator she indicated she was aware the MDS was not completed for this resident and that was why the resident's care plans were not completed. The Interdisciplinary Care Plan policy provided by the Administrator on 2/14/20 at 9:00 a.m., indicated The interdisciplinary care plan (ICP) team, "will participate in the development of a comprehensive care plan for each resident... The interdisciplinary care plan will be reviewed at least quarterly to evaluate effectiveness and be revised/updated as necessary to address resident needs in accordance with the most current assessment. Interventions that have proved ineffective must be changed on care plane immediately." 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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			

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	hygiene; Based on observation, interview, and record review, the facility failed to provide residents' Activities of Daily Living assistance related to showers and toenail care for 2 of 4 dependent residents reviewed. (Resident 17 and Resident 25). Findings include: 1. During an interview and observation on 2/10/20 at 11:43 a.m., Resident 17 indicated she did not know who was suppose to cut her toenails. They were very long and needed trimmed. The resident pulled her blanket up and revealed her feet. The resident's toenails on both feet were long. During an interview and observation on 2/12/20 at 11:32 a.m., the resident indicated her long toenails were bothering her toes with being so long. The residents toe nails were observed to be very long. During an interview and observation on 2/13/2020 at 9:55 a.m., Resident 17 was lying in bed. The resident indicated her toenails were still long and they were bothering her. During an observation on 2/13/20 at 12:39 p.m., LPN 8 indicated the resident's toenails were very long. The foot doctor usually was the one to cut the residents toenails. During an interview on 2/13/2020 at 12:45 p.m., LPN 8 indicated she cut Resident 17's toenails. During an interview with the Director Of Nursing on 2/13/20 at 2:22 p.m., she indicated the nurses were responsible to ensure residents' nail care was provided. The CNA's were able to trim toenails if the resident did not have diabetes.	F 0677	1. Resident 17's toenails were cut by LPN. Resident 25 received a shower and had shower schedule updated to reflect Resident's preference in showers. 2. The Director of Nursing/designee completed an audit of current residents to ensure that all resident toenails were trimmed. The Director of Nursing/designee completed an audit by 3/17/20 of current residents to ensure that all residents had a shower schedule indicating Resident's shower preference. 3. The facility's Director of Nursing/ Designee will educate current licensed nurses and Certified nursing assistants on the importance of ADL Care related to toenails and showers. Education will be completed by 3/17/20. DON/ designee will complete an audit weekly of 10 random resident's toenails x4 weeks and then monthly x 3 months then randomly as determined through QAPI. DON/designee will complete an audit daily on all scheduled work days of resident's shower schedule to ensure that residents are receiving showers based on their preferences x4 weeks then monthly x3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's	03/17/2020

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	The clinical record for Resident 17 was reviewed on 2/13/20 at 1:18 p.m. The resident's diagnoses included, but were not limited to, anemia, dysphagia, gout, hypercholesterolemia, schizophrenia, anxiety, depression, muscle weakness, arthritis, and pain. The resident did not have a diagnosis of diabetes. The Quarterly Minimum Data (MDS) assessment, dated 11/16/19, indicated the resident was cognitively intact for daily decision making, reasonable and consistent. The resident had no rejection of care. The resident was totally dependent of one staff member for personal hygiene. The foot care policy was provided by the Administrator on 2/17/2020 at 9:15 a.m., the purpose was to prevent infection of the feet, irritation of the feet, prevent break in skin integrity, promote cleanliness and relieve pain. Toenails are to be clipped and filed smoothly. The podiatrist or licensed nurse clip toe nails for all diabetic residents. 2. During an interview with Resident 25 on 2/10/20 at 1:36 p.m., she indicated she did not receive showers at the facility. "The staff wash her off that was it." The resident would like "at least one a week". The resident felt like she was beginning to smell. The resident was observed to have black substance underneath her fingernails. The Admission MDS assessment, dated 11/22/19, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of two staff members for transfers. The resident did not ambulate. The resident was totally dependent of one staff member for bathing.		monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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Review of the Activity of Daily Living (ADL) sheet for showers on the Electronic Health Record (EHR), dated 1/10/20 through 2/10/20, indicated the resident had not received a shower for the last 30 days. There were no documentation of the resident's refusal of showers.

Review of the shower sheets, dated 1/10/20 through 2/10/20, indicated for the past 30 days the resident had not received a shower. There were no documentation of the resident's refusal of showers.

During an observation and interview on 2/14/2020 at 10:45 a.m., Resident 25 was sitting in her room in a wheelchair. The resident's hair was greasy and she was scratching her head. The resident indicated her head was "itching her". The resident had a dark substance under her fingernails on both hands.

During an interview with the Director Of Clinical Education on 2/14/20 at :31 p.m., she indicated she was responsible to assign showers for residents. There was a mistake made and Resident 25 shower assignment. The resident's shower assignment had been put on a different unit's assignment sheet and not the assignment sheet for the unit the resident resides on. This was why the resident had not been receiving showers and it would be corrected.

During an interview with the DON (Director of Nursing) on 2/14/20 at 12:36 p.m., she verified there was no documented showers for Resident 25 for the last thirty days.

The shower policy provided by the Administrator on 2/17/2020 at 9:30 a.m., the purpose of the policy

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	was to cleanse and refresh the resident, observe the skin and provide circulation. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 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. Based on observation, interview, and record review, the facility failed to have an accurate assessment for bruising for 2 of 2 residents reviewed for non-pressure related skin conditions, (Resident 5 and 17), and failed to follow the physician's orders to obtain a daily blood pressure for 1 of 5 residents reviewed for Quality of Care. (Resident 33) Findings include: 1. The clinical record for Resident 5 was reviewed on 2/12/20 at 11:30 a.m. Her diagnoses included, but were not limited to, gastro-esophageal reflux disease, high blood fats, high blood pressure, postmenopausal bleeding, diabetes mellitus, heart disease, early onset Alzheimer's disease, depression, and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 10/26/19, indicated the resident was moderately cognitively impaired. She understood others and others understood her and	F 0684	1. Resident 5 had a skin assessment performed. Resident 33 had a blood pressure reading with results within normal ranges. Resident 17 had a skin assessment performed. 2. The Director of Nursing/designee completed an audit of current residents to ensure that all residents have a weekly skin assessment. 3. The facility's Director of Nursing/ Designee will educate current licensed nurses that weekly skin assessments must be accurately completed based on the Facility's skin assessment schedule. Education will be completed by 3/17/20. DON/ designee will complete an audit weekly to ensure that weekly skin assessments were done on all residents and randomly select ten	03/17/2020

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	she received a blood thinner. On 2/11/20 at 10:24 a.m., Resident 5 was observed with a half dollar sized dark purple bruise on her left arm above the wrist. On 2/14/20 at 11:23 a.m., Resident 5 was observed in bed and the bruise on her left forearm was purple with yellow tones in the bruise. The resident indicated she received the bruise at the hospital from a needle stick. Current physician's orders included an order for Eliquis (blood thinner) Tablet 2.5 milligrams, give 1 tablet by mouth two times a day related to chronic atrial fibrillation, with a start date of 5/2/19. A care plan, last reviewed 12/17/17, indicated the resident was at risk for complications related to an anticoagulant medication. The intervention included, but were not limited to, apply prolonged pressure to venipuncture sites and observe for signs and symptoms of bleeding, and "Report results to physician and follow up as indicated." Review of Progress Notes between 2/6/20 and 2/13/20 and a Weekly Skin Review, dated 2/8/20, indicated the resident's skin was intact and lacked any documentation of a bruise. During an interview, on 02/14/20 at 1:29 p.m., the Director of Nurses (DON) indicated she could not find any documentation of the bruise. If there was a bruise or scratch or something of that nature they would do an assessment and put it in SBAR (Situation, Background, Assessment, Response) for a significant change, and follow it. The DON indicated the resident had been at the hospital for a cat scan with contrast and it could have come from that.		(10) residents to audit for assessment accuracy x4 weeks and then monthly x 3 months then randomly as determined through QAPI. The Director of Nursing/designee completed an audit of current residents requiring daily blood pressure readings to ensure that all residents requiring daily blood pressure readings are having daily blood pressure readings. Education will be completed by 3/17/20 to all Nursing staff on following physician orders related to blood pressure readings and weekly skin assessments. DON/designee will complete audit daily x5 days per week x4 weeks to ensure that daily blood pressure readings are being obtained then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	2. The clinical record for Resident 33 was reviewed on 2/11/20 at 1:55 p.m. The resident's diagnoses included, but were not limited to, high blood pressure and gastro-esophageal reflux disease. A Significant Change MDS assessment, dated 12/6/19, indicated the resident was cognitively intact. The current physician's orders included the following medications for high blood pressure: - Lisinopril 5 mg, give in the morning for essential hypertension (high blood pressure) started 11/5/19. - Bystolic table, 10 mg, give 1 tablet by mouth one time a day for essential hypertension, started 11/5/19. - Amlodipine besylate tablet 10 mg, give 1 tablet by mouth in the morning for essential hypertension, hold if systolic blood pressure is less than 110, started 11/5/19. - Aspirin, give 81 mg by mouth in the morning for essential hypertension, started 11/5/19. The current Physician's orders indicated for the resident's blood pressure to be checked one time a day related to essential (primary) hypertension. During an interview on 2/17/20 at 11:36 a.m., LPN 3 indicated the daily blood pressures were documented in the Electronic Health Record (EHR). The blood pressures were done at 5:00 a.m. and documented under the weights and vitals in the EHR.			

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	On 2/17/20 at 2:24 p.m., the DON provided a copy of the blood pressures for Resident 33 that were obtained in January and February 2020. The resident had two blood pressures obtained in January and one blood pressure obtained in February. On 2/17/20 at 3:48 p.m., the Administrator indicated they didn't have a policy for following physician orders. 3. During an observation on 2/10/20 at 11:56 a.m. and 2/11/20 at 10:15 a.m., Resident 17 had a large purple/blue bruise on her left hand. During an observation on 2/12/20 at 11:32 a.m. and 2/13/20 at 9:55 a.m., the resident's bruise on her left hand was fading and was purple/red color. The skin assessment, dated 2/11/2020 9:52 p.m., indicated the resident had no bruising. During an interview with the DON on 2/13/20 at 2:22 p.m., she indicated the nurses were responsible to ensure skin assessments were completed and accurate. She had completed the skin assessment on 2/10/2020 and had not seen the bruise on the resident's left hand. She felt the lighting in the resident's room was the reason she did not see the bruise. The resident was reassessed on 2/13/2020 and the bruise was observed on the resident's left hand. The clinical record for Resident 17 was reviewed on 2/13/20 at 1:18 p.m. The resident's diagnoses included, but were not limited to, anemia, dysphagia, gout, hypercholesterolemia, schizophrenia, anxiety, depression, muscle weakness, arthritis, and pain.			

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	The physician's order for February 2020, indicated the resident was to have weekly skin assessments. The Skin Integrity Guideline provided by the Administrator on 2/13/20 at 9:15 a.m., the licensed nurse would be responsible for performing a skin evaluation/observation weekly. 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §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. Based on observation, interview, and record review, the facility failed to provide a dressing change to a pressure ulcer as ordered by the physician and to monitor and evaluate pressure ulcers weekly for 3 of 4 residents reviewed for pressure ulcers (Resident 11, 25, and 36). Findings include: 1. During an interview and observation on 2/11/20 at 2:52 p.m., Resident 11 was lying in bed. The	F 0686	1. Resident 11 is no longer in facility. Resident 25 had a skin assessment performed. Resident 36 had a skin assessment performed. 2. The Director of Nursing/designee completed an audit of current residents to ensure that all residents have a weekly skin assessment. 3. The facility's Director of	03/17/2020

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	resident's right foot was wrapped in gauze and dated 2/6/2020. The resident indicated he had a "sore" on his foot. The nurses put iodine on it and he was unsure how often it was done. The resident indicated he had "never refused to have the dressing changed". During an interview and observation on 2/11/2020 at 2:59 p.m., RN 7 observed the resident's dressing on his right foot and verified the date on it was 2/6/2020. This indicated the dressing change had not been completed for 5 days. During an observation and interview on 2/11/2020 at 3:20 p.m., RN 7 removed the old dressing from the resident's right foot. The dressing was dried and stuck to the resident's foot. The RN indicated the dressing was stuck to the resident's foot. There was slough (white substance) and dark skin pulled off during the removal of the old dressing. The resident had facial grimacing, wincing, and pulling his leg back during the dressing change. The resident indicated it hurt, but would not rate how bad his pain was. At 3:29 p.m., the Director Of Nursing (DON) came in the resident's room and RN 7 reported that the old dressing was dated 2/6/2020. The DON indicated the resident acquired the pressure ulcer from his shoe and wheeling himself around the facility. RN 7 applied iodine to the area, let dry, applied calcium alginate then covered and wrapped in gauze. The area was large on the right heel with pink and mostly slough with a small black/brown area. During an observation and interview on 2/12/2020 at 2:15 p.m., the Director Of Clinical Education provided the treatment for the resident's pressure ulcer and the Nurse Practitioner measured the pressure ulcer at 3.5 centimeters (cm) by 4.3 cm by 0.3 cm. The wound had 30 % (percent) red non		Nursing/ Designee will educate current licensed nurses that weekly skin assessments must be accurately completed based on the Facility's skin assessment schedule. Education will be completed by 3/17/20. DON/ designee will complete an audit to ensure that weekly skin assessments were completed as scheduled and randomly select ten (10) residents to audit for assessment accuracy x4 weeks and then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	granulated skin , 70 % slough and 10 % eschar cap. The resident indicated he did not experienced any pain with the dressing change. During an interview with Director Of Nurse (DON) on 02/13/2020 at 2:18 p.m., she provided a statement from LPN 4 that was on a piece of notebook paper, dated 2/11/2020. The LPN indicated, on 2/10/2020, the resident had refused to have his dressing changed to the right heel. LPN 4 thought hospice was going to complete the dressing change. A hospice note, dated 2/10/2020, indicated the resident's dinner came and he refused to allow the nurse to unwrap his heel to assess the wound. The resident stopped talking after his dinner came and was eating well. During an interview with the DON on 2/14/20 at 12:18 p.m., she indicated there was no documentation in the resident's clinical record that he refused his dressing change or that anyone re-approached him after he ate dinner on 2/10/2020 to have his dressing changed to right heel pressure ulcer. The clinical record for Resident 11 was reviewed on 2/17/2020 at 1:00 p.m. The resident's diagnoses included, but were not limited to, complete traumatic amputation at knee level of left leg, diabetes mellitus, chronic kidney disease, hypertensive heart disease, atrial fibrillation, acute respiratory failure, urinary tract infection, major depressive disorder, abnormal weight loss, depression, and urinary retention. The Significant Change Minimum Data (MDS) assessment, dated 11/4/19, indicated the resident was cognitively intact for daily decision making, consistent and reasonable. The resident had no behaviors of rejection of care. The resident was			

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	totally dependent of one staff member for bed mobility, transfers and toileting needs. The resident did not ambulate. The resident was at risk of acquiring a pressure ulcer and did not have a pressure ulcer during this assessment. The plan of care, dated 1/7/2020, indicated the resident had a skin breakdown/Pressure ulcer of the right heel. The intervention included, but was not limited to, treatments as ordered. The Braden pressure ulcer risk assessment, dated 1/24/2020, indicated the resident was at high risk for developing pressure ulcers. The physician's order, dated February 2020, indicated the resident was to have betadine applied to wound, allow to dry, apply calcium alginate along edges of the wound, and cover with abdominal pad and wrap with gauze every Monday, Wednesday, and Friday. The wound assessment, dated 2/5/2020, indicated the resident acquired an unstageable (obscured full-thickness skin and tissue loss) pressure ulcer on 1/29/2020. The pressure ulcer measured 3.4 centimeter (cm) by 5 cm by 0.1 cm. and had a small amount of serous drainage with mild odor. The wound had 26 to 50% slough and 51 to 75% eschar. 2. The clinical record for Resident 25 was reviewed on 2/18/2020 at 2:00 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, edema, Cererbrovascular disease, major depression disorder, osteoporosis, (1/10/2020) pressure ulcer of sacral region stage two, The Admission MDS assessment, dated 11/22/19,			

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	indicated the resident was moderately impaired for daily decision making. The resident had no psychosis or behaviors. The resident required extensive assistance of two staff members for bed mobility, transfers and toileting needs. The resident did not ambulate. The resident was at risk to develop pressure ulcers. The resident had no pressure ulcers during this assessment. The progress note, dated 1/9/2020 at 6:30 p.m., indicated the resident had an open area stage two (partial thickness skin loss with exposed dermis) pressure ulcer on coccyx. The wound measured 1.5 cm by 1.0 cm by 1.0 cm. This assessment did not have any other description elated to this pressure ulcer. The would evaluation flow sheet assessment, dated 1/11/2020 at 8:33 a.m., indicated the resident had a open area on the coccyx that measured 1.5 cm by 1.0 by 0.1 cm. The assessment did not not have any other description was documented related to this pressure ulcer. The skin assessment, dated 1/25/2020 at 1:08 a.m., indicated the resident's skin was intact. The resident lacked a completed skin assessment for 14 days. During an interview with the Administrator on 2/13/2020 at 9:50 a.m., she indicated the stage two pressure ulcer was identified on 1/9/2020. The wound measurements were completed on 1/11/2020 as a stage two pressure ulcer. The next assessment completed on the resident's pressure ulcer was on 1/25/2020 and the resident's skin was intact. During an interview with the DON on 2/13/2020 at 2:28 p.m., she indicated there was no			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	documentation that the resident's pressure ulcer was monitored or evaluated from 1/11/2020 to 1/25/2020. The floor nurse would have been responsible to complete the pressure ulcer assessments weekly. This indicated the resident was not assessed for 14 days after a pressure ulcer had developed. 3. The clinical record for Resident 36 was reviewed on 2/10/20 at 3:01 a.m. The resident's diagnoses included , but were not limited to, hyperosmolality and hypernatremia, urinary tract infection, other seizures, anxiety disorder, hypokalemia, insomnia due to other mental disorder, cellulitis, pressure ulcer of unspecified buttock, dysphagia, altered mental status, trisomy and partial trisomy of autosomes, dementia in other diseases classified elsewhere with behavioral disturbance, down syndrome, unspecified intellectual disabilities, and localized edema. The current physician's orders indicated the resident's wound bed was to be cleaned with normal saline, calmoseptine to both buttocks very thick TID (three times a day) and as needed for soilage. The wound was to be left open to air, every shift related to the pressure ulcer of unspecified buttock and unspecified stage During an observation on 2/12/20 03:15 p.m., the resident's pressure ulcer dressing was changed by the nurse practitioner and RN 1. The left buttock wound measured 5.5 cm by 0.8 cm by 0.2 cm. There was 80 % epithelial tissue. The right buttock wound measured 4.8 cm by 2.5 cm by 0.1 cm. There was 95 % epithelial granulation. The calmoseptine cream was applied thickly to the left and right buttock. The resident's Braden Scale for predicting			

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	pressure sore risk, dated 11/23/19, indicated the resident was at a high risk for a pressure ulcer development, with a score of 12 (10-12 High risk). The Weekly Skin Review, dated 11/23/19, indicated the resident's wounds description for the right buttock and left buttocks were purple. The Weekly Skin Review, dated 11/28/19, indicated the resident's skin condition was redness with no site identified. The description was purplish red in color with a small healing sore. The Weekly Skin Review, dated 2/6/20, indicated the resident's skin condition was and open area continues to coccyx. The treatment applied per MD orders. The site of the wound was the coccyx. A description was approximately the size of a quarter with no depth to right buttock and approximately the size of a nickel with no depth to the left. The Weekly Skin Review, dated 2/13/20, indicated the resident's skin condition was a pre-exiting open area to both buttocks. The order was for calmoseptine and no description of the wound sites was documented. The Wound Evaluation Flow Sheet for weekly wound assessments indicated the wound was identified on 11/23/19 to the right buttock. The wound type was documented as a pressure ulcer. The clinical record lacked a completed wound evaluation flow sheet from 11/30/19 through 12/21/19. The Wound Evaluation Flow Sheet for weekly wound assessments indicated the wound was identified on 12/3/19 to the left buttock. The wound type was documented as a pressure ulcer.			

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	The clinical record lacked a completed wound evaluation flow sheet from 12/10/19 through 1/1/20. During an interview on 2/17/20 at 2:45 p.m., RN 2 indicated the Director of Nursing was responsible to make sure skin assessments were completed. The Skin Integrity Guideline provided by the Administrator on 2/13/20 at 9:15 a.m., indicated the "purpose: To provide a comprehensive approach for monitoring skin conditions. To decrease pressure ulcer, pressure injury, and/or wound formation by identifying those patients/residents who are at risk, and implementing appropriate interventions. To promote healing of wounds of any etiology, whether admitted or acquired... Documentation of Weekly Skin Evaluation/Observations: Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the weekly skin review. Each facility will keep a running log of all wounds in the building that includes number, type, stage, treatment and preventative measure in place, date of wound identification...Monitoring Compliance:... wound evaluation flow sheet is accurately and thoroughly completed for wounds (one per wound)..." 3.1-40(a)(1) 3.140-(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement new fall interventions after falls to prevent further falls for 1 of 2 residents reviewed for accidents. (Resident 47) Findings include: During an observation and interview, on 2/11/20 at 11:45 a.m., Resident 47 was seated in his wheelchair in his room.. The resident indicated he had been caught in his sheets and fell out of the bed twice. The resident's clinical record was reviewed on 2/12/20 at 2:21 p.m. The resident's diagnoses included, but were not limited to, hemiplegia (weakness) affecting right dominant side, schizoaffective disorder, history of traumatic brain injury, visual loss, pain, depression, unsteady on feet, anxiety, and history of falls. A Quarterly Minimum Data Set (MDS) assessment, dated 1/3/2020, indicated the resident was moderately cognitively impaired, and had one fall with no injury since admission. A quarterly Interdisciplinary Resident Review, dated 7/13/19, indicated the resident's fall risk assessment score was 17. A total score of 10 or above deems the resident at risk. A quarterly Interdisciplinary Resident Review, dated 1/15/20, indicated the resident's fall risk assessment score was 12.	F 0689	1. Resident 47's falls were reviewed with updated interventions. 2. The Director of Nursing/designee completed an audit of current residents to ensure that any resident who has had a fall since 2/18/20 has interventions in place. 3. The facility's Director of Nursing/ Designee will educate current licensed nurses that falls must have an immediate intervention. Education will be completed by 3/17/20. DON/ designee will review the plan of care for those residents who incur a fall daily on all scheduled work days x4 weeks and then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	03/17/2020

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An annual clinical health status assessment, dated 10/15/19, indicated the resident's fall risk assessment score was a 14.

The resident's care plan, dated as last reviewed on 2/7/19, indicated the resident was at a risk for falls related to medications, incontinence, and poor safety awareness. The resident rejected care at times and had impaired cognition, hearing, visual function, speech, and communication. The resident was to have a decreased risk for falls with injury through the next review. The resident required one to two staff members with a gait belt for transfers. The resident required a Bariatric bed in the low position. There were call don't fall signs by the bed and in the bathroom. The Call light or personal items were to be available and in easy reach and provide a reacher (a tool to extend ones reach). The resident was educated to call for assistance when needing to get something out of reach.

A Progress note, dated 1/28/2020 at 4:57 p.m., indicated the resident had a fall. The Situation, Background, Assessment, Response (SBAR) for a Change of Condition Situation indicated the resident's foot got tangled in bed control while trying to transfer self to wheel chair unassisted. The resident was found lying on the floor with the right side of his face against the wall. The resident had a hematoma to his right temporal area and an abrasion to his right side of the back. The resident indicated he was getting up to go eat supper and his foot got tangled. The resident's foot was tangled in the control cord.

A Progress note, dated 1/20/2020 at 4:30 p.m., indicated the resident had a fall. The SBAR for a Change of Condition Situation indicated the

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	resident was observed standing in the hallway. He was holding onto the assistive rail with his wheelchair behind him. When the resident went to sit down the wheelchair was not locked and the resident fell on his buttocks in a sitting position. A Progress note, dated 12/23/2019 at 11:00 a.m., indicated the resident had a fall. The SBAR for a Change of Condition Situation indicated the resident was found sitting on the floor beside his bed facing bed. The resident was trying to transfer by himself and indicated his feet slipped out from under him. The resident's clinical record lacked new interventions between falls to address the reason the resident had fallen. On 2/17/20 at 9:07 a.m., the Administrator indicted they had gotten away from the root cause analysis, and they put it back in place in January 2020. On 2/17/20 at 11:05 a.m., the MDS Coordinator indicated new interventions would be on the resident's care plan. New interventions would be addressed after resident falls. The resident had one new intervention in place, dated 1/22/20, for staff to provide a reacher and encourage the resident to use the reacher related to falls. A "Falls Management Guideline", with an effective date of 4/25/18, was provided by the Administrator on 2/14/20 at 9:15 a.m. The Policy included, but was not limited to: "Guideline Statement: Each Living Center implements the falls prevention and intervention program. Process: The falls prevention and intervention program includes...Following a resident's fall...Appropriate interventions are implemented.			

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	Care plan is updated...Monitoring/Compliance...Residents at risk for falls are care planned with individualized interventions...." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §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. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must			

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	ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to maintain a resident's catheter bag in a sanitary manner off the floor to prevent urinary tract infections for 1 of 1 resident's reviewed for catheters (Resident 11). Findings include: During an observation on 2/10/20 at 11:38 a.m., Resident 11 was lying in bed with the bed in the low position, his catheter bag was not in a privacy bag and was hanging on the frame of the bed. The catheter bag was laying on the floor. The resident had Intravenous therapy (IV) of sodium chloride running at 50 milliliters an hour. During an observation on 2/11/20 at 2:52 p.m., Resident 11 was lying in bed with the bed in the low position, his catheter bag was not in a privacy bag and was hanging on the frame of the bed. The catheter bag was laying on the floor. The clinical record was reviewed for Resident 11 on 2/17/2020 at 1:00 p.m. The resident's diagnoses included, but were not limited to, urinary tract infection and urinary retention. The physician's order, dated 2/8/2020, indicated the resident was prescribed Sodium Chloride solution 0.9 % (percent) IV 50 ml/hour for five days and zosyn solution (antibiotic) 3.375 grams IV every eight hours for five days for an urinary tract infection. During an interview with the Director of Nursing (DON) on 2/13/2020 at 2:18 p.m., she indicated the	F 0690	1. Resident 11 is no longer in facility. 2. The Director of Nursing/designee completed an audit of current residents who have catheter bags to ensure proper positioning to decrease the risk of urinary tract infections. 3. The facility's Director of Nursing/ Designee will educate current Nursing staff that residents with catheter bags are properly positioned to decrease the risk of urinary tract infections. Education will be completed by 3/17/20. DON/ designee will complete an audit of current residents with catheter bags to ensure they are properly positioned to decrease the risk of urinary tract infections weekly X4 weeks, then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived.	03/17/2020

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	nurse and the CNA's were responsible to ensure the resident's catheter bag was in a privacy bag and not on the floor to ensure good infection control practices. The preventing catheter associated urinary tract infection policy provided by the Administrator on 2/13/2020 at 9:15 a.m., indicated the purpose of this procedure was to provide guidelines for the prevention of catheter associated urinary tract infections. The guidelines included, but were not limited to, do not place the drainage bag on the floor. 3.1-41(a)(2)		5. Date Completed: 3/17/2020	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to maintain a dialysis communication book to provide assessments prior to, during, and after a resident received dialysis for 1 of 1 resident reviewed for dialysis. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 2/13/20 at 11:02 a.m. The resident's diagnoses included, but were not limited to, heart disease, end stage renal disease, diabetes mellitus with diabetic chronic kidney disease, low blood pressure upon standing, and generalized muscle weakness,	F 0698	1. Dialysis communication forms were obtained for Resident 29. 2. The Director of Nursing/Designee will conduct an audit of all Dialysis residents to ensure all residents have a dialysis communication book containing pre and post assessments. 3. The facility's Director of Nursing/ Designee will educate current licensed nurses that the Dialysis pre and post assessments must be completed	03/17/2020

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	A Significant Change Minimum Data Set (MDS) assessment, dated 12/1/19, indicated the resident was cognitively intact and received dialysis services During an interview, on 2/10/20 at 2:54 p.m., Resident 29 indicated he went to dialysis three times a week. The physician's order, dated 2/25/19, indicated the resident had an order for a post dialysis weight every Monday, Wednesday, and Friday to be done on the evening shift. The resident was scheduled to go to dialysis on January 1, 3, 6, 8, 10, 13, 15, 17, 20, 22, 24, 27, 29, and 31, 2020. The Progress notes indicated the resident refused to go to dialysis on January 22 and 24, 2020. The Progress note, dated 1/27/20, indicated the resident was in the hospital and received dialysis there. The review of the Dialysis Communication book indicated the resident had a Pre and Post Dialysis form for January 3, 6, and 20, 2020. The resident was scheduled to go to dialysis on February 3, 5, 7, 10, 12, and 14, 2020. The Progress notes indicated the resident refused to go to dialysis on February 14, 2020. There were no other days in February documented that the resident refused to go to dialysis. The review of the Dialysis Communication book indicated there were no Pre and Post Dialysis		for each dialysis appointment. Education will be completed by 3/17/20. DON/ designee will complete an audit 3x per week to ensure that Dialysis pre and post assessments are being received for all residents receiving dialysis x4 weeks and then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	Forms for any of the days the resident went to dialysis in February of 2020. During an interview, on 2/17/20 at 2:25 p.m., the Director of Nursing (DON) indicated the facility was missing the resident's dialysis book. They had called and received copies of the communication book from the dialysis provider. If there were no forms in the Dialysis Communication book then the forms were not filled out correctly. A "Dialysis Guideline" was provided by the Administrator on 2/17/20 at 3:48 p.m. The Guideline indicated, but was not limited to: "The Interdisciplinary team must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences...Whether residents receiving hemodialysis are transported out of the center, or receive dialysis in house, communication is essential for continuity of care. Education regarding the unique needs of the resident on hemodialysis is also important. Communication between the dialysis provider and center staff should include: Written communication including review of daily weights, changes in condition or mood, response to the treatment, and evaluation of the vascular access site (bleeding at site, patency issues, or signs of infection)...Post Dialysis Protocol: Review transfer forms or...documents for any pertinent information...Monitoring/Compliance: The following elements are in place for the center to demonstrate satisfactory compliance with the guide: Center has communication system/process with dialysis provider staff...."			

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F 0745 SS=D Bldg. 00	3.1-37(a) 483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to follow up, monitor, and assist a resident's psychosocial needs after an allegation of abuse for 1 of 2 residents reviewed for abuse (Resident 25). Findings include: During an interview with Resident 25 on 2/10/2020 at 1:26 p.m., she indicated she had been physically abused by a staff person and "it just happened". Two female staff were trying to force her to go to bed and the tall female staff picked her up and threw her in the bed. The resident did not know the female staff members names. When the staff had lifted her up, it hurt her under her right arm. She yelled and the nurse came into her room. She reported the abuse to the nurse. The resident indicated "I am fearful to stay here." During an interview with the Administrator on 2/11/2020 at 9:39 a.m., the staff involved with the allegation of abuse was LPN 4 , CNA 5, and CNA 6. LPN 4 was educated to report allegations of abuse to the Administrator. CNA 5 and CNA 6 was educated to honor residents wishes if they did not want to do something. The allegation had been investigated and was unsubstantiated. The clinical record for Resident 25 was reviewed, on 2/18/2020 at 2:00 p.m. The resident's diagnoses	F 0745	1. Social Services Director followed up with Resident 25. Resident 25 expressed no fear or concerns with staff at that time. 2. The Health Facility Administrator / designee will conduct an audit of all reportable instances since 2/18/2020 ensure all reportable instances have Social Services Follow Up. 3. The facility's Health Facility Administrator/ Designee will educate Social Services Director that all Residents involved in instances of alleged abuse/neglect must have appropriate social services follow up with a note to Resident's medical record. Education will be completed by 3/17/20. HFA/ designee will complete an audit weekly of reportable incidents to ensure that social services follow up occurred in all instances of alleged abuse/neglect x4 weeks and then monthly x 3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad	03/17/2020

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	included, but were not limited to, chronic obstructive pulmonary disease, hypertension, edema, Cererbrovascular disease, major depression disorder, diabetes mellitus, pain, and age related osteoporosis without current pathological fracture. The Admission Minimum Data Set (MDS) assessment, dated 11/22/19, indicated the resident was moderately impaired for daily decision making. The resident had no psychosis or behaviors. The resident required extensive assistance of two staff members for bed mobility, transfers, and toileting needs. The resident did not ambulate. During an observation and interview on 2/14/2020 at 9:30 a.m., Resident 25 was in her room crying. The resident indicated she was upset that staff threw her into her bed and she told them she was going to report them. The staff said "go ahead and tell they did not care". The resident was very upset with tears flowing down her face and sobbing into a tissue. An interview with the Social Service Director (SSD) on 2/14/2020 at 10:00 a.m., indicated she had not done a follow up with the resident since the allegation of abuse. No one had updated her on the allegation of abuse. She had seen the involved staff member back at work and she was working. The SSD assumed it was unsubstantiated. An interview with Administrator on 2/14/2020 at 10:16 a.m., she indicated the SSD should have followed up with the resident whether the allegation of abuse was substantiated or not. Social services and nursing should continue to monitor and follow up with the resident. The facility had morning meetings and afternoon		Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	155157	A. BUILDING 00 B. WING	02/17/2020

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	meetings and this resident had been talked about and the expectation was for her to be followed up on. The protection from abuse policy provided by the Administrator on 2/17/2020 at 1:15 p.m., indicated the social service staff would assess and document relevant information regarding resident's adjustment following their involvement in alleged abuse situation. If needed, the social service staff would provide or arrange counseling for residents and assist with staff education as appropriate. 3.1-34(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §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			

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	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 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. Based on record review and interview, the facility failed to evaluate the need for a resident's use of an antipsychotic medication and to have a acceptable diagnosis for the use of an antipsychotic medication for 1 of 5 residents review for unnecessary psychotropic medications. (Resident 212). The clinical record for Resident 212 was reviewed on 2/11/20 at 2:06 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, peripheral vascular disease, longstanding persistent atrial fibrillation, urinary tract infection, major	F 0758	1. Resident 212's order for Seroquel was discontinued. 2. The Director of Nursing/designee completed an audit by 3/17/20 of current residents with a psychotropic medication for appropriate diagnosis. 3. The facility's Director of Nursing/ Designee will educate current Nurses that residents have clinical justification for psychotropic medication and monitoring the use of medication.	03/17/2020

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	depressive disorder, upraventricular tachycardia, enterocolitis due to clostridium difficle, and insomnia. The current physician's order indicated the resident was prescribed seroquel (antipsychotic medication) tablet 25 mg, to be given, 1 tablet by mouth at bedtime related to insomnia. A General Note Text: on 2/13/20 at 9:17 a.m., indicated there was a call received from the resident's Personal Care Physician, nurse indicated the resident had only been on the medication since 12/11/19. They had received a call from the resident's home care nurse indicating the resident was very upset and had not been able to sleep with prescribed sleep medications. The seroquel was prescribed and the resident needed to go to a follow up appointment. The resident missed her doctors appointment since she was hospitalized and then sent to facility. The physician indicated it was ok to discontinue the medication. An interview on 2/13/20 at 9:45 a.m., with the Administrator she indicated, "I called the physician that had ordered the seroquel, before the resident was admitted to the facility, he said, he had ordered it for insomnia at that time, and he had given the facility an order to discontinue it today." Review of the Behavior Management Guideline provided by the Administrator on 2/14/20 at 9:20 a.m., indicated...Psychotropic drugs should not be used unless the clinical record documents that the patient/resident has one or more of the following "specific conditions", as dictated and documented by the physician: A. Conditions other than dementia: 1. schizophrenia, 2.		Education will be completed by 3/17/20. DON/ designee will complete an audit weekly x4 weeks of psychotropic medication and to ensure appropriate diagnosis for medication on current residents then monthly x 3 months then randomly as determined through QAPI. DON/Designee will audit new admissions for unnecessary psychotropic weekly x4 weeks then monthly x3 months then randomly as determined through QAPI. 4. Results of these audits will be reviewed during the facility's monthly QAPI meetings. An Ad Hoc QAPI will be held on 3/13/2020 to review all audits with the next regularly scheduled monthly meeting occurring on 3/27/2020. QAPI committee will identify trends and make recommendations based on audit results. QAPI committee will continue monitoring until 95% compliance is acheived. 5. Date Completed: 3/17/2020	

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	schizo-affective disorder, 3. delusional disorder, 4. mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features, 5. psychosis in the absence of dementia, 6. medical illnesses with psychotic symptoms (e.g. neoplastic disease or delirium), 7. schizophreniform disorders, 8. atypical psychosis, 9. tourette's disorder, 10. huntington's disease, 11. nausea and vomiting associated with cancer or chemotherapy, 12, hiccups (not induced by other medications)... 3.1-48(a)(4)			