STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. Building B. Wing	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20835 Based on observations and interviews, it was determined that the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents' dignity and respect in full recognition of his or her individuality by multiple observations of residents not being provided glasses to drink from instead of milk cartons and prefilled plastic juice containers. Additionally, observations were made of residents drinking from disposable plastic cups. An interview revealed that facility staff failed to honor A1's (anonymous resident) request for privacy while using the bathroom. Findings include: 1. 10/29/19 12:55 PM - During the dining observation in the Eastburn unit, E6 (CNA) opened R81's Lactaid milk carton, but did not pour the milk into a drinking cup or glass. 10/29/19 1:17 PM - An interview with E6 (CNA) revealed that a non disposable drinking cup or glass was not provided on the tray from the Dietary Department for R81's milk to be poured into. 2. 10/29/19 1:20 PM - During the dining observation in the Eastburn unit, R39's milk carton was opened by E7 (CNA), but was not poured into a drinking cup or glass. R39 was observed spilling milk on his shirt while trying to drink from the carton. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM. 20883 3. Observation on 10/29/19 from 12:43 PM through 1:10 PM revealed R145 drinking juice and water from disposable plastic cups during the midday meal. Although the water arrived on the tray in a reusable plastic cup, a staff member poured half of it into a disposable plastic cup. 4. Observation on 10/29/19 from 12:43 PM through 1:10 PM revealed R82 drinking juice from a disposable plastic cup during the midday meal. 5. Observation on 10/29/19 from 12:43 PM through 1:10 PM revealed R68 drinking milk from a disposable plastic cup during the midday meal. 6. Observation on 10/29/19 from 12:43 PM through 1:10 PM revealed R95 drinking iced tea from a disposable plastic cup during the midday meal. (continued on next page)

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.

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

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	7. During an interview on 10/29/19 at 11:11 AM, when asked if he/she felt they had privacy, A1 (Resident who wished to remain anonymous and was alert and oriented) stated that recently when he/she was seated on the bathroom toilet a CNA didn't knock first and busted into the bathroom to fill a water basin. A1 stated that when he/she told the CNA they were upset, the CNA wiggled her hands near her ears at me. A1 stated that he/she did not inform other staff of the incident. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/6/19 at approximately 12:30 PM. 32545 8. Observation on 10/29/19 at 12:10 PM in the [NAME] unit dining room during lunch revealed the following: - R1 was drinking from a pre-filled plastic container with the seal cover pulled back, but still attached to the container; - R64, R67, R106 and R116 were served beverages in pre-filled plastic containers with the seal covers pulled back, but still attached to the containers; and - R122 and R104 were served beverages in clear, disposable plastic cups. 9. Observation on 10/29/19 at 12:26 PM revealed R366, who ate in her room in the [NAME] unit hallway, was served 2 beverages in clear, plastic disposable cups. 10. Observation on 11/4/19 at 8:43 AM in the [NAME] unit dining room during breakfast revealed the following 6 residents (R62, R104, R116, R122, R154 and R368) were served beverages in either clear, plastic disposable cups or pre-filled plastic containers. 11/6/19 at 2 PM - During a combined interview, findings were reviewed with E31 (FSD #1) and E9 (FSD #2). The facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents' dignity and respect in full recognition of his or her individuality by multiple observations of residents being served beverages in clear, disposable cups or pre-filled disposable plastic containers.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 20835 Based on interview and record review, it was determined that the facility failed to ensure for one (R148) out of five residents investigated for choices, that R148's preference for choice of shower was honored. Findings include: Review of R148's clinical record revealed: 7/11/19 - R148 was admitted to the facility from the hospital with diagnoses including multiple sclerosis. 8/26/19 (Most recent revision date) - The care plan for Activities of Daily Living (ADL) documented that R148 was unable to perform own ADLs without assistance related to weakness. Interventions included, . shower 2 days per week, clean and check fingernails and toenails. Bed bath may be substituted for shower if necessary/refused/declined . 7/17/19 - The significant change MDS assessment documented that it was important for R148 to choose between tub bath, shower, bed or sponge bath. In addition, R148 required physical assistance from two plus staff for bathing. 9/2019 - The Documentation Survey Report, where the CNA documented care and services to R148 indicated that R148 was scheduled for a bath/shower during the 3:00 PM to 11:00 PM shift on Mondays and Thursdays. The report documented that R148 was scheduled for nine (9) showers during this period of time. R148 was showered on 9/9/19 and 9/23/19 and for the remainder of the seven (7) scheduled showers, R148 was given a partial or a complete bed bath. There was lack of evidence that R148's preference for showers twice a week were offered, refused, or declined for seven (7) out of nine (9) scheduled showers for 9/2019. 10/2019 - The Documentation Survey Report documented that R148 was scheduled for a bath/shower on Mondays and Thursdays during the evening shift. The report documented that R148 was scheduled for nine (9) showers during this period of time. R148 was showered once on 10/10/19. On 10/21/19, one of R148's scheduled bath/shower days, the facility documented NA (not applicable). For the remaining seven (7) scheduled shower days, R148 was given either a partial or a complete bed bath. There was lack of evidence that R148's preference for showers twice a week was offered, refused, or declined for seven (7) out of nine (9) scheduled showers for 10/2019. 11/6/19 10:55 AM - An interview with E4 (RN, UM) revealed that E4 had spoken with the CNA who provided care to R148 during the 3:00 PM to 11:00 PM shift on 10/21/19 and that R148 had refused a shower, partial or a complete bath. E4 verbalized that the current CNA documentation in the facility's EMR did not include whether the facility offered R148's choice of a shower and/or refusal of a shower. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on observation, clinical record review and interview, it was determined that the facility failed to maintain comfortable sound levels in one out of 5 nursing units on 11/1/19 from 9:09 AM until 9:21 AM. Findings include: 11/1/19 from 9:02 AM to 9:35 AM - A continuous observation revealed a loud secondary remote alarm from R134's AVAPS device sounding from the [NAME] nurses' station. - at 9:07 AM - R102 was sitting in her wheelchair directly across from the nurses station and complained out loud about the alarm and E36 (Unit Clerk) seated in the nurses station said in response, I know. E36 got up and walked out of the nurses station and approached R102 and moved the resident to an open area near the [NAME] unit exit door where music was playing from a radio. - at 9:09 AM - R134 was observed exiting his room and being pushed by a CNA to the shower room. This surveyor continued to hear the loud secondary remote alarm from the nurses station. - at 9:21 AM - R134 and the CNA were observed exiting the shower room and returned to R134's room. This surveyor continued to hear the loud secondary remote alarm from the nurses station. - at 9:35 AM - Observed R134's alarm was off. During this continuous observation from 9:02 AM through 9:35 AM, the surveyor observed the two [NAME] Unit nurses passing medications to residents in the opposite hallway and observed E20 (Unit Manager) exit her office across from the [NAME] nurses station and walking around the unit. Review of R134's clinical record revealed a care plan with an intervention, last revised on 8/27/19, stating, When AVAP is not in use, 2nd remote alarm may be turned off. 11/7/19 at approximately 10:30 AM - During an interview, E2 (DON) stated that R134's AVAPS device 2nd remote alarm could not be turned off. 11/7/19 at approximately 3 PM - During an interview, E35 (Respiratory Therapist) stated that R134's AVAPS 2nd remote alarm does not need to stay activated when the device was not in use during meals and when showering the resident. 11/7/19 at approximately 6 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed failed to maintain comfortable sound levels in one out of 5 units on 11/1/19 from 9:09 AM until 9:21 AM.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 32545 Based on interview and review of the clinical record and facility documentation as indicated, it was determined that for one (R58) out of 67 sampled residents, the facility failed to have evidence that an alleged violation of neglect, a choking incident involving R58 on 8/18/19, was thoroughly investigated and that appropriate corrective action was taken as a result of the investigation findings. Findings include: Cross refer to F684 The facility's policy entitled, Accidents and Incidents - Investigating and Reporting, last revised 7/2017, stated, . All accidents or incidents involving residents .occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation . 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: .c. The circumstances surrounding the accident or incident; . e. The name(s) of witnesses and their accounts of the accident or incident; . k. Any corrective action taken; . m. Other pertinent data as necessary or required . 8/18/19 at 1:55 PM - The facility's incident report stated, . Nursing responded to an overhead emergency page to go to Eastburn wing as there was a resident is (sic) distress. Upon arrival to the unit, nursing staff was performing the Heimlich maneuver to resident as the resident was observed unable to clear her airway. Resident was unable to speak or respond when asked if she was choking. Cyanosis (bluish discoloration) noted to resident's lips. Per verbal report, resident began choking on food during lunch meal service on (sic) the unit dining room under staff supervision. Her current diet confirmed as CCD/Mechanical Soft/Thin Liquids. Finger sweeps of airway, Heimlich maneuver, and back thrusts in progress when supervisor arrived. 911 was activated by nursing staff. Heimlich maneuver and back thrusts continued until resident airway cleared and resident was able to breathe on her own. Resident was able to expel food bolus as a result of the interventions implemented by staff. Oxygen applied via mask and oxygen saturation noted at 90% (normal range is 95- 100% per the Mayo Clinic) and increased to 92% when rescue (EMS) arrived to the facility. HR, pulse, oxygen saturation and respiratory status monitored closely throughout the incident. Circulation, skin color and resident's baseline cognition returned to normal and the resident was transferred (sic) the emergency room for further evaluation. MD and RP notified of resident's transfer . Resident's normal baseline is AAO to self only . At time of choking episode, patient was limp and not responsive. The facility lacked evidence of a thorough investigation. The facility's incident report lacked the names of all facility staff involved and their individual statements. The investigation also lacked a root cause analysis and what interventions were put into place upon R58's return from the hospital. 8/18/19 at 4:11 PM - The facility reported the choking incident to the State Survey Agency, however, they did not identify the resident involved and the facility staff involved/witnesses. 8/23/19 - The facility's 5-day follow-up on the choking incident to the State Survey Agency stated the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Root Cause Analysis: Isolated incident; - Were changes made to the Care Plan? No; - Were system changes put into place? No. 11/7/19 at 10:30 AM - During an interview, E2 (DON) provided the surveyor with a copy of the 8/18/19 incident report and an undated statement from E8 (CNA). 11/7/19 at 11 AM - During a follow-up interview with E8 (CNA), the surveyor showed E8 her typed statement that was just handed to the surveyor. E8 stated, Yes that is what I told E2 (DON) and she wrote it. When asked when did you sign this statement as it was not dated, E8 stated, I signed it today (11/7/19). 11/7/19 at 2:07 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E33 (Corp. Nurse). The facility failed to thoroughly investigate R58's choking incident in the Eastburn dining room on 8/18/19.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 20835 Based on record review and interview, it was determined that the facility failed to review and revise a care plan for one (R126) out of two sampled residents reviewed for pressure ulcer investigation. Findings include: Review of R126's record review revealed the following: 9/1/17 - R126 was admitted to the facility from the hospital with diagnoses including peripheral vascular disease and dementia. 9/20/19 - The significant change MDS assessment documented that R126 was on hospice care, effective 9/10/19. R126 was severely impaired for decision making, required extensive assistance of one staff for bed mobility and had no pressure ulcers. 10/2/19 - A physician's order was written to offload R126's heels while in bed (keep pressure off of the heels so they don't touch the mattress). 10/2/19 (Most recent revision date) - A care plan for potential for impairment to skin integrity related to fragile skin included a goal that R126 would not have skin impairment through the next review date. Interventions included application of barrier cream to the buttocks after incontinence episodes to protect the skin from breakdown, keep skin clean and dry and to use lotion on dry skin, monitor/document location, size and treatment of skin injury; report abnormalities, pressure relieving/reducing mattress and pillows to protect the skin while in bed; and to turn and reposition and assess skin every 2 hours. There was lack of an intervention to offload the heels while R126 was in bed. 11/4/19 2:00 PM - An interview with E5 (LPN) confirmed that the above care plan failed to include the intervention to offload the heels while R126 was in bed. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 20883 Based on observations and interviews, it was determined that the facility failed to provide services that meet professional standards of quality in the area of medication administration for two (R9 and R131) out of nine (9) sampled residents. Findings include: The facility's pharmacy policy and procedure, titled Medication Administration General Guidelines, version 2018, stated, .Administration .3. When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med pass or for more than one resident at a time . The facility's pharmacy policy and procedure, titled Oral Medication Administration, version 2018, stated, .6 . Do not leave medications at bedside . 1. On 11/1/19 at approximately 8:25 AM, E21 (LPN) was observed passing medications. During the medication pass a souffle cup was observed in the top drawer of the medication cart. The souffle cup had another souffle cup in it with writing on it. When asked what was in the cup and who it was for, E21 stated that she had prepoured R131's medication earlier because the resident always asked for her medication immediately upon returning from breakfast. The facility failed to follow professional standards of practice in medication administration when medications were prepoured for R131. 11/6/19 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 32545 2. On 11/4/19 at 4:58 PM, during a medication pass observation, E25 (LPN) was observed leaving R9's medications on the overbed table, which was located next to R9's right side of the bed. E25 exited R9's room to retrieve a stethoscope in the nurses station. E25 returned to R9's room with a stethoscope and proceeded to wash his hands. After washing his hands, E25 left R9's room again (at 5:01 PM) to retrieve a box of gloves (larger size) to replace the empty box in the resident's bathroom. R9's medications remained on the overbed table next to the resident during this observation. 11/7/19 at 2:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to follow professional standards of practice in medication administration when R9's medications were left at the bedside.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 20835 Based on observations, interviews, and review of related clinical information, it was determined that the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain personal hygiene for two (R86 and R148) out of eight sampled residents for ADL review. Findings include: 1. Review of R148's clinical record revealed: 7/11/19 - R148 was admitted to the facility from the hospital with diagnoses including multiple sclerosis. 7/17/19 - The significant change MDS assessment documented that R148 was moderately impaired for decision making, required extensive assistance of one staff member to meet her personal hygiene needs and she had range of motion (ROM) impairment affecting one side of her body in the upper extremity/limb. 8/26/19 (Most recent revision date) - The care plan for Activities of Daily Living (ADL) documented that R148 was unable to perform her own ADLs without assistance related to weakness. Interventions included, . shower 2 days per week, clean and check fingernails and toenails . 9/2019 - The Documentation Survey Report, where CNA's documented care and services provided to R148 indicated that R148 was scheduled for a bath/shower during the 3:00 PM to 11:00 PM shift on Mondays and Thursdays. There was a lack of evidence that R148 was provided nail care during the nine (9) scheduled baths/showers for 9/2019. 10/2019 - The Documentation Survey Report documented that R148 was scheduled for a bath/shower on Mondays and Thursdays during the evening shift. There was a lack of evidence that R148 was provided nail care during the nine (9) scheduled baths/showers for 10/2019. 10/29/19 1:52 PM - An observation of R148's finger nails revealed that they were untrimmed with encrusted debris underneath the nails. The fingernails extended approximately half an inch past the fingertips. R148 verbalized that she was unable to perform her own nail care due to limitations of her right hand and that her nails needed to be trimmed and polished. 11/4/19 11:35 AM - An interview with E11 (CNA) revealed that she has provided care to R148 for the past couple of months and E11 verbalized that nail care was to be done during the resident's scheduled shower days. E11 provided documentation that R148 was scheduled for showers on Mondays and Thursdays every week during the 3:00 PM and 11:00 PM shift. 11/6/19 11:10 AM - An interview with E4 (RN, UM) confirmed that the facility had no evidence that nail care was offered based on the current method of CNA documentation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM. 38827 2. Review of R86's clinical record revealed: 9/26/18 - R86 was admitted to the facility with diagnoses that included chronic pain syndrome, weakness, pain in both hands, and contractures. 10/10/18 - A care plan focus for activities of daily living had an intervention to clean and check R86's fingernails two times a week during showers. 9/11/19 - A significant change MDS assessment revealed that R86 was able to make her own decisions and required extensive two person assistance for personal hygiene. October 2019 - Review of R86's Documentation Survey Report indicated that she was scheduled for a bath or shower on Tuesdays and Fridays. On 10/30/19 at 2:42 PM - R86 was observed with very long, dirty fingernails. R86 was observed to have contractures of both hands. When asked by the surveyor if she wanted her nails this long, R86 replied No. On 11/4/19 at 1:36 PM - During an interview, E19 (CNA) was asked who's responsibility it was to trim resident's fingernails. E19 responded that the nurse's aides were responsible for resident nail care. The surveyor pointed out that R86's fingernails were long and E19 responded that she was unable to cut the nails without a large nail clipper. R86 stated there were large clippers in her bedside drawer, and upon investigation by E19, a pair of large nail clippers was observed in R86's bedside table drawer. On 11/4/19 at 3:03 PM - During an interview, E20 (UM) confirmed that R86's nail care should be done during the resident's bath or shower. The facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good nail care. Findings were reviewed with E2 (DON) on 11/7/19 at 11:30 AM.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 32545 Based on interviews and reviews of clinical records and facility documentation as indicated, it was determined that for one (R58) out of 5 hospitalization s reviewed, the facility failed to ensure that each resident received treatment and care that was in accordance with professional standards of practice and the plan of care. For R58, the facility failed to ensure that R58 was served a mechanically altered diet for lunch on Sunday, 8/18/19; and failed to follow the 8/2/19 physician's order for verbal/tactile assistance during meal intake to prevent R58 from over stuffing her mouth with food. R58 choked on a mouthful of food, resulting in R58 becoming limp and unresponsive. R58 required life-saving efforts of the Heimlich Maneuver, back thrusts and finger sweeps to dislodge the food bolus. R58 was transferred to the hospital for evaluation and admitted . R58 developed aspiration pneumonitis and sustained harm from the 8/18/19 choking incident. Findings include: Cross refer to F610 The facility's policy and procedure entitled Assisting the Resident with Meals, last revised on 12/2013, stated, .Preparation . 1. Review the resident's care plan and provide for any special needs of the resident . 3. Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow . Review of R58's clinical record revealed: 1/24/14 - R58 was readmitted to the facility and had diagnoses that included, but were not limited to, Alzheimer's disease, obsessive compulsive disorder and obesity. 4/16/18 - R58 was care planned for unable to do own ADL's without assistance secondary to cognitive loss with interventions that included, but were not limited to: - assist with meal tray, opening items and set-up as needed; and - supervision assist with feeding. 6/14/19 - A quarterly MDS assessment stated that R58 was severely cognitively impaired for daily decision making; had disorganized thinking where the behavior comes and goes and changes in severity; required eating setup help only by one staff person and supervision (oversight and cueing); required a mechanically altered diet (change in texture of food or liquids); R58 was 5 feet tall and weighed 197 pounds; and had no swallowing disorders or dental issues noted. R58 resided in a locked dementia unit. 8/2/19 - A Speech Therapy evaluation stated, .referred for coughing occasionally during meals . reportedly has rapid rate of presentation . has had acute presentation of tremors in her jaw and arms, predominantly in right arm and this has overall impacted her ADL task of eating/drinking . 8/2/19 at 11:07 AM - A Speech Therapy Progress Note stated, .Patient now on caseload after referral for coughing noted on (sic) meals. The following is recommended: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1) Community dining/supervision during meals. 2) Upright out of bed for all meals. 3) She warrants verbal/tactile assistance during meal intake where staff can help her modify her rate of presentation so she does not stuff her mouth. 4) SLP (Speech Language Pathologist) recommends external environmental modifications of community dining staff to administer verbal cueing or tactile cueing to finish what is in her mouth before adding more food. 5) SLP recommends help patient control her amounts of food or liquid through pinching the straw during drinking on occasion to help ration off the liquid or help her with her cup sips by helping her hand bring it to her mouth if she has difficulty to minimize labial spillage. 6) SLP also recommends pharmaceutical review/MD review for potential adjustments as needed because tremors in the arm can also contribute to tremors in swallow muscles which can impact patient airway safety during ADL task of eating. 8/2/19 at 6:41 PM (last revised) - An electronic physician's order for R58's diet was revised to include the following under Additional Directions: Supervision and 1:1 assistance as needed to decrease rate of intake and minimize risks for aspiration/choking. Provide verbal/tactile cues as needed. Offer finger foods when available (e.g. sandwiches no crust, potato wedges, etc.). 8/7/19 at 3:34 PM - An Occupational Therapy note stated, . Pt (patient) seen during breakfast meal requiring SUP (supervision) and verbal and tactile cues for pacing, HOH (hand over hand) to stabilize sippy cup for intake of beverages. COTA discussed recommendations with nursing staff. 8/16/19 (last revision) - R58's care plan stated, . potential for altered nutrition r/t (related to) need for Therapeutic diet, due to DM, obesity. Mech altered diet due to hx (history) coughing with meals/dysphagia . Interventions: . - Resident requires supervision and 1:1 as needed . - Serve diet as ordered: CCD, mechanical soft with thin liquids. Offer finger foods when available (e.g. sandwiches no crust, potato wedges, etc.). Continue all other therapeutic dietary restrictions. Special Instruction: No crust on sandwiches. Moisten food items, emphasis on meats, with extra sauce/gravy (last revised on 8/2/19) . R58's care plan was not updated with the Speech Therapy recommendations of 8/2/19. 8/16/19 - A Speech Therapy treatment note stated, .Precautions: tremors (acute) . trained patient in rate of presentation through verbal cues and tactile redirection. patient insisted on attempting to stuff mouth. (R58) benefited from tactile cues and verbal cues . to swallow 'slowly' . and take small bites . to maximize patient safety during ADL task of eating . 8/18/19 at 1:47 PM - The EMS Prehospital Care Report stated the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Facility staff reported R58 was eating lunch which included spaghetti and ground up meatballs when R58 started choking; - Facility staff reported that they performed numerous abdominal thrusts and 'deep' finger sweeps in the pt's (patient's) mouth to remove the lodged food; - Observed red substance that appeared to be blood around R58's mouth; and - Facility staff confirmed it is blood noting they 'had to go down in there pretty far' (while performing the finger sweeps) to get the food out of the pt's (patient's) airway. 8/18/19 at 1:55 PM - The facility's incident report stated, . Nursing responded to an overhead emergency page to go to Eastburn wing as there was a resident is (sic) distress. Upon arrival to the unit, nursing staff was performing the Heimlich maneuver to resident as the resident was observed unable to clear her airway. Resident was unable to speak or respond when asked if she was choking. Cyanosis noted to resident's lips. Per verbal report, resident began choking on food during lunch meal service on the unit dining room under staff supervision. Her current diet confirmed as CCD/Mechanical Soft/Thin Liquids. Finger sweeps of airway, Heimlich maneuver, and back thrusts in progress when supervisor arrived. 911 was activated by nursing staff. Heimlich maneuver and back thrusts continued until resident airway cleared and resident was able to breathe on her own. Resident was able to expel food bolus as a result of the interventions implemented by staff. Oxygen applied via mask and oxygen saturation noted at 90% and increased to 92% when rescue (EMS) arrived to the facility. HR, pulse, oxygen saturation and respiratory status monitored closely throughout the incident. Circulation, skin color and resident's baseline cognition returned to normal and the resident was transferred (sic) the emergency room for further evaluation. MD and RP notified of resident's transfer . Resident's normal baseline is AAO to self only . At time of choking episode, patient was limp and not responsive. 8/18/19 at 2:38 PM - The hospital record stated, . Patient is reported to have been eating spaghetti and meatballs when she began choking. Staff at her facility vigorously attempted to finger sweep the obstruction . Patient is considered to be high risk for development of aspiration pneumonia . Patient did have mild bleeding from pharynx after this event which is currently resolved . Plan to admit . monitoring for development of pneumonitis . 8/19/19 - The OT Discharge Summary for R58's dates of service from 7/31/19 to 8/16/19 stated, .Pt progressed in decreased spillage during self-feeding tasks and requires SUP (supervision) during self-feeding tasks in the form of verbal cues for pacing and occasional proximal support to right elbow for distal stability during hand to mouth movements secondary to tremors . Caregivers educated on proper verbal and tactile cues to . monitor pacing, and provide RUE (right upper extremity) support during self-feeding tasks . 8/21/19 - A Speech Therapy Discharge Summary for services provided from 8/1/19 through 8/16/19 stated, . Prior to patient discharge to hospital, patient was making gains in her tremors after medicine was adjusted by MD and returned to being able to self-present food items. She warrants environmental cueing for slow rate of presentation, to finish what is in her mouth before adding more. She was orally manipulating soft solids and thin liquids with external cueing and modification of rate of presentation. Then patient got discharged to hospital. 8/25/19 - R58 was discharged from the hospital with a diagnosis of aspiration pneumonitis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	8/26/19 - A Speech Therapy evaluation stated, . readmitted from the hospital with a diagnosis of aspiration pneumonitis related to a x1 (one time) choking incident reportedly on 'spaghetti and meatballs'. It should be noted that a chest x-ray was administered and it showed NO acute process. Patient did have mild bleeding from pharynx after episode per evaluation in the hospital .Prior Level of Function: Intake/Diet Level=thin liquids ., soft and bite sized . (Mechanical Soft/Chopped); swallowing abilities=distant supervision; . Assessment: clinical impressions: patient at a level 4 - pureed solids. her prior level of function was level 5. Patient has improving tremors that were a side effect of her Zoloft. Patient mild dysphagia was exacerbated following a x1 choking incident on 'spaghetti and meatballs' and became acutely hypoxic. Her chest x-ray did not show any acute process forming but from the choke incident itself, she had a mild bleeding from pharynx after the episode. Patient had some increased acute chronic mouth stuffing more recently that increased her choking hazard risk. She is currently on pureed solids and warrants retraining for rate of presentation . Recommendations: thin liquids, pureed .supervision yes (verbal cues for patient to finish what is in her mouth before adding more). 11/6/19 at 8:28 AM - During an interview, E3 (Dietician) stated that she has seen R58 eat very quickly. When asked to describe a mechanical soft diet, E3 stated meats chopped up with sauce or gravy on it to make it moist, buttered noodles that break apart easily, not like regular pasta like spaghetti, and mashed potatoes. E3 stated that a machine in the kitchen was used to chop food items for residents on a mechanical soft diet. When asked if spaghetti and meatballs are served on a mechanical soft diet, E3 stated yes, as long as they are cut up separately in the kitchen and then put back together on the plate. 11/6/19 at 9:10 AM - During an interview, E27 (Speech Therapist) stated that R58 can handle meals and liquids in small amounts with supervision, which means community dining, not direct supervision. E27 stated that R58 needs verbal cueing by staff for rapid eating. E27 stated that R58 was placed on a pureed diet because the resident shovels food in her mouth. 11/6/19 at 9:48 AM - During an interview, E7 (CNA) stated that she recalled the incident and the residents were served spaghetti and meatballs for lunch. E7 stated that she and the other CNA (E8) were in the Eastburn dining room and they were supervising and assisting the residents. E7 stated that R58 was seated apart from the other residents because R58 will grab food from other residents trays and other items. E7 stated that R58's meatball was ground, however, the spaghetti served was not cut up. E7 stated that the spaghetti was like how we eat it, long noodles. When asked if R58 was served a roll or garlic bread, E7 stated she could not recall and stated that R58 could not have them because she couldn't chew them. E7 stated another resident (R98) needed attention with something and when we looked at R58, she was turning blue. E7 stated that E8 (CNA) immediately responded and performed the Heimlich Maneuver and couldn't dislodge, performed back blows and a finger sweep. E7 stated it was when E8 (CNA) did the finger sweep that dislodged the obstruction. E7 stated that nursing responded with the crash cart. E7 stated that once the obstruction was dislodged, R58 was alert and smiled and lowered to the floor. E7 stated that EMS personnel responded and R58 was taken to the hospital. E7 stated that she was assisting the other residents as they were present in the dining room when this was occurring. 11/6/19 at 11:11 AM - During an interview, E28 (Nurse) stated that she observed R58 sitting in a chair in the dining room slumped over with E8 (CNA) performing the Heimlich Maneuver and reaching into R58's mouth and pulling out spaghetti noodles. E28 stated that the spaghetti noodles were not cut up. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11/6/19 at 12:41 PM - During an interview, E29 (Nurse) stated that she observed R58 choking and E8 (CNA) performing the Heimlich Maneuver with a nurse next to the CNA. E29 stated that R58 had a habit of stuffing food in her mouth. E29 stated at first that she didn't remember specifically what food was involved. When asked what did the food look like coming out of R58's mouth, E29 stated ground meat and spaghetti (some was chopped in smaller pieces and some in longer pieces). 11/6/19 at 1:16 PM - During an interview, E30 (Nurse) stated that she was told during nursing shift report that the CNAs had been cutting R58's food. E30 stated that she walked to the nurse's station in the Eastburn unit to put something in the refrigerator for a resident when she heard yelling and her name being called. E30 stated that she went back to the dining room and saw that R58's color was navy blue and E8 (CNA) was performing the Heimlich Maneuver. E30 stated that she said to E8 (CNA) to let me take over, but E8 (CNA) would not let me. E30 stated that R58 was hard to perform the Heimlich Maneuver due to her size and stature. E30 stated that E8 (CNA) had her hand down R58's throat and pulled out a roll and spaghetti. After R58 started breathing again, E8 stated that she did a sweep of R58's mouth and got a hand full of blood. When asked about what came out of R58's mouth again, E30 stated that a big piece of a soft roll and a bunch of long spaghetti came out of R58's mouth. E30 stated that R58 doesn't chew her food and grabs food off of other residents plates. E30 stated that R58 was the last person to get her tray. E30 stated that she was told in nursing shift report that staff had been feeding R58. E30 stated that R58 can eat very quickly. 11/6/19 at 2 PM - During a combined interview with E31 (FSD #1) and E9 (FSD #2), E9 stated that mechanical soft diets are prepared in a Robot Coupe machine in the kitchen. E9 (FSD #2) stated that food items are done individually in batches in the Robot Coupe machine. E9 confirmed that the Robot Coupe was used for chopping pasta. E9 stated that the Robot Coupe machine operated with only 2 speeds: the high speed prepared pureed food and the low speed prepared ground food in one size only. When asked if E31 (FSD #1) was aware of a choking incident on 8/18/19, he stated No and stated that No one talked to me about it. E31 stated that he participated in morning meetings with facility staff around the time of the incident. 11/6/19 at 2:17 PM - During an interview, E32 (Cook, Supervisor) stated she was in charge on Sunday, 8/18/19. E32 stated that no one spoke to her about the choking incident. When asked if there were any problems identified with the Robot Coupe machine during the month of August 2019, E32 stated, No. E32 stated that a dinner roll was part of the mechanical soft diet. 11/6/19 at 2:28 PM - During an interview, E8 (CNA) stated that all residents were sitting down for lunch. E8 stated that E7 (CNA) went over to another resident (R98) to check on the resident as she was coughing. E8 stated she was sitting next to another (unidentified) resident and looked over at R58. E8 stated she saw that R58's face was red; R58 was sitting with her hands laying on the table; and R58 was shaking, like a seizure. E8 stated that R58 eats very fast. E8 stated that she took her finger to clear R58's mouth and R58's top denture came out with spaghetti. E8 stated that she got around her to do the Heimlich Maneuver trying to clear her airway. E8 stated that R58 had a lot of food in her mouth. E8 stated that she opened R58's mouth and pulled out spaghetti. When asked if any nurses offered to help, E8 stated, Nope. E8 stated that she did hear nurses responding. E8 stated she was focused on R58. E8 stated that they did not have to feed R58. E8 stated that she thought E7 (CNA) cut R58's food. 11/6/19 at 2:58 PM - During a follow-up interview with E7 (CNA), when asked if she cut up R58's food on the day of the choking incident, E7 stated, No, I did not give (R58) her meal tray. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11/7/19 - Review of the CNAs' Tasks (both current and resolved) for R58 revealed a lack of evidence of Speech Therapy's 8/2/19 recommendations for verbal and tactile cueing R58 during meal intake so staff can monitor and help pace so R58 does not stuff her mouth. The CNA tasks listed at the time of the incident on 8/18/19 were: CCD mechanical soft diet with thin liquids. May have pleasure smooth mechanical soft snacks (e.g. bananas, etc.) as tolerated with distant supervision/community dining for enhanced quality of life; Eating: Feeds self after set up with sippy cup with lid and handles. 11/7/19 at 11 AM - During a follow-up interview with E8 (CNA), this surveyor showed E8 her typed statement that was just handed to the surveyor. E8 stated, Yes that is what I told E2 (DON) and she wrote it. E8 was asked when she signed this statement as it was not dated, E8 stated, I signed it today (11/7/19). 11/7/19 at 12:18 PM - During a follow-up interview with E8 (CNA), the surveyor asked if she was aware about using verbal and tactile cueing when R58 was eating. E8 stated, Yes, I was aware. I have been working with the resident for a long time. I know that the resident shovels food in her mouth. 11/7/19 at 2:07 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E33 (Corp. Nurse). R58 sustained harm from the 8/18/19 choking incident when the facility failed to do the following: - failed to ensure that R58 was served a mechanically altered diet for lunch on Sunday, 8/18/19; - failed to ensure that Speech Therapy recommendations from 8/2/19 were communicated in the CNA Tasks screen and in R58's plan of care; and - failed to follow the 8/2/19 physician's order for verbal/tactile assistance during meal intake to prevent R58 from over stuffing her mouth with food. R58 choked on a mouthful of food, resulting in R58 becoming limp and unresponsive.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 20835 Based on observation, record review and interview, it was determined that the facility failed to ensure, during a random dining observation, that two residents (R98 and R118) were offered the fortified food item that was prescribed to them to increase their caloric intake. Findings include: Cross refer F803, Example #4 1. Review of R98's clinical records revealed the following: 10/21/17 - R98 was admitted to the facility with diagnoses including dementia. 3/28/19 - An order was written for a fortified food program. 9/16/19 - The Annual Nutrition Assessment included recommendations to continue on the fortified food program for all meals due to a variable oral intake. The plan was to continue monthly weights, monitor oral intake and fluid status, and reassess nutritional status as needed. 11/4/19 12:55 PM - An observation of R98's meal ticket revealed R98 was to be provided half a cup of fortified mashed potatoes, however, there were no mashed potatoes on the tray. 11/4/19 12:58 PM - An interview with E8 (CNA) confirmed that the tray lacked evidence of the fortified mashed potatoes. 11/4/19 1:20 PM - An interview with E12 (Cook) revealed that the lunch menu did not include mashed potatoes, thus, the fortified mashed potatoes were not provided. 11/6/19 9:49 AM - An interview with E3 (RD) revealed that R98 was ordered the fortified food program on 3/28/19 in an effort to provide R98 with extra calories. E3 stated this would include fortified cereal in the morning and fortified mashed potatoes for lunch and dinner. The facility failed to have a system to ensure that R98 was provided the fortified food as ordered on 3/28/19. Cross refer F803, Example #3 2. Review of R118's clinical record review revealed the following: 3/27/19 - R118 was admitted to the facility with diagnoses including dementia. 3/28/19 - An order was written for a fortified food program. 9/20/19 - The Annual Nutrition Evaluation documented that R118 was prescribed double portions at meals and was on a fortified food program for all meals for added caloric intake. The plan was to continue to monitor oral intake, skin, fluid status, and reassess nutritional status as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/4/19 12:55 PM - During a lunch observation, R118's meal ticket documented that R118 was to have a half a cup of fortified mashed potatoes, however, there were no mashed potatoes on the tray. 11/4/19 12:57 PM - An interview with E7 (CNA) confirmed that there was no half a cup of fortified mashed potatoes on the tray. 11/4/19 1:20 PM - An interview with E12 (Cook) revealed that the lunch menu did not include mashed potatoes, thus, the fortified mashed potatoes were not provided. 11/5/19 11:30 AM - An interview with E5 (LPN) revealed that it was the responsibility of the staff who was providing the meal tray to ensure that the staff check for accuracy of the meal being provided, including to ensure items on the meal ticket are on the actual tray and if there are any discrepancies, the kitchen was to be notified. 11/6/19 9:49 AM - An interview with E3 (RD) revealed that R118 was prescribed the fortified food program on 3/28/19 to provide extra calories per meal. The facility failed to have a system to ensure that R118 was provided the fortified food as ordered on 3/28/19. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 20835 Based on observation, staff interview and review of the facility policy and procedure as indicated, the facility failed to ensure that two (R46 and R74) out of three (3) residents sampled, who were fed by enteral means received the appropriate treatment and services to prevent complications. Direct care staff was observed checking placement of the gastric tube using methods no longer considered the standard of practice and the facility policy did not reflect the current standard of practice. Findings include: Review of the following current standards of practice for tube placement verification revealed that auscultation was no longer recommended: - Auscultation verification of gastric tube (feeding tube) placement solely by auscultation (listening), which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric (abdominal) region for the sound of air, is no longer recommended. (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). - Nurses should not use the auscultatory (air bolus) . (American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16). The facility's contracted pharmacy policy titled Medication Administration: Administration of Medications by Enteral Route with a revision date of 3/2014 stated, .Medication Administration .Nurse checks placement and patency by Auscultating the resident's abdomen below the sternum with a stethoscope. Gently insert 10 mL of air in the tube. You should hear the bubble entering the stomach. If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric content implies that the tube is patent and in the stomach. If no gastric content appears, the tube may be against the lining of the stomach or the tube may be obstructed . 1. 11/4/19 1:30 PM - During a medication administration observation, E10 (LPN) auscultated R74's abdomen using a stethoscope while injecting air via the syringe, but failed to aspirate gastric contents to verify tube placement before medication was administered through R74's feeding tube. 11/4/19 3:00 PM - An interview with E10 (LPN) confirmed that E10 failed to aspirate the gastric contents to ensure the tube was patent and in the stomach. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM. 20883 2. During a medication pass observation on 11/4/19 at approximately 12:40 PM, E22 (LPN) was observed administering medication via R46's feeding tube. E22 auscultated R46's abdomen using a stethoscope while injecting air with a syringe. E22 failed to aspirate gastric contents to verify placement of the feeding tube according to current standards of practice before administering the medication. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings were reviewed with E1 (NHA) and E2 (DON) on 11/6/19 at 12:30 PM.

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Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20883 Based on observation and interview, it was determined that the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. Review of three (3) out of five (5) medication carts and two (2) out of four (4) medication storage rooms revealed the presence of expired medications. Findings include: The facility's pharmacy policy and procedure titled Storage of Medications, version 2018, stated, .Expiration Dating .8. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining . 1. On 11/7/19 at 2:50 PM, the facility's Stash Room (supply of backup medications) was observed with E23 (RN). The following expired medications were found: - four (4) 12 ounce bottles of Ri-Mox Antacid/Antigas expired 10/2019; - two (2) Aspirin 325 mg (milligram) 100 count bottles expired 12/2018; - one (1) Acetaminophen (Tylenol) 500 mg 100 count bottle expired 1/2018; - eleven (11) Multivitamin with Iron 100 count bottles expired 6/2018; - one (1) Iron tablet 325 mg 100 count bottle expired 12/2018; - one (1) Diphenhydramine (used for allergic reactions) 25 mg 100 count bottle expired 3/2018; - two (2) Diphenhydramine 25 mg 100 count bottles expired 4/2019; - one (1) Vitamin C 250 mg 100 count bottle expired 2/2019; - two (2) Vitamin C 500 mg 100 count bottles expired 7/2019. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/7/19 at approximately 4:00 PM. 2. On 11/7/19 at 3:25 PM, an Ashland unit medication cart was observed with E24 (UM). The following expired medication was found: - one (1) 12 ounce bottle of Ri-Mox Antacid/Antigas expired 10/2019. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/7/19 at approximately 4:00 PM. 3. On 11/7/19 at 3:50 PM, a [NAME] unit medication cart was observed with E25 (LPN). The following was found: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a bottle of Latanoprost opthalmic solution (eye drops) was opened and did not have an opened date listed. Manufacturer's directions stated that when opened store at room temperature and discard after six (6) weeks. This finding was confirmed by E26 (UM) immediately after the observation. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/7/19 at approximately 4:00 PM.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20883 Based on clinical record reviews and interviews, it was determined that the facility failed to adequately monitor psychoactive medications for two (R89 and R112) out of five residents sampled for medication review. Findings include: An article titled Effectiveness Evaluation of a Pharmacist-Driven Monitoring Database for Tardive Dyskinesia (TD), published by the US National Library of Medicine National Institutes of Health stated, .Consensus statements from the American Psychiatric Association (APA) for monitoring of TD state that patients should be evaluated for extrapyramidal side effects and TD before initiation of any antipsychotic medication with regular follow-up monitoring after starting an antipsychotic medication .the APA recommends that patients be evaluated for TD every 6 months while receiving a FGA (first generation antipsychotic) and every 12 months while receiving a SGA (second generation antipsychotic). Those patients at high risk of developing TD, including the elderly and those having significant extrapyramidal side effects .should be examined every 3 months while receiving a FGA and every 6 months while taking a SGA . https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062734/ 1. Review of R89's clinical record revealed the following: R89 was admitted to the facility on [DATE]. 4/3/19 - An order was written for R89 to receive the antipsychotic medication Seroquel daily. 4/4/19 - An AIMS scale was completed for R89. 6/25/19 - A care plan for the potential for psychotropic drug related side effects was developed and included the intervention AIMS testing per facility protocol. The clinical record lacked evidence of any additional AIMS scales being completed. The facility failed to ensure that periodic monitoring for side effects of antipsychotics was completed for R89 according to current standards of practice. Review of the November 2019 medication administration records revealed that R89 continues to receive Seroquel daily. 11/7/19 at 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). A request was made for the facility's policy regarding AIMS monitoring, but none was provided. 2. Review of R112's clinical record revealed the following: R112 was admitted to the facility on [DATE]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/18/19 - A care plan for the potential for psychotropic drug related side effects was developed and included the intervention AIMS testing per facility protocol. 6/3/19 - An order was written for R112 to receive the antipsychotic medication Risperdal daily. 7/10/19 - An AIMS scale was completed on R112, approximately one (1) month after Risperdal was started. The facility failed to complete an initial AIMS scale when R112 was started on Risperdal on 6/3/19. 11/7/19 at 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). A request was made for the facility's policy regarding AIMS testing, but none was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40264 Based on observations and interviews, it was determined that: for 2 out of 5 medication carts observed, the facility failed to date medications appropriately; The facility failed to store and maintain drugs in accordance with acceptable professional principles in 2 of the 4 medication carts by storing oral medications in disposable paper cups inside the medication cart; and the facility failed to provide separately locked and permanently affixed compartments for storage of controlled narcotic drugs for 2 (Eastburn Wing and [NAME] Wing) out of 4 surveyed medication rooms. In addition, the facility failed to ensure that all refrigerated drugs and biologicals were stored under proper temperature controls. Findings include: 1. A. 11/7/19 at 2:45 PM - An observation of the Eastburn medication cart top drawer revealed nine opened bottles of house stock medications (for constipation, pain, sleep, and heartburn) that were undated. This finding was immediately confirmed by E5 (LPN). B. 11/7/19 at 3:23 PM - An observation of the [NAME] medication cart top drawer revealed four opened bottles of house stock medications (as above, except for heartburn tablets) that were undated. This finding was immediately confirmed by E14 (LPN). 2. 11/7/19 at 2:40 PM - E5 (LPN) unlocked the Eastburn medication cart and removed from the top drawer a prefilled disposable paper cup containing 4 tablets. When asked what the tablets were, E5 stated that they were Calcium with Vitamin D which she got from another medication cart. E5 pulled out from the med cart bottom drawer an empty bottle of Calcium with Vitamin D and poured the 4 tablets into the bottle. In addition, E5 was also observed removing from the bottom med cart drawer a plastic cup filled with cranberry juice with a straw and a couple of opened applesauce and pudding cups. These findings were immediately confirmed by E5 (LPN). 3. A. 11/7/19 at 3:00 PM - A review of the medication storage room on the Eastburn Wing revealed the locked medication refrigerator containing a bottle of Ativan (for anxiety) concentrate for R126. The bottle was positioned upright on the side shelf of the refrigerator door and was not placed inside the permanently affixed locked narcotic box. This finding was immediately confirmed by E5 (LPN). B. 11/7/19 at 3:05 PM - Further inspection of the Eastburn medication refrigerator revealed a temperature at 40 degrees Fahrenheit which was acceptable. When asked for a record of medication refrigerator temperature logs, E5 confirmed that, We do not keep a record of the temperature readings. We just check the thermometer gauge and make sure it's between 36-46 degrees Fahrenheit. There was no evidence that the Eastburn Wing staff were monitoring the medication refrigerator for proper temperature controls. C. 11/7/19 at 3:15 PM - A review of the medication storage room on the [NAME] Wing revealed the locked narcotic box was not permanently affixed in the medication refrigerator. E13 (LPN) removed the detached locked narcotic box containing Ativan liquid oral medication for R44. The finding was immediately confirmed by E13. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference on 11/7/19, at approximately 5:00 PM.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 20835 Based on observations, clinical record review, and interviews, it was determined that the facility failed to ensure that the residents received the selected food from the menu for four (R81, R98, R118, and R126) residents during a random dining observation. Findings include: 1. 10/29/19 12:53 PM - During a random dining observation, R126's lunch tray and comparison of the meal ticket (a form used by the facility in which residents check their meal selection) did not match. The resident was to receive a pureed breadstick and applesauce. 10/29/19 12:54 PM - An interview with E18 (CNA), who was feeding R126 confirmed that the lunch tray did not include the pureed breadstick or the applesauce. 2. 11/4/19 12:55 PM - During a random dining observation, R81's lunch tray and comparison of R81's meal ticket did not match. The resident was to receive Hearty Vegetable Soup and Lactaid milk, however, these items were not provided per the meal ticket. 11/4/19 12:58 PM - An interview with E7 (CNA) confirmed that the lunch tray did not include the soup and the Lactaid milk. Cross refer F692, Example #2 3. 11/4/19 1:00 PM - During random dining observation, R118's lunch tray and comparison of R118's meal ticket did not match. The resident was to receive half a cup of fortified mashed potatoes. 11/4/19 1:02 PM - An interview with E7 (CNA) confirmed that the lunch tray did not include the half a cup of fortified mashed potatoes. 11/4/19 1:20 PM - An interview with E12 (Cook) revealed that the lunch menu did not include mashed potatoes, thus, the fortified mashed potatoes was not provided. Cross refer F692, Example #1 4. 11/4/19 1:05 PM - During a random dining observation, R98's lunch tray and comparison of R98's meal ticket did not match. The resident was to receive half a cup of fortified mashed potatoes. 11/4/19 1:07 PM - An interview with E8 (CNA) confirmed that the lunch tray did not include the half a cup of fortified mashed potatoes. 11/4/19 1:20 PM - An interview with E12 (Cook) revealed that the lunch menu did not include mashed potatoes, thus, the fortified mashed potatoes were not provided. The facility failed to have a system, which ensured that residents menu's were followed. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on observation, it was determined that for 1 (one) out of 2 (two) meal test trays, the facility failed to provide food and drink that were served at appetizing temperatures. Findings include: 11/4/19 from 12 Noon to 12:19 PM - An observation on the [NAME] unit revealed that after all residents on the unit were served lunch (including the dining room and residents' rooms), the food and beverages on the meal test tray were checked for temperatures by E9 (FSD) using the facility's thermometer. The following was identified: - spaghetti was 130.6 degrees F; - green beans were 128.0 degrees F; and - carton of milk was 54.1 degrees F. Surveyors tasted the food and drink and determined that the spaghetti, green beans and milk were not served at appetizing temperatures. 11/7/19 at 6:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to provide food and drink that were served at appetizing temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36017 Based on observations and interviews, it was determined that the facility failed to ensure proper food storage, food handling, and food service worker and nursing staff personal hygiene. Findings include: 1. During the kitchen tour on 10/31/19 9:30 AM, it was observed that the reach in refrigerator gasket was not closing completely. Finding was reviewed and confirmed by E9 (FSD) on 10/31/19 at approximately 10 AM. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/6/19 at approximately 10 AM. 40264 2. An observation was made during the lunch service on 10/29/19 from 12:30 PM - 12:45 PM of E15 (Dietary Aide) resting her gloved hands on the counter in the food service area of the [NAME] Wing dining room. E15 then started moving food supplies (bags of sandwiches and dinner rolls) from the food cart. Wearing the same gloves, E15 rested her hand on the stacks of clean plates touching the food contact surface of the top most plate. E15 was next observed plating a dinner roll using the same plate from the top of the stack of plates with the same contaminated gloved hand touching the dinner roll. 3. In another observation on 10/29/19 at 12:48 PM in the food service area, E16 (Dietary Aide) was observed holding her mobile phone and placing it on the counter with gloved hands. At 12:50 PM, E16 was still wearing the same gloves, E16 was observed picking up her mobile phone from the counter and putting it in the back pocket of her pants. Without changing her gloves, E16 then plated a sandwich by touching it with gloves that were contaminated when she handled her cell phone. Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference on 11/7/19, at approximately 5:00 PM.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32545 Based on clinical record review and interview, it was determined that for two (R58 and R123) out of 67 residents sampled, the facility failed to ensure that the residents' clinical records were accurately documented. Findings include: 1. Review of R58's clinical record revealed: 8/11/19 - R58 was sent to the emergency room . She was diagnosed with a urinary tract infection (UTI) and returned to the facility the same day. 8/14/19 at 8:08 AM - A physician's note stated, .8/14/19 . readmission note/hospital record review . s/p (status post) hospitalization . H&P (History & Physical) . presented to hospital after choking episode while eating . was admitted for Aspiration pneumonitis . was seen by speech therapy during this hospitalization and started her on a dysphagia 1 diet . She had a fall on 8/11/2019 with no injury. The recent fall or injury likely exacerbated by the UTI . 8/18/19 at 1:55 PM - R58 experienced a choking incident during lunch and was sent to the hospital for evaluation and admitted . 8/25/19 - R58 was discharged from the hospital with a diagnosis of aspiration pneumonitis. The facility failed to ensure that R58's medical record was accurately documented when a physician's note/H&P, dated 8/14/19, documented a choking incident that occurred on 8/18/19. 36017 2. Review of R123's clinical record revealed: 9/23/19- A quarterly MDS assessment stated that R123 required 2+ staff person assist for bathing. R123's ADL care plan, last revised on 5/26/16 and last reviewed on 9/23/19, indicated that R123 was to be a two staff person extensive assist for bathing. Review of the CNA documentation report for bathing revealed that R123 was documented as one staff assist instead of 2+ staff assist for bathing on 10/15/19, 10/25/19, 10/20/19, and 11/3/19. The facility failed to accurately document R123's clinical record with respect to staff assistance for bathing. Findings were reviewed and confirmed by E1 (NHA) and E2 (DON) on 11/6/19 at approximately 10 AM.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 20835 Based on clinical record review and interview, it was determined that for one (R126) out of one sampled resident reviewed for hospice investigation, the facility failed to have complete and readily accessible hospice records. Findings include: 8/6/14 - Review of the written agreement between the hospice provider and the facility included, but was not limited to, the following: - .3. Responsibilities of Hospice . (e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning, and care coordination. At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility: (i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility; (ii) Election Form . (iii) Certifications. Physician certifications and recertifications of terminal illness; . 6. Records . (a) Creation and Maintenance of Records. Each party shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Facility Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines .Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluation, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party . Review of R126's clinical record revealed: 9/1/17 - R126 was admitted to the facility with diagnoses including dementia. 11/5/19 - Review of R126 's hospice binder located in the nurse's station lacked evidence of the following: - The most recent hospice plan of care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hospice election form. - Physician certification and recertification of the terminal illness specific to R126. - Names and contact information for hospice personnel involved in R126's hospice care. - Hospice physician's notes. 11/5/19 11:45 AM - A telephone interview with HOS1 (Hospice RN, Team Director) revealed that R126 was admitted to hospice on 9/10/19. The surveyor advised HOS1 about the lack of hospice documentation and HOS1 verbalized that the hospice agency would fax the necessary documentation to the facility today, 11/5/19. 11/5/19 2:30 PM - During an interview with E2 (DON), E2 confirmed that all of the hospice documentation was not in the hospice binder, including the Hospice Election Form, the Physician Certification and Recertifications of terminal illness, and the hospice's physician's note. E2 verbalized that the facility will obtain these records from the hospice agency. 11/6/19 9:20 AM - The Surveyor was provided the following information: - The most recent IDT Care Plans (3): Dates ranging from 9/16/19 through 11/5/19. - Certification/Recertification of Terminal Illness and Physician Narrative and the Provider Visit Note dated 9/26/19. - Hospice Provider Visit Notes dated 9/18/19 and 10/30/19. - Nurse Visit Notes (8 visits): From 9/12/19 to 11/2/19. - HHA Supervisory Assessment (5 visits): From 9/19/19 through 10/28/19. The facility failed to ensure that R126's hospice records were complete and readily accessible. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 11/7/19 at 6:15 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 20883 Based on observations, record review, interview and review of facility policies, it was determined that the facility failed to 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. Observations of facility staff revealed deficient practices in the areas of disinfection of glucometers, hand hygiene, and cleaning of resident equipment. Additionally, the facility failed to ensure that monthly surveillance data was reviewed, analyzed and acted upon if indicated, and that the door between the clean and dirty side of the laundry was closed. Findings include: The facility's Infection Control policy, dated 8/2015, stated, .Guidelines 1. The facility assures there is an infection control program that is effective for investigating, controlling, and preventing infections. This facility will assign an infection control coordinator to collect data, monitor, analyze and make recommendations. This data will be submitted to the QI (Quality Improvement) committee monthly. 2. The facility will prevent the spread of infection via procedures in the infection control manual .4. Surveillance data shall be routinely reviewed and recommendations made for the prevention and control of additional cases .c. Maintains a record of incidents and corrective actions related to infections .h. Infection rates and analysis will be submitted to the quality assurance/improvement committee meetings monthly .6. Staff, including direct care . use gloves and other equipment, as necessary, in accord with clean principles. 7. Procedures will be followed to prevent cross-contamination: handwashing, changing of gloves, or when performing tasks where cross contamination may occur .9. The facility shall follow the CDC's (Centers for Disease Control and Prevention) Guidelines .12. The facility establishes protocols for handling linens on the resident care floors and in the laundry area to prevent the spread of infection . The facility's policy Handwashing, dated 8/2015, stated, .Wash hands whenever they are soiled with body substances .when each resident's care is completed, and whenever gloves are changed . The facility's policy for Blood Sampling-Capillary (Finger Sticks), dated 9/2014, stated, .Equipment and Supplies .6. Approved EPA (Environmental Protection Agency) registered disinfectant for cleaning of sampling device .General Guidelines 1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .Steps in the Procedure 1. Wash hands. 2. Don gloves .6. Obtain the blood sample .8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. 9. Remove gloves .10. Wash hands . The manufacturer's instructions Cleaning and Disinfecting the Assure Prism multi Blood Glucose Monitoring System stated, To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions .The meter should be cleaned and disinfected after use on each patient .Environmental Protection Agency (EPA) registered disinfectant product may be used to clean and disinfect the blood glucose meter. The disinfectant wipes listed .have been shown to be safe for use with this meter. Please read the manufacturer's instructions before using their wipes on the meter .Super Sani-Cloth Germicidal Disposable wipe . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The facility's surveillance data from January 2019 through October 2019 revealed that the facility completed monthly line listings of infections including data regarding type of organisms, signs and symptoms, sites of infection and treatments used. However, the facility failed to have documented evidence of ongoing review, analysis and interpretation of surveillance data and no evidence of any follow up activity in response to the data collected. 11/6/19 12:30 PM - During an interview, E2 (DON) stated that she was not able to locate any monthly analysis information. 2. 11/1/19 from 7:55 AM through 8:30 AM - The following was observed during medication pass observation with E21 (LPN): - E21 pulled a vial of liquid Morphine Sulfate (MSO4) from the medication cart to administer to R10 for pain. E21 entered the room, applied gloves, drew up the appropriate amount of medication in the syringe and administered it to R10 sublingually (under the tongue). E21 discarded the gloves, left the room and placed the MSO4 back into the medication cart. E21 did not wash her hands or use a hand sanitizer; - E21 then pulled an insulin pen for R34 from the medication cart. E21 also pulled out a blood glucose meter to check R34's blood sugar level. Upon entering R34's room, E21 gloved, completed the blood glucose testing, adjusted the insulin pen to the correct dose and administered the insulin to R34's right upper extremity. E21 returned to the medication cart, used an alcohol wipe to clean off the glucometer and discarded her gloves. E21 did not wash her hands or use a hand sanitizer; - E21 pulled an insulin vial and the glucometer from the medication cart and proceeded to R19's room. The surveyor then questioned E21 about the disinfection of the glucometer between resident use. E21 confirmed she used an alcohol wipe to clean the glucometer. E21 was instructed to check with E24 (Unit Manager) regarding the disinfection of the glucometer. E21 discarded her gloves and went to E24, who told E21 she needed to use the Sani-Cloth Wipes. The surveyor informed E24 that an alcohol wipe was used. E21 proceeded back to R19's room where she gloved and cleaned the glucometer with a Sani-Cloth Wipe. Immediately after cleaning the glucometer, E21 picked it up to begin testing of R19's blood sugar. The surveyor asked E21 if she had read the instructions on the wipe? E21 stated that she had not and she proceeded to do so. Upon reading the instructions, E21 found that the glucometer needed to be wiped thoroughly and allowed to air dry for two (2) minutes in order to be effective. E21 then rewiped the glucometer with a Sani-Cloth Wipe, waited the required amount of time, completed R19's blood glucose testing, drew up R19's insulin and administered it in his abdomen. E21 returned to the medication cart where she disinfected the glucometer with a Sani-Cloth Wipe. E21 discarded her gloves, but again did not wash her hands or use hand sanitizer; - E21 then proceeded to pull medication for R131, which was pre-poured, from the medication cart and a tympanic (ear) thermometer. E21 gloved and administered R131's medication and took her temperature. Upon return to the medication cart, E21 disinfected the thermometer with a Sani-Cloth Wipe and discarded her gloves. E21 did not wash her hands or use hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Findings were reviewed with E21 immediately afterwards regarding the lack of proper disinfection of the glucometer and the lack of hand washing and/or use of hand sanitizer. E21 stated that she had worn gloves. 11/6/19 at approximately 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 3. 11/7/19 11:25 AM - Observation of the facility's laundry room with E34 (Housekeeping Manager) revealed that the door separating the dirty and clean sides was propped open. This deficient practice allowed contamination from the dirty to the clean side of the laundry room. Interview with E34 immediately after confirmed that the door should remain closed at all times. 11/6/19 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 32545 4. During a medication pass observation on 11/4/19 at approximately 5:05 PM, E25 (LPN) was observed washing his hands and then exited the bathroom holding the paper towels that he used to dry his hands as there was no trash can in the bathroom. E25 was observed touching the inside of the clear plastic trash bag with his clean bare hands. 5. During a medication pass observation on 11/4/19 at 5:47 PM, E25 (LPN) was observed cleaning R9's nebulizer medicine cup with 2 tissues and then immediately placing R9's nebulizer medicine cup in a plastic bag. The plastic bag was then placed in R9's bedside drawer. According to the American Lung Association's website, last updated 4/12/19, under How to clean a nebulizer, it stated, . Cleaning your nebulizer is important to prevent the spread of germs and keep you from getting sick . It is recommended to wash the parts of your nebulizer after each use .medicine cup . wash the medicine cup . in warm soapy water and rinse. Shake off the excess water and let the (medicine cup) air-dry in a cool, dry place until the next use . 11/7/19 at 2:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure infection prevention and control practices were followed during a medication administration observation on 11/4/19.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 20883 Based on record reviews, interview and review of facility policy, it was determined that the facility failed to ensure the appropriate use of antibiotics for three (R42) out of eight (8) residents reviewed for facility infection control practices, specifically in the area of antibiotic stewardship. Findings include: The facility's policy titled Antibiotic Use Policy, last reviewed 2/5/19, stated, .2. Providers will utilize the McGeer Criteria for Long Term Care surveillance Definitions of Infection when considering initiation of antibiotics, documenting their findings in the medical record (i.e. signs and symptoms of infection present/absent, decision to initiate antibiotics despite resident not meeting criteria) .5. Do not treat colonized bacteria (Asymptomatic Bacteriuria [presence of bacteria in urine]) with antibiotics .8. 48-72 hours after antibiotic initiation or first dose in the facility, the Time Out Protocol will be implemented, where the resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential. Laboratory testing results, response to therapy, resident condition, and facility needs will be considered. Completion of an antibiotic time-out must be recorded in the resident's chart .10. Providers will decrease their use of fluoroquinolones (class of antibiotics approved to treat or prevent certain bacterial infections) to treat UTIs (Urinary Tract Infections) in response to current concerns that include the emergence of bacterial resistance . The facility's Surveillance Definitions for Urinary Tract Infections, reviewed 1/1/19, stated, For residents WITHOUT an indwelling catheter (both criteria 1 and 2 must be present): 1. At least one of the following sign or symptom subcriteria: - Acute (sudden onset) dysuria (painful or difficult urination) or acute pain .; - Fever or leukocytosis (increase in white blood cells indicating infection) And at least one of the following localizing urinary tract subcriteria: - Acute costovertebral angle (located on your back at the bottom of your ribcage at the 12th rib; the 90-degree angle formed between the curve of that rib and your spine) pain or tenderness; - Suprapubic (area above the pubic bone) pain; - Gross hematuria (blood in the urine that can be seen with the naked eye); - New or marked increase in incontinence (lack of bladder control); - New or marked increase in urgency; - New or marked increase in frequency. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the absence of fever or leukocytosis, then two or more of the following localizing urinary tract subcriteria: - Suprapubic pain; - Gross hematuria; - New or marked increase in incontinence; - New or marked increase in urgency; - New or marked increase in frequency. 2. One of the following: - At least 105 (100,000) cfu/ml (colony forming units per milliliter of urine) of no more than two species of microorganisms in voided urine sample; - At least 102 (100) cfu/ml of any number of organisms in a specimen collected by in-and-out catheter. 1. Review of R112's clinical record revealed the following: 3/23/19 - R112 was admitted to the facility with a diagnosis of Alzheimer's disease. 3/23/19 7 PM through 3/27/19 4:15 PM - Review of nurse's progress notes revealed that R112 had no fevers, no complaints of pain or burning with urination, no odor or blood in the urine. The progress notes also stated that R112 was continent of bladder (had full control). 3/23/19 through 3/27/19 - Review of the CNA Documentation Survey Report revealed documentation under Bladder Continence that R112 was incontinent (lack of bladder control) of urine on 3/25/19 11PM -7 AM shift and on 3/27/19 on the 11PM to 7 AM and 7 AM to 3 PM shifts. Documentation on all other shifts noted that R112 was continent of urine. Further review of the CNA Documentation Survey Report revealed additional documentation under Bowel & Bladder Diary that stated R112 was incontinent of urine on the following shifts, despite prior documentation to the contrary: 3/24/19 through 3/27/19 on the 7 AM to 3 PM shift and on 3/26/19 on the 11 PM to 7 AM shift. 3/26/19 - The physician's history and physical stated, .Has had some recent urinary incontinence, unusual for her .Check UA (urinalysis), C&S (culture and sensitivity) due to incontinence . 3/28/19 through 4/1/19 - Review of nurse's progress notes revealed that R112 had no fevers, no complaints of pain or burning with urination, no odor or blood in the urine. The progress notes also stated that R112 was continent of bladder. 3/28/19 through 3/31/19 - Review of the CNA Documentation Survey Report revealed that R112 was incontinent of bladder on 3/31/19 on the 3 PM to 11 PM shift. All other shifts noted R112 was continent. 4/1/19 - The final laboratory report for the UA and C&S revealed that the colony count was 50,000. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/1/19 6:13 PM - A nurse's progress note stated, U/A (urinalysis) cult (culture) results called in .Col (colony) count 50,000 .No new orders at this time .NP working with Dr. (doctor) will consult Dr. Dr will call back if they want resident treated but lab (laboratory) values not indicating treatment at this time. 4/2/19 - A physician's progress note stated, .Some frequency .Dementia with likely UTI .Bactrim x (times) 5 days . 4/2/19 10:24 AM - A nurse's progress note stated there was a new order to start R112 on an antibiotic for UTI. The note also stated No c/o (complaint of) pain on urination, frequency or foul urine odor reported so far. 4/2/19 - A physician's order stated for R112 to receive Sulfamethoxazole-Trimethoprim (Bactrim-antibiotic) tablet 800-160 milligram twice a day for 5 days for UTI. 4/2/19 through 4/6/19 - Review of nurse's progress notes revealed that throughout the course of the antibiotic treatment, R112 had no fevers or complaints of painful urination, frequency or odor. The nurse's notes now stated that R112 remains incontinent. The facility failed to ensure that their policy regarding the prescribing of antibiotics was followed. R112 failed to meet the criteria for antibiotic treatment of a urinary tract infection. Additionally, the facility failed to implement their Time Out protocol and failed to reassess R112 for the continued need of the antibiotic after 48-72 hours of starting the antibiotic. 11/6/19 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 2. Review of R81's clinical record revealed the following: 4/6/18 - R81 was admitted to the facility with diagnoses that included dementia and overactive bladder. R81 had a history of urinary tract infections. 8/21/19 - Review of the medication administration record revealed R81 was receiving Hiprex (antibiotic) twice a day for UTI prophylaxis. 9/30/19 3:10 PM - A nurse's note stated R81 was seen by the doctor for restlessness and irritability and there were no new orders. The note also stated the resident occasionally complained of burning during toileting. 9/30/19 3:59 PM - A nurse's note stated R81 was seen by the doctor and when questioned about burning during toileting, she only complained of leg pain. 10/1/19 - A progress note completed by the NP stated, .Nursing reports patient with change in behavior .past medical history for recurrent UTI .Nursing denies any fevers .Will order UA C&S to rule out UTI. Continue . Hiprex for UTI prophylaxis . 10/3/19 - The final report of a urine culture colony count stated, .Colony Count: < (less than) 10,000 Negative (no) bacteriuria . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/3/19 9:26 PM - A nurse's note stated R81's temperature was 99.2 F (Farenheit/ normal 98.6). 10/3/19 9:33 PM - A nurse's note stated the NP was notified of the negative urine results and there were no new orders. 10/4/19 3:26 PM - A nurse's note stated R81 continued to display general malaise and had a temperature of 99.5 F. 10/5/19 6:26 PM - A nurse's note stated R81 was seen by the physician and an order was written for the resident to receive Levaquin (a fluoroquinolone antibiotic) daily for 5 days for UTI prophylaxis. R81 continued to receive the Hiprex as previously ordered. 10/5/19 6:18 AM through 10/9/19 3:04 PM - Review of nurse's notes revealed R81 was voiding without pain, burning or difficulty, her urine was clear and she had no fevers. 10/8/19 - A progress note completed by the NP stated, .Nursing staff reports patient has been having hallucinations. She was just recently checked for UTI which was negative .Urinalysis with less than 10,000 colony count . The facility failed to ensure that their policy regarding the prescribing of antibiotics was followed. R81 failed to meet the criteria for antibiotic treatment of a urinary tract infection and the facility failed to implement their Time Out protocol and failed to reassess R81 for the continued need of the antibiotic after 48-72 hours of starting the antibiotic. Additionally, there was no physician documentation found in R81's clinical record regarding their findings in the medical record pertaining to signs and symptoms of infection present/absent, and the decision to initiate antibiotics despite the resident not meeting criteria. The facility also administered Levaquin, a fluoroquinolone antibiotic, despite their policy that providers will decrease their use of fluoroquinolones to treat UTIs in response to current concerns that include the emergence of bacterial resistance. 11/6/19 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 3. Review of R416's clinical record revealed the following: 9/25/19 - R416 was admitted to the facility. The clinical record stated R416 had no known drug allergies. 10/11/19 - A final laboratory report for R416's urine culture revealed a colony count of greater than 100,000. The organism susceptibility report, which identifies which antibiotics are effective against the bacteria identified in the culture, listed several oral antibiotics as being effective. 10/11/19 - An order was written for R416 to receive the fluoroquinolone antibiotic Ciproflaxin every 12 hours for 7 days for a UTI. The facility failed to implement their Antibiotic Use Policy for providers to decrease use of fluoroquinolones to treat UTIs in response to current concerns that include the emergence of bacterial resistance. 11/6/19 12:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON).