| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 085015 | A. Building<br>B. Wing | 05/03/2019 |

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| Seaford Center | 1100 Norman Eskridge Highway<br>Seaford, DE 19973 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>35205<br><br>Based on record review, observation and interview it was determined that the facility failed to honor preferences for two (R16 and R60) out of 23 active residents sampled for investigations. Findings include:<br><br>1. Review of R16's clinical record revealed:<br><br>10/27/16 - The care plan for requires assistance / is dependent for ADL care included the goal that R16's ADL care needs would be anticipated and met. Review of the interventions did not include anything about getting out of bed to the chair.<br><br>10/26/18 - The Quarterly MDS Assessment documented that R16 was totally dependent with two staff for transfer in and out of bed.<br><br>3/27/19 - A care plan meeting note documented up in the Gerry (Geri) Chair every day for 2 hrs (hours). 1400 to 1600 hrs (2:00 PM to 4:00 PM). The evaluation included that R16 was gotten up daily with complete assist of 2 CNA's with (name of mechanical lift).<br><br>April 2019 - Review of R16's current orders lacked an activity order for being out of bed.<br><br>April 2019 - Review of R16's current CNA tasks / documentation and Kardex showed the entry of OOB (out of bed) to reclining chair, seating and positioning . Under the time column was every shift (every shift) without a specific time frame.<br><br>4/26/19 - An Annual MDS Assessment documented that R16 was totally dependent on two staff for transfer out of bed into the chair.<br><br>4/29/19 (10:30 AM) - R16's mother was observed visiting at the bedside.<br><br>4/29/19 (2:35 PM and 3:45 PM) - Observed R16 in bed and not in the chair. R16's mother was no longer visiting at the bedside.<br><br>April 2019 - Review of CNA documentation revealed that R16 was not gotten out of bed daily and was not out of the facility. R16 was up in the chair 40% (12 out of 30 days) in April.<br><br>(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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5/1/9 (2:20 PM and 3:10 PM) - Observed R16 in bed and not in the chair.<br><br>5/2/19 (8:55 AM) - During an interview with E2 (DON) to discuss the frequency and timing for R16 to be out of bed, E2 said, We get (R16) up around two (2:00 PM) for day shift, then (R16) is up into evening shift. R16's mother wants R16 out of bed daily. The surveyor mentioned that the Kardex, CNA tasks, and care plan did not delineate a time and that R16 was observed being in bed for two afternoons recently. E2 commented that when R16 was out of the facility for appointments, he/she may not be gotten out of bed in the afternoon.<br><br>5/2/19 - Review of April 2019 nursing progress notes revealed that R16 was not out of the facility on days that R16 remained in bed.<br><br>2. Review of R60's clinical record revealed:<br><br>3/15/19 - A care plan for routines that are meaningful included an the intervention I like to snack between meals and prefer water and apple juice.<br><br>3/17/19 - The Nutritional Assessment identified that R60 required nectar thick liquids in order to drink safely and likes to drink water and apple juice.<br><br>4/24/19 - Review of the current Kardex listed Encourage resident to consume all fluids of choice _____ during meals. The space was blank and did not list R60's preference. The statement I like to snack between meals and prefer water and apple juice was also written on the Kardex.<br><br>4/24/19 (12:30 PM) - During lunch observation R60 was served a cup of apple juice and a cup of cranberry juice. F1 (R60's spouse) was at the bedside and informed the CNA serving the juice that R60 would not drink cranberry juice and asked for thickened water instead. F1 expressed to the surveyor that he/she wanted either two apple juices, two waters, or one of each and stated that he/she had informed the facility previously of R60's juice preference.<br><br>4/26/19 (9:00 AM) - During breakfast observation a cup of cranberry juice and a cup of liquid supplement was sitting on R60's bedside table prior to being fed the meal.<br><br>4/29/19 (12:55 PM) - During an interview with F1 (R60's spouse) it was stated that they tried to serve cranberry juice again at lunch . I asked for water.<br><br>4/30/19 (8:50 AM) - The interview with E3 (RN, UM) to inform of the observations of R60 being served cranberry juice, E3 stated he/she would add it to allergies so it appears at the top of the eMAR for the nurses and add it to tasks for CNAs to see. At 9:12 AM, E3 informed and showed the surveyor the inclusion of cranberry juice under allergies, on the CNA tasks, and within R60's dehydration care plan.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0606<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not hire anyone with a finding of abuse, neglect, exploitation, or theft.<br><br>35205<br><br>Based on interview and review of other facility documentation it was determined that the facility failed to ensure that abuse registries were checked and histories were investigated prior to employment for one (E12) out of 16 sampled employees. Findings include:<br><br>Review of the facility policy entitled Abuse Prohibition (last revised 7/1/18) included that the center will not employ or otherwise engage individuals who have been found guilty by a court of law of abuse, neglect, exploitation, misappropriation of property, or mistreatment or have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of others or misappropriation of property or have had disciplinary action in effect against his/her professional license by a state licensure body<br><br>Review of the State Agency's personnel audit sheet completed by E29 (Human Resources) revealed:<br><br>E12's (RD) first day in the facility was 10/16/18 and the adult abuse registry and fingerprint clearance did not occur within the State Agency electronic background check system until 4/23/19. The child abuse registry check occurred on 4/3/19, approximately 6 months after employment began.<br><br>This finding was reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference starting at 11:15 AM. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>35205<br><br>Based on record review and interview it was determined, that for two (R9 and R16) out of two residents sampled for abuse or neglect, the facility failed to identify and immediately report allegations of neglect or abuse. Findings include:<br><br>Facility policy entitled Abuse Prohibition policy (revised 7/1/18) defined abuse as the willful infliction of injury . with resulting physical harm, injury . Neglect was defined as the failure of the center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish or emotional distress .<br><br>- Prevention actions include identifying, correcting and intervening in situations in which abuse, neglect and/or misappropriation of patient property is more likely to occur .<br><br>- Staff will identify events - such as suspicious bruising of patients .<br><br>- Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property, is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately.<br><br>- The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation.<br><br>1. Review of R16's clinical record revealed:<br><br>10/28/16 - A care plan problem for potential for skin breakdown included the intervention to turn and/or reposition and check skin every 2 hours or as specified by the plan of care.<br><br>4/26/19 - The Annual MDS Assessment identified R16 as being totally dependent on two staff for repositioning in bed.<br><br>5/2/19 (8:40 AM) - While reviewing R16's combined progress notes and eMAR notes the following comments were written by E16 (LPN) under the eMAR entry Turn and Reposition every 2 hours .and document which side patient is on .:<br><br>- 4/12/19 (8:43 PM): resident was not turned.<br><br>- 416/19 (8:24 PM): was not turn (sic).<br><br>- 4/17/19 (8:33 PM): Resident was not turn (sic).<br><br>- 4/20/19 (8:30 PM): was not turned.<br><br>- 4/26/19 (6:15 PM): not turned.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 4/30/19 (6:00 PM): was not turned.<br><br>- 4/30/19 (10:20 PM): Aid (sic) stated that she can not turn (R16) by (him/herself) so (he/she) did not turn (R16).<br><br>- 5/1/19 (6:44 PM): was not turned.<br><br>- 5/1/19 (10:38 PM): CNA stated that (he/she) will not turn resident.<br><br>5/2/19 (8:50 AM) - During an interview E2 (DON) revealed the allegation of neglect found among eMAR notes was not reported to administration.<br><br>5/2/18 (1:35 PM) - During a follow-up interview with E2 (DON), E2 stated the facility was investigating the allegation of neglect and had already reported it to the State Agency.<br><br>5/2 (3:08 PM) - During an interview E2 (DON), provided the surveyor with copies of employee statements and investigation documents and E2 stated that E16 (LPN) received a final written disciplinary warning and that I will terminate the aide tomorrow. It was revealed that the aide was hired through an agency providing temporary staff. Review of investigation documents found that E16 (LPN) admitted to not informing anyone that R16 was not turned. E21 (CNA) indicated that all the other aides were busy and that E16 told me 'her back' when I asked if he/she was going to help me.<br><br>35959<br><br>2. Review of R9's clinical records revealed:<br><br>11/4/18 - A Skin Check Assessment was completed for R9. No injury/wound found.<br><br>11/10/18 7:19 AM - A progress note revealed that at 7:00 AM the resident agreed to be sent to emergency room . R9 was sent to the hospital by ambulance at 7:20 AM.<br><br>11/10/18 7:35 AM - Hospital Discharge Documentation (provided to facility from the hospital) listed, under History of Present Illness, that R9 presented with bruising to both sides of the neck which raised concerns. These could be finger marks. Hospital Discharge Documentation also lists Neck: Supple, there appear to be bilateral bruising at the base of the patients neck as if (R9) was grabbed by the neck.<br><br>11/13/18 1:32 PM - A Progress note documented that R9 was readmitted to facility. The reason for admission to the hospital was an UTI.<br><br>11/13/18 - A Skin Check Assessment was completed for R9. A skin injury/wound was identified. The skin injury/wound was documented as not being a new concern and detailed as being discoloration on chest area. No previous Skin Check Assessments described this skin injury/wound.<br><br>4/25/19 - All Allegations of Abuse investigations were requested for the previous 6 months. There were no investigations for R9.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5/1/19 12:49 PM - An interview with E2 (DON) revealed that a call was received from the hospital regarding the allegations and the caller informed the facility that the findings were being reported to the State Survey Agency. R2 stated that an investigation was completed by the facility.<br><br>5/1/19 1:10 PM - The facility's folder on this incident included R9's face sheet, skin check assessments, progress notes surrounding the incident and several witness statements from witnesses present when R9 was discharged to the hospital.<br><br>5/2/19 2:11 PM - During an interview, E2 (DON) explained that the emergency room nurse called as a courtesy and told the facility's charge nurse that a concern was being reported regarding R9 because it looked like someone strangled her. Later, R9's family member mentioned the concern of the ambulance and hospital staff, as well. E2 revealed that the statements were gathered to determine if there was an incident, such as a fall, that E2 was unaware of, that could have caused the markings. E2 stated that this situation was never considered an allegation of abuse as R9 frequently had such markings on R9's body due to behaviors, therefore, the facility was sure that abuse did not occur. E2 stated that since this occurred outside the facility and was already being reported to the State E2 was unaware that the facility was still required to report to the state agency as well.<br><br>The facility failed to identify and immediately report R9's possible allegation of abuse after being notified by the hospital of suspicious bruising and the concerns noted twice in the hospital's discharge documentation regarding possible strangulation.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35205<br><br>Based on record review and interview it was determined that, for three (R70, R96 and R9) out of four residents reviewed for hospitalization , the facility failed to provide written bed hold information to the resident/responsible party when the residents were transferred to the hospital. Findings include:<br><br>1. Review of R70's clinical record revealed:<br><br>R70 was hospitalized [DATE], 1/23/19 and 4/24/19.<br><br>12/4/18 - There was no evidence that the responsible party (RP) was notified of the bed hold as the RP copy of the notice remained in the chart.<br><br>4/24/19 - There was no evidence of bed hold notification to the resident and RP since the resident and RP copies remained in the chart.<br><br>4/30/19 (9:30 AM) - An interview with E30 (Unit Clerk) confirmed the resident and/or RP copies of the bed hold notice were in the chart.<br><br>5/1/19 (8:10 AM) - During an interview with E15 (Billing) about the process for bed hold notification to the family, E15 stated my assistant does it. After the surveyor explained about the copies in the chart, E15 added, If we did not get the copies, then they were not mailed.<br><br>2. Review of R96's clinical record revealed:<br><br>R96 was hospitalized on [DATE]. There was no evidence in the chart that the responsible party (RP) was provided a bed hold notice.<br><br>5/2/19 (3:20 PM) - During an interview with E1 (NHA) it was confirmed that the bed hold (notice) was not able to be located.<br><br>35959<br><br>3. Review of R9's clinical record revealed:<br><br>11/10/18 7:19 AM - A progress note revealed that R9 was sent via ambulance to the hospital.<br><br>5/1/19 3:30 PM - E2 (DON) revealed that the notice of bed hold policy would have been handled by an employee whom is no longer with the facility.<br><br>5/2/19 at 12:10 PM - E1 (NHA) was asked for the bed hold notice for R9's November 2018 hospitalization .<br><br>There was no evidence that R9 received a bed hold notice when hospitalized on [DATE].<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>20835<br><br>Based on record review and interview, it was determined that the facility failed to ensure that the MDS assessment's accurately reflected the resident's status for six (R6, R13, R41, R60, R85 and R196) out of 23 sampled residents. Findings include:<br><br>Cross refer F791<br><br>1. Review of R41's clinical records revealed:<br><br>11/18/16 - R41 was admitted to the facility.<br><br>2/24/19 - A Nutrition Assessment documented that R41 had both upper and lower dentures. R41 reported that the lower denture fit poorly and R41 was selective of meats he/she consumed.<br><br>2/27/19 - The Quarterly MDS assessment incorrectly documented that R41 did not have any issues with broken or loose fitting dentures.<br><br>5/2/19 at approximately 12:45 PM - During a meal observation, R41 verbalized to the surveyor that R41 had problems chewing due to a poor fitting lower denture.<br><br>5/2/19 at approximately 2:15 PM - An interview with E6 (RNAC) confirmed that the facility failed to accurately document the poor fitting denture in the 2/27/19 MDS assessment.<br><br>35205<br><br>2. Review of R60's clinical record revealed:<br><br>3/12/19 - R60 was admitted to the facility from another nursing facility to be closer to family.<br><br>3/15/19 - Physicians' orders discontinued the antipsychotic medication scheduled to be given at bedtime.<br><br>3/19/19 - The Admission MDS Assessment documented that R60 received the antipsychotic every day during the seven-day look back period.<br><br>March, 2018 - Review of the eMAR revealed that R60 received the antipsychotic medication only three days before it was discontinued.<br><br>5/1/19 (11:13 AM) - An interview with E5 (RNAC) confirmed that he/she corrected the error.<br><br>3. Review of R6's clinical record revealed:<br><br>10/27/16 - R6 was admitted to the facility with multiple diagnoses including hemiplegia (weakness on one side of the body) after a stroke.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9/1/16 - The physicians' orders included iron to be given by mouth for iron deficient anemia.<br><br>12/5/18 - R6's weight was documented as 202.6 pounds.<br><br>1/18/19 - The Annual MDS Assessment included paraplegia (weakness from the waist down) among the diagnoses, but did not include anemia. R6's weight was recorded as 130 pounds. R6 did not have paraplegia and weighed over 70 pounds more than what was coded.<br><br>5/1/19 (11:13 AM) - An interview with E5 (RNAC) confirmed the errors. E5 stated the diagnosis of paraplegia was removed, anemia was added and the weight was changed in the modification of the assessment.<br><br>4. Review of R13's clinical record revealed:<br><br>10/26/18 - The Quarterly MDS Assessment included that R13 was continent of urine.<br><br>October 2018 - Review of CNA documentation showed that R13 experienced an incontinent episode on the night shift on October 26.<br><br>5/1/19 (11:13 AM) - An interview with E5 (RNAC) confirmed the incontinent episode. E5 stated that it did not auto-populate into the MDS, and made the correction.<br><br>5. Review of R196's clinical record revealed:<br><br>4/13/19 - The admission nursing assessment did not include any information about R196's pneumonia or influenza vaccination status.<br><br>4/20/19 - The Admission MDS Assessment documented that the historical administration of pneumonia and influenza vaccines was coded as not assessed.<br><br>4/29/19 (approximately 4:10 PM) - During an interview with E1 (DON) it was discovered that the consent forms were completed in the chart showing that R196 received the influenza vaccine in October 2018 and historically (undated) received the pneumonia vaccination.<br><br>5/1/19 (11:13 AM) - During an interview with E5 (RNAC), E5 confirmed the error and stated he/she made the modification.<br><br>35959<br><br>6. Review of R85's clinical records revealed:<br><br>3/29/19 - R85 was admitted to the facility.<br><br>3/29/19 - A Care Plan was initiated for Resident/patient exhibits or is at risk for distressed / fluctuating mood symptoms related to: Anxiety.<br><br>The following medication orders were written for R85:<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3/29/19 - 4/5/19 - Amitriptyline at bedtime for depression.<br><br>3/29/19 - 4/2/19 - Alprazolam three times a day for anxiety.<br><br>4/2/19 - 4/5/19 - Alprazolam every 8 hours as needed for anxiety.<br><br>4/4/19 - Clonazepam two times a day for anxiety.<br><br>4/5/19 - The Admission MDS Assessment did not include anxiety or depression as active diagnoses.<br><br>4/12/19 - A Change of Therapy MDS Assessment also did not include the diagnoses of anxiety or depression.<br><br>5/1/19 11:13 AM - During an interview E5 (RN) confirmed that R85 had both diagnoses and stated that corrections were made to both MDS Assessments.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>20835<br><br>Based on record review and interview, it was determined that the facility failed to develop and develop a comprehensive person-centered care plan for three (R41, R63 and R70) out of 23 sampled residents. Findings include:<br><br>Cross refer F641, example #1<br><br>Cross refer F791<br><br>1. Review of R41's clinical records revealed:<br><br>11/18/16 - R41 was admitted to the facility.<br><br>2/24/19 - A Nutrition Assessment documented that R41 had both upper and lower dentures. R41 reported that the lower denture fit poorly and R41 was selective of meats she/he consumed.<br><br>2/27/19 - The Quarterly MDS assessment incorrectly documented that R41 did not have any issues with a broken or loose fitting denture.<br><br>5/2/19 At approximately 2:15 PM - an interview with E6 (RNAC) confirmed that the facility failed to develop and implement a care plan for poor fitting lower denture and subsequently that R41 required her/his meat to be ground.<br><br>32810<br><br>The facility policy entitled Pain Management, last updated on 8/21/18, indicated the following:<br><br>An individualized interdisciplinary care plan will be developed and include: addressing and treating underlying causes of pain to the extent possible; non pharm (pharmacological) and pharm approaches using specific strategies for preventing or minimizing different levels or sources of pain or pain related symptoms.<br><br>2. Review of R63's clinical records revealed:<br><br>3/16/19 - A quarterly MDS Assessment documented that R63 received PRN pain medication and non-pharmalogical interventions for frequent pain.<br><br>Review of R63's care plans revealed the absence of a care plan for pain managment.<br><br>During an interview on 5/2/19 at 11:18 AM, E4 (RN, UM) confirmed that R63 did not have a care plan for pain managment.<br><br>35205<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Cross Refer F695, Example 2<br><br>3. Review of R70's clinical record revealed:<br><br>3/22/18 - R70 was admitted to the facility with hemiplegia, dysphagia, aphasia and tube feeding from multiple strokes, as well as diabetes.<br><br>3/23/18 - R70's care plan for enteral tube feeding included the intervention to provide mouth care every shift and PRN.<br><br>6/26/18 - R70 had a physicians' order for a mouth rinse that destroys germs to be used twice a day and spit out.<br><br>December 2018 - April 2019 - Nursing progress and eMAR notes revealed multiple factors placing R70 at increased risk for infection from aspiration (fluid / food entering lungs):<br><br>- Diagnosis of dysphagia (when swallowing something in the mouth, a portion enters lungs).<br><br>- Dependent on staff for oral care to keep mouth clean.<br><br>- Received PRN medication to reduce oral secretions (Levsin): December 20 times; January 6 times; February 20 times; March 19 times; and April 6 times.<br><br>- Vomiting: 2/1/19 and 4/14/19.<br><br>- hospitalization for increased oral secretions/respiratory distress: 12/4/18, 1/23/19 and 4/24/19. Two of these admissions to the hospital (1/23/19 and 4/24/19) were to treat sepsis from suspected / probable aspiration pneumonia.<br><br>There was no care plan for the risk of infection due to aspiration.<br><br>5/1/19 (approximately 4:10 PM) - During an interview E2 (DON) confirmed that R70 did not have a care plan for the being at risk for infection due to aspiration.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>35205<br><br>Based on record review, observation and interview it was determined that the facility failed to revise the care plan for one (R13) out of 23 sampled residents. Findings include:<br><br>Review of R13's clinical record revealed:<br><br>3/3/17 - R13's care plan for fall risk related to placing self on floor (last revised 2/13/19) had a goal that R13 would have no falls with injury. Interventions included: Encourage non skid socks; Dycem (anti-slip material) in wheelchair; Low bed; Call light in reach; Remind to use the call light; Personal items in reach; Monitor /assist with toileting; and Chair/bed alarm.<br><br>6/15/17 - The care plan for Behaviors safety hazard - throwing self on the floor . included the interventions: Psychiatric evaluation; Provide calm, quiet well-lit environment; and Approach resident in calm, unhurried manner.<br><br>February - April, 2019 - Review of facility fall investigations revealed that R13 had 17 falls without injury including one fall occurring outside the resident's room in the front lobby.<br><br>4/24/19 (9:10 AM) - R13 was observed in bed and a large wooden piece of furniture resembling a podium (lecture stand) with a place to kneel was sitting in the resident's room.<br><br>4/25/19 (approximately 3:55 PM) - During an interview E2 (DON) stated that R13 had fallen so many times. E2 added that there have been times when (R13) fell 15 times a month and other times when (R13) had not fallen for several months.<br><br>5/1/19 (approximately 1:00 PM) - An interview with E3 (RN, UM) revealed that R13 had been approved by PT to get on and off the floor. E3 added that R13 scoots a lot on the floor instead of walking and explained that in the past R13 would say he/she was praying on the floor, so we got (R13) a kneeling bench. E3 added that every time R13 gets on the floor, we need to treat it as a fall.<br><br>There was nothing in R13's care plan about praying on the floor, the kneeling bench or PT's clearance for getting on/off floor.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>35205<br><br>Based on record review and interview it was determined that the facility failed to follow the plan of care to promote range of motion (ROM) for one (R16) out of two sampled residents reviewed for ROM. Findings include:<br><br>Review of R16's clinical record revealed:<br><br>11/18/16 - E16's care plan for the prevention of deformities had the goal to prevent further contractions. Interventions included passive ROM (straightening / moving arms and legs to prevent contractures) twice a day for 15 minutes each to all extremities (arms and legs); and teach family to perform the ROM exercises. Interventions added on 1/7/19 included knee splints two hours a day on 7-3 and 3-11 (day and evening shifts), and bilateral (both sides) hand splints 2-3 hours on per (each) shift as tolerated.<br><br>12/6/18 - R16's contracture measurements documented a severe contracture in the left knee and a moderate contracture in the right knee.<br><br>April 2019 - Current CNA tasks:<br><br>- Splint / palm guard application #2, knee splints to prevent contractures, to wear 4 hours every day, 2 hours per shift (7-3 and 3-11). This task was listed twice with one scheduled for day shift and one scheduled for evening shift.<br><br>- Splint / palm guard application #1: place on bilateral hands and legs, place at 2 PM. This task was scheduled for 10 AM and 2 PM although it was to be completed at 2 PM.<br><br>- Splint / palm guard removal #1 off at 6 PM.<br><br>- Passive ROM twice a day for a total of 15 minutes each time to all extremities.<br><br>March - April 2019 - Review of CNA documentation revealed numerous times when there was no evidence that ROM and splint application was performed:<br><br>- March - 10 out of 31 days;<br><br>- April- 17 out of 30 days.<br><br>April 2019 - Review of nursing progress / eMAR notes revealed 9 out of 30 days when the day-shift nurse documented that the facility failed to implement physician orders for splint application: April 1, 2, 6, 7, 11, 15, 20, 21 and 27.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5/1/19 - The Occupational Therapy (OT) note documented that R16 was screened due to report of L (left) hand contracture. R16 had no change in contractures, which were documented in the OT evaluation on 1/3/19. PT recommendation was made to continue splints or rolled wash cloth to both hands to promote good skin integrity.<br><br>5/2/19 (1:35 PM) - Knee measurements revealed that both knees had moderate contractures. The left knee improved from the December 2018 assessment. It was noted that R16's muscle tone and spasticity (tightness of muscles) can lead to varying degrees of contracture measurements.<br><br>5/3/19 (approximately 9:00 AM) - An interview with E9 (LPN) revealed the facility had no restorative aide (CNA dedicated to performing ROM) now and that the unit CNAs were to complete the ROM. E9 added, We just need the staff to do the range of motion and that the assignment that R16 was in lost the regular aide. E9 clarified that R16 had not been having a consistent aide assigned during the day.<br><br>5/3/19 (9:10 AM) - An interview with E10 (CNA) revealed that the facility had no restorative aide for 4-6 weeks.<br><br>5/3/19 (approximately 9:14 AM) - E17 (CNA) stated that he/she performed R16's ROM during bathing and E17 lifted his/he own arms to mimic putting on clothing. When asked how R16 tolerated ROM and splints, E17 stated, I think he/she likes it but, (R16) tenses up. E17 explained that R16's splints get removed around 6:00 PM, but was not sure about the day time since E17 did not usually work during the day.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>35205<br><br>Based on observation and interview it was determined that, for one (R43) out of one sampled resident reviewed for Catheter or UTI (urinary tract infection), the facility failed to provide care and services in a manner to minimize the risk of infection from an indwelling urinary catheter (tube held in the bladder by a small balloon to drain urine). Findings include:<br><br>2009 Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (CAUTIs) from the Healthcare Infection Control Practices Advisory Committee provided recommendations to minimize the risk of developing a UTI. One category 1B recommendation (strong recommendation supported by low quality evidence) for catheter maintenance included Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor .The source of microorganisms (bacteria / germs) causing CAUTI .can enter the urinary tract on the outside of the catheter (contamination during catheter or incontinence care) or by movement along the inside of the catheter from a contaminated collection bag. https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines.pdf<br><br>Review of R43's clinical record revealed:<br><br>8/29/18 - The Admission MDS Assessment documented that R43 had a Stage 4 pressure ulcer and severe cognitive impairment.<br><br>4/7/19 - A care plan problem for requiring a foley (brand of urinary catheter) due to a pressure ulcer included the following interventions: provide catheter care twice a day and PRN; keep catheter off the floor; and assess continued need of catheter.<br><br>4/25/19 (2:02 PM) - During an observation of incontinence care to remove bowel movement (BM) from R43, E31 (CNA) first used a wet paper towel, then changed to a wet bath towel. While R43 was on his/her right side, E31 wiped R43 from front to back while standing behind the resident. E31 rearranged the bath towel so the contaminated section with BM was inside the towel before E31 wiped the resident a second time with the bath towel. E31 did not rearrange the towel and used the contaminated section of the bath towel to wipe R43 a third time. The contaminated towel can transfer bowel organisms onto the area around the urinary catheter.<br><br>4/25/19 (approximately 2:20 PM) - An observation was made of E7 (LPN) assisting E31 (CNA) with repositioning R43 onto his/her left side. The urinary catheter drainage bag had not been emptied for the shift. The urine bag was raised above the resident and passed to the far side of the bed. Raising the bag higher than the resident's bladder could lead to urine flowing from the tubing and back into R43's bladder, increasing the risk for developing a CAUTI.<br><br>4/26/19 (12:30 PM) - During an interview with E2 (DON) to review the aforementioned observations, no additional information was offered.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35205<br><br>Based on record review, interview and review of other facility documentation it was determined that the facility failed to maintain fluid and electrolyte balance in one (R70) out of three sampled residents receiving enteral feeding.(Total of 6 residents with enteral feeding in the facility.) The facility failed to provide the calculated minimal amount of fluid in the presence of diarrhea, excessive oral secretions and sweating. This failure resulted in harm when R70 required treatment in the hospital for fluid and electrolyte imbalance on 12/4/18 and 1/23/19. After the second hospitalization for dehydration, the facility conducted a root cause analysis, provided education for dietitians and nursing leadership, implemented laboratory blood testing to monitor hydration status for residents receiving nutrition by tube feeding and conducted audits. The failure to readjust fluid intake is past non-compliance. Findings include:<br><br>Facility policy entitled Fluid Balance (last revised 7/24/18) included the facility will provide patients with sufficient amounts of fluids based on individual needs .Patient's hydration status will be determined through routine nursing evaluation. Patients identified as being at risk for dehydration or needing acute rehydration will be monitored to identify appropriate care plan interventions for promoting adequate hydration.<br><br>Review of R70's clinical record revealed:<br><br>3/22/18 - Admission to the facility with multiple diagnoses including diabetes, multiple strokes resulting in aphasia, dysphagia and hemiplegia.<br><br>3/23/18 - A care plan for enteral feeding tube to meet nutritional needs included the goal that R70 would display no signs of aspiration (fluids from mouth entering the lungs). Interventions included: Aspiration precautions; Check patency and placement of tube daily and before administering feedings and meds; Dietary evaluation and monitoring; Free water; Monitor for nausea, vomiting, diarrhea, cramping, fatigue, weakness and vital sign changes and report; and Mouth care every shift and PRN.<br><br>3/27/18 - A care plan for nutritional risk included interventions: Glucerna 1.5 (tube feeding formula) with flush (water) as ordered; and Monitor for signs of aspiration.<br><br>Manufacturer ([NAME] Laboratories) nutritional information revealed that each 1,000 mL of Glucerna 1.5 contained 759 mL of free water.<br><br>4/4/18 - A care plan for being at risk for dehydration had the goal that R70 will not exhibit signs of dehydration as evidence by moist mucous membranes. Interventions included: Monitor for signs of dehydration (increased temperature, decrease output, mental status changes, dry mucous membranes, orthostatic hypotension, tachycardia); and Obtain dietitian consult as needed/ordered.<br><br>6/29/18 - A Significant Change MDS Assessment included that R70 had received nutrition by tube feeding.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 11/7/18 (3:23 AM) - Nursing progress note documented Increased secretions noted around mouth. Tick, white sputum which was difficult to suction. Feeding held for one hour as a nursing measure and patient sitting up with HOB (head of bed) elevated. Staff has noted an increase in secretions and the need to be suctioned. Not written in NP's book to make aware of problem.<br><br>11/13/18 - NP note acknowledged the increased oral secretions.<br><br>11/21/18 (2:20 AM) - Nursing progress note documented R70 had a coughing spell and had a large amount of flatulence (gas). Abdomen was very distended. Feeding held from 1:15 AM - 2:45 AM.<br><br>11/24/18 (8:17 AM) - Nutrition note included spoke with nursing regarding explosive bowel movements with reports of 3 movements daily. Reviewed MAR and noted orders for (name of stool softener) .if holding stool softener does not correct loose stools will review adding fiber to firm stools .<br><br>11/24/18 - A Nutritional Assessment showed the fluid factor used by E12 (RD) was 30 mL per kilogram (kg) of weight. E12 (RD) used 114 pounds (from 11/12/18) to calculate calorie and fluid needs. E12 documented that R70 was having some diarrhea (noted today) and that RD unsure of diarrheal frequency. Nutrition plan included if R70's diarrhea continues, (R70) may need a formula which contains less dietary fiber.<br><br>- Fluid needs determined to be 1,554 mLs daily.<br><br>- Nutrition plan for Glucerna 1.5 at 85 mL per hour for 14 hours (provided 903 mL water);<br><br>-150 mL water flush every 6 hours (provided 600 mL water);<br><br>- Totaled 1,503 mL water daily which did not meet R70's calculated fluid needs of 1,554 mL.<br><br>November, 2018 - eMAR review discovered that R70 received one dose of PRN medication for increased oral secretions (Levsin).<br><br>November, 2018 - Review of CNA documentation showed that R70 had frequent diarrhea:<br><br>- 39 medium / large loose bowel movements (BMs); and<br><br>- 5 medium / large watery BMs.<br><br>12/3/18 - A change of condition note revealed E8 (NP) was notified of shortness of breath and ordered nebulizer (breathing) treatments, blood tests and chest x-ray.<br><br>12/3/18 (10:06 PM) - A nursing progress note documented crackles (abnormal sounds indicating fluid, mucus, secretions) over trachea (upper breathing tube in neck area) and suctioned thick, bloody mucus secretions. Chest x-ray was negative for pneumonia.<br><br>12/4/18 (6:30 AM) - A late entry nursing progress note documented resident's pulse was 130 and respirations were reading at 40 physician was notified at 6:30 AM .911 was notified . Resident had secretions coming from mouth while ambulance were preparing (R70) for transport.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 12/4/18 - Emergency Department physician documentation included that R70 was unresponsive, had a fever (102.2 F), low blood pressure (82 / 40) and high heart rate (150s). Elevated blood tests revealed fluid and electrolyte imbalance and acute renal failure (kidney injury) [sodium 155, BUN 91, creatinine 1.73, potassium 5.6, hematocrit 46.2, urine specific gravity 1.026]. R70's condition improved with IV fluids.<br><br>12/4/18 - Hospital History and Physical included the following diagnoses: Acute renal failure .Acute hypotension (low blood pressure) and sinus tachycardia (high heart rate) .sec (secondary) to dehydration . Acute hypernatremia (high sodium) and hyperkalemia (high potassium), and (sic) due to dehydration and AKI (acute kidney injury) .<br><br>Hypernatremia is most often the result of unreplaced water that is lost from the gastrointestinal tract (diarrhea), skin (sweat) or urine (increased urine production with high blood glucose). https://www.uptodate.com/contents/treatment-of-hypernatremia-in-adults<br><br>12/11/18 - R70 returned to the facility with the continuation of hospital tube feeding orders:<br><br>- Glucerna 1.5 at 55 mL per hour for 14 hours (provided 583 mL water); and<br><br>- 150 mL water flush every 6 hours (provided 600 mL);<br><br>- Totaled 1,183 mL water daily which was even less than prior to hospitalization .<br><br>12/12/18 - A NP progress note documented that during the hospital stay, (R70) had shown improvement in clinical status and blood pressure is now stable. (R70's) tube feed rate has advanced and R70 tolerated it well. R70 finished a seven-day course of antibiotics for a urinary tract infection (UTI). R70's mental status is at baseline.<br><br>12/12/18 (1:39 PM) - A nursing progress note documented that R70 had some diaphoresis (sweating) once this morning.<br><br>12/12/18 (10:55 PM) - A nursing progress note documented that R70 was given a PRN (as needed) Levsin after a coughing episode and saliva draining out the sides of R70's mouth.<br><br>12/16/18 (4:52 AM) - A nursing progress note documented R70 had moderate amount of foamy white sputum (secretions) draining from his/her mouth. Mouth suctioned and PRN Levsin was effective.<br><br>12/16/18 - The Nutritional Assessment used R70's weight of 117.4 pounds (from 12/11/18) for calculating calorie and fluid needs. 117.4 pounds divided by 2.2 kg equals 53.6 kg. E25 (RD) kept the fluid factor at 30 mL per kg of resident weight to equal 1,600 mL of water even though the resident was recently readmitted to the facility after being hospitalized for fluid and electrolyte imbalance. Nutrition plan included:<br><br>- Glucerna 1.5 increased to 65 mL per hour for 14 hours (provided 692 mL water);<br><br>- 150 mL water flush every 6 hours (provided 600 mL water);<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - R70's weight increased by seven pounds in the past 14 days, which may be related to fluids delivered in the hospital.<br><br>- E25 did not calculate R70's daily water (totaled 1,292 mL which did not meet R70's calculated minimal fluid needs of 1,600 mL). The facility failed to ensure fluids provided met the 1,600 ml minimum.<br><br>12/23/18 - A Nutritional Assessment used R70's weight of 117 pounds (from 12/19/18) for calculating calorie and fluid needs (117 pounds divided by 2.2 equals 53.18 kg).<br><br>- E25 (RD) still used the fluid factor of 30 mL per kg which equaled 1,595 mL.<br><br>- Nutrition plan included tube feeding at 65 mL per hour for 14 hours (provided 692 mL water).<br><br>- E25 requested weekly weights and did not calculate the daily amount of water provided (including the flushes) that totaled 1,292 mL which did not meet R70's 1,600 mL calculated minimal fluid needs.<br><br>December, 2018 - January, 2019 - Review of eMARs, nursing progress notes and CNA documentation revealed that R70 received many doses of PRN medication for increased oral secretions and had frequent diarrhea:<br><br>- Levsin PRN for increased secretions (20 doses in December, after 12/11/18; and 6 doses in January, until 1/23/19);<br><br>- December: 33 medium / large loose BMs and 6 medium / large watery BMs; and<br><br>- January: 34 medium / large loose BMs and 3 medium / large watery BMs.<br><br>1/23/19 (4:24 PM) - A nursing progress note documented that R70 was sent to the hospital for shortness of breath, facial swelling, increased oral secretions, and heart rate in 130s.<br><br>1/23/19 - The hospital History and Physical included that R70 was sent to the hospital from the nursing home with gurgling sounds from his/her throat. Lab tests showed elevated sodium 157, BUN 63 (indicating dehydration - low fluid volume) and WBC 16.4 (indicating infection). Chest x-ray did not show pneumonia. Admitting diagnoses included sepsis from suspected aspiration pneumonia and hyperosmolar hypernatremia (elevated sodium level from a decrease in total body water) caused by insensible losses from sepsis.<br><br>The hospital did not identify that the amount of free water in R70's nutrition plan in the nursing home was not meeting the resident's 1,600 mL minimal calculated needs.<br><br>1/26/19 - R70 was readmitted to the facility with tube feeding orders(continued from the hospital):<br><br>- Glucerna 1.5 at 40 mL per hour (provided 728 mL water); and<br><br>- 200 mL water every 4 hours (provided 1,200 mL water).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - Daily water totaled 1,928 mL.<br><br>1/27/19 - A nutrition note by E25 (RD) documented that R70 had increased need for hydration and that R70 sweats profusely.<br><br>1/29/19 - A Nutritional Assessment revealed that E12 (RD) calculated calorie and fluid needs based on R70's weight of 117.4 (from 1/27/19).<br><br>- Fluid factor was increased to 35 mL per kg (1,855 mL daily) - surveyor calculation: 117.4 divided by 2.2 equals 53.36 then times 35 equals 1,867 mL calculated fluid need;<br><br>- Glucerna 1.5 at 65 mL per hour for 16 hours (provided 789 mL water); and<br><br>- 200 mL water every 4 hours (provided 1,200 mL).<br><br>- Daily water totaled 1,989 mL which was the first nutritional plan that met R70's calculated fluid needs.<br><br>The amount of free water ordered was doubled from 150 mL four times a day (600 mL) to 200 mL every 4 hours (1,200 mL).<br><br>5/1/19 (around 1030 AM) - During an interview with E8 (NP) to discuss prior hydration needs in relation to number of loose and watery stools, E8 said I increased the free water since then.<br><br>5/1/19 (10:55 AM) - During an interview with E2 (DON) to review hydration needs in relation to R70's loose and watery stools, E2 stated, I identified the issue and involved corporate who provided education to the dietitians to ensure residents with tube feedings receive adequate hydration in consideration of insensible fluid loss (secretions, diarrhea, sweating). The hydration issue was identified after the January 2019 hospitalization . E2 explained the results of the 1/30/19 root cause analysis including that nursing relied on dietitians for calculating the amount of feedings and water flushes. E2 conducted an audit of current residents receiving tube feeding to calculate the amount of free water ordered for administration. Education provided to the dietitians included that sensible fluid loss should be assessed when calculating free water. Education provided to nursing leadership involved the completeness of tube feeding and fluid orders as well as the completion of blood testing within two weeks after hospitalization . E2 or designee audited tube feeding, fluid needs and blood testing daily, three times a week, weekly and monthly and achieved 100% compliance. R70's nutritional assessment from 2/11/19 incorporated sensible fluid losses and documented R70 was given medication for his/her secretions. (R70) has excess secretions .saliva/drool observed around lips and on his/her chin .lips appear slightly cracked .skin appears moist, but well hydrated.<br><br>5/1/19 (12:55 PM) - During an interview with E12 (RD) to find out how the amount of free water is determined for a resident receiving tube feeding, E12 said the gold standard for normal folks is 25-35 mL per kg. When asked how insensible fluid loss gets determined, E12 said it's anecdotal, talk with nurses and aides. They don't do I & O (intake and output measuring) here which makes it hard. After the surveyor showed R70's tallies of medium and large loose / watery stools by month, E12 stated that staff mentioned that R70 had some explosive watery diarrhea. After discussion about review of the facility's root cause analysis findings, E12 added that R70 is in a better place now.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility failed to provide R70 with the calculated minimal amount of fluid in the presence of diarrhea, excessive oral secretions and sweating. This failure resulted in harm when R70 required treatment in the hospital for fluid and electrolyte imbalance / dehydration on 12/4/18 and 1/23/19. During the survey the facility was in substantial compliance with meeting hydration needs for residents receiving nutrition and hydration by tube feeding.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>35205<br><br>Based on record review, observation and interview it was determined that the facility failed to administer medications through an enteral tube according to standards of practice for two (R16 and R43) out of two sampled residents receiving medications by enteral feeding tube during medication administration observation. Findings include:<br><br>Facility policy entitled Medication Administration: Enteral (last revised 10/17/18) included the process: Administer medications individually. Pour medication into syringe so entire dose is administered. Allow medication to flow down the syringe via gravity (pour into the syringe and allow to flow in slowly). Do not push medication through the tube (with the syringe) .Flush with at least 15 mL tap or sterile water in between each medication. After administering all medications, flush with at least 15 mL tap or sterile water or per physician order.<br><br>Facility policy entitled Enteral Feeding: Administration by Syringe Bolus (last revised 10/1/18) included to avoid letting the syringe empty completely.<br><br>1. Review of R16's clinical record revealed:<br><br>Physicians' orders included several medications to be given by enteral tube as scheduled:<br><br>1/26/19: Cough medicine every 4 hours.2/1/19: Tylenol every 8 hours for pain.<br><br>2/18/19: Reglan (promote tube feeding to move through the stomach) every 6 hours.<br><br>4/23/19 (5:00 AM) - During a medication administration observation, after pouring the medications, measuring the gastrostomy tube length and checking for gastric residual (30 mL), E11 (RN) pulled up a liquid medication into the syringe and pushed the liquid into R16's feeding tube. This was repeated for all three liquid medications without flushing the tube in between each medication. The water flush administered after all three medications were given was done by gravity. E11 failed to administer the medications by gravity and flush between each medication as stated in the facility policy.<br><br>Cross Refer F695, Example 1<br><br>2. Review of R43's clinical record revealed:<br><br>Physicians' orders included medications to be administered to R43 by enteral feeding tube as scheduled:<br><br>2/1/19: Blood pressure medication twice a day; and seizure medication three times a day.<br><br>2/2/19: Different blood pressure medication daily; iron twice a day; folic acid daily; probiotic daily; blood thinner daily; potassium daily; protein supplement twice a day; and vitamin B6 daily.<br><br>4/22/19: antibiotic daily for pneumonia.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/25/19 (9:10 AM - 10:00 AM) - During a medication administration observation, E7 (LPN) crushed tablets, opened capsules and poured liquid medications, each medication was placed in an individual medicine cup. E7 verified tube placement and checked for residual. E7 was next to R43's bed and the bedside table containing all of the medicine cups were positioned to the nurse's right side.<br><br>- E7 turned away from R43 and toward the table to pour water into the crushed medication in the first cup. E7 then poured the mixture into the syringe and gave it by gravity. Once the syringe was empty, a small amount of air entered the feeding tube.<br><br>- E7 turned toward the table then poured more water into the medicine cup to ensure all of the medication was mixed with the water. As E7 poured the mixture in the syringe, the air that was in the feeding tube entered R43's stomach.<br><br>- When E7 turned to pour water into the empty medicine cup (for water flush between medications) more air entered the feeding tube as the syringe emptied. When the water was poured in the syringe, more air entered R43's stomach.<br><br>- This process of several administrations of water mixed with crushed medication followed by plain water flush continued for 10 more medications. Air entered R43's feeding tube when each medication cup with water/mixture was poured into the syringe. The syringe was allowed to empty between each administration of medication cup of liquid.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>35205<br><br>Based on record review, observation and interview it was determined that the facility failed to ensure that respiratory care was provided in a manner consistent with professional standards for two (R43 and R60) out of three sampled residents reviewed for respiratory care. Findings include:<br><br>Cross Refer F693, Eaxmple 2<br><br>1. Review of R43's clinical record revealed:<br><br>8/22/18 - R43 was admitted to the facility with multiple diagnoses including stroke resulting in weakness, contractures, dysphagia (inability to swallow safely - fluids enter lungs instead of stomach), and the need for tube feeding (liquid nutrition given through a tube inserted in the stomach).<br><br>12/9/18 - A care plan for being at risk for respiratory failure due to a history of respiratory failure included that R43 received continuous oxygen by nasal cannula (soft prongs in the nose with tubing wrapped behind the ears to hold in place).<br><br>4/24/19 (9:00 AM) - Observed approximately 200 mL liquid and sputum was in the suction canister and the suction machine tubing was undated. The Yankauer (hard plastic device to suction secretions from the mouth) was in an undated open paper wrapper. It was not clear how long the Yankauer and suction machine tubing had been in place, increasing the risk for contamination. The nasal cannula tubing did not have any cushions to protect R43's ears from irritation since the oxygen was used continuously.<br><br>April 2019 - Review of R43's eMAR revealed an intervention for suctioning excess oral secretions. There were no instances when the nurse signed off that this task was performed from April 1-24 although there was evidence in the suction canister that R43 had been suctioned.<br><br>4/25/19 (9:10 AM) - An observation of the undated Yankauer tucked between the motor and suction canister with the Yankauer tip (part that goes in the resident's mouth) was uncovered and contaminated. The suction machine tubing remained undated, however, there was now 250 mL of liquid and sputum in the canister, indicating it had been used since the previous day. R43's nasal cannula tubing did not have cushions attached for ear protection.<br><br>4/25/19 (approximately 2:00 PM) - The surveyor observed R43's ears for irritation from the nasal cannula tubing in the presence of E7 (LPN) and E31 (CNA).<br><br>4/25/19 (2:11 PM) - A nursing progress note documented foam pads applied to nasal cannula tubing to prevent irritation to top of ears.<br><br>4/26/19 (8:30 AM) - An observation found the suction machine tubing remained undated and now had approximately 300 mL of liquid/sputum in the canister, showing that R43 had been suctioned in the previous 24 hours. The Yankauer tip was sitting inside a disposable glove laying on top of the suction machine. It was not clear if the glove was clean or used (dirty). Ear cushions were now visible on R43's nasal cannula tubing.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/26/19 (945 AM) - Observed that R43 had vomited a small amount while lying on his/her right side and wearing the nasal cannula. E32 (CNA) put the tube feeding machine on hold before lowering the head of the bed flat to clean R43's face. E32 stated he/she would get someone to help change R43 as E32 raised the head of the bed and restarted the feeding pump.<br><br>4/26/19 (10:30 AM) - R43 was receiving care with the door closed.<br><br>4/26/19 (11:30 AM - 12:00 PM) - Observed R43 with a towel across his/her chest with light brown / tan vomit on the towel and breathing at an increased rate. An interview with E33 (LPN) revealed that R43 was suctioned first thing in the morning and that R43 was not retaining tube feeding formula in his/her stomach. E33 added that he/she made a written entry in the NP communication book for the NP to see R43 today. After the surveyor informed E8 (NP) at the nursing station of R43's current status, E8 and E33 entered R43's room. E33 discovered that R43 was not wearing the nasal cannula / continuous oxygen (O2) as ordered. After E33 picked up the nasal cannula from the bedside table and placed it on R43, E8 requested the amount of O2 be increased. R43's blood oxygen level (O2 saturation) was low at 83% and R43 was breathing fast at 28-30 breaths a minute. Since R43 was not able to follow the command to breathe through his/her nose, E8 ordered that oxygen be given by face mask.<br><br>4/26/19 (12:20 PM) - An interview with E8 (NP) revealed that R43's blood oxygen level was up to 91% with the face mask in place.<br><br>4/26/19 (untimed, after lunch) - E2 (DON) provided a copy of the facility policy entitled Respiratory Equipment / Supply Cleaning / Disinfection (last revised 12/1/18) which included that the suction machine canister and connecting tubing should be changed weekly and PRN. The policy did not address the frequency that the Yankauer should be replaced to minimize the risk for contaminants to enter a resident's mouth and flowing into the lungs due to dysphagia, causing an infection.<br><br>4//27/19 (2:00 PM) - A change of condition nursing note documented notified (E8, NP) of declining respiratory condition, abnormal vital signs (high BP 213/92, fast heart rate 100), decreased O2 saturation (82%) and fever (100.3 axillary). R43 was sent to the hospital.<br><br>4/27/19 (10:25 PM) - A nursing note documented that R43 was admitted to the hospital with aspiration pneumonia.<br><br>4/29/19 (8:35 AM) - An observation of R43's room revealed that the suction machine tubing and canister had been replaced and were dated 4/26/19.<br><br>For R43, the facility:<br><br>- failed to replace R43's nasal cannula after providing care causing a drop in blood oxygen levels;<br><br>- failed to document when R43 was suctioned;<br><br>- failed to ensure equipment used for oral suctioning was clean / replaced to minimize the risk for infection from germs being in the resident's mouth and entering the lungs due to dysphagia; and<br><br>- failed to apply ear cushions on R43's nasal cannula that was used continuously to minimize skin irritation.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Cross Refer F656, Example 3<br><br>2. Review of R70's clinical record revealed:<br><br>3/22/18 - R70 admitted to the facility with weakness, aphasia, dysphagia and received tube feeding after having multiple strokes.<br><br>4/23/19 (6:32 AM) - R70's Yankauer was observed uncovered, undated and sitting on top the suction machine.<br><br>4/23/19 (9:30 AM) - An observation of resident sleeping revealed R70 was receiving oxygen by nasal cannula. The suction machine canister contained approximately 200 mL whitish /clear fluid and no components / tubing were dated. The Yankauer still laid uncovered and undated on top of the suction machine. The cleanliness of the Yankauer tip that enters the resident's mouth for suctioning of oral secretions was unknown.<br><br>April, 2019 - A review of the eMAR / eTAR found no intervention for suctioning excess oral secretions.<br><br>4/24/19 (2:46 AM) - A nursing note documented that R70 was sent to the hospital at 1:30 AM for increased oral secretions, periods of shortness of breath, fast breathing (22-40 a minute), high heart rate (130-135 a minute) and diarrhea. R70 was admitted to the hospital with the diagnosis of aspiration pneumonia.<br><br>For R70, the facility:<br><br>- failed to ensure equipment used for oral suctioning was clean / replaced to minimize the risk for infection from germs being in the resident's mouth and entering the lungs due to dysphagia; and<br><br>- failed to document when R43 was suctioned.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>32810<br><br>Based on interviews and review of facility documentation it was determined, that for 12 residents who wished to remain anonymous (A1, A2, A3, A4, A5, A6, A7, A8, A9, A10, A11 and A12) and one resident (R16), the facility failed to provide sufficient nursing staff on a 24 hour basis to meet resident care needs. Findings include:<br><br>11/1/18 - An anonymous allegation received by the State Agency documented that they are short staff and required to care for 18-22 residents on the 3:00 PM to 11:00 PM shifts.<br><br>2/4/19 - Resident Council meeting minutes documented we (residents) should not have to come to you (staff) every day about our care, when you are staff challenged; you are fully aware of your staffing. Split shifts are not working.<br><br>2/8/19 - E1's (NHA) documented response to the 2/4/19 staffing concerns from the Resident Council directed residents to Inform the charge nurse, supervisor or nurse manager when you have a concern. Timely reporting is required to address your specific care concern.<br><br>3/11/19 - Resident Council meeting minutes documented you know, as well as we know, that you are staff challenged, but why do we have to keep writing these things down? What about the residents that can't report these things? We are not always getting proper care.<br><br>3/14/19 - E1's (NHA) documented response to the 3/11/19 staffing concerns from the Resident Council indicated that any specific concerns have been addressed.<br><br>4/9/19 - An anonymous allegation received by the State Agency reported short staffing at the facility.<br><br>4/12/19 - An anonymous allegation received by the State Agency documented that the facility is very understaffed. There are only 4 aides on the 3-11 shift and they each have 15/16 residents a piece. There are some nurses and administrators in the building but they aren't doing anything to help the CNA's or care for the residents. They are walking past call bells and ignoring residents requests. CNA cannot handle the amount of work the facility is expecting of them.<br><br>4/23/19 - The updated Staffing Plan section of the facility's submitted Facility Assessment indicated that based on resident population and their needs for care and support to ensure sufficient staff to meet the needs of residents at any given time direct care staff ratios should be: days CNA 1:8 (1 CNA for every 8 residents), evenings CNA 1:10, and nights CNA 1:16.<br><br>During an interview on 4/23/19 at 9:25 AM, A1 stated, CNA's don't answer the call bells, for 45 minutes sometimes. I've seen other resident's call bell on for an hour sometimes only three aides (CNA's) working.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 4/23/19 at 9:44 AM, when asked was there enough staff for the resident to get the care and assistance needed, A2 responded, definitely not, 3-11 (shift) is terrible, they must hide. Can't find or see. Terrible on weekends. Less than a skeleton crew.<br><br>During an interview on 4/24/19 at 10:07 AM when asked was there enough staff for the resident to get the care and assistance needed without having to wait a long time, A3 reported being unable to determine length of time (to answer a call bell), but it takes too long. When asked if he/she ever had an incontinence episode while waiting, A3 stated, Yes.<br><br>During an interview on 4/23/19 at 10:18 AM, A4 stated, We need more aides (CNA's).<br><br>During an interview on 4/23/19 at 10:41 AM, A5 reported he/she often has to wait to use the bathroom.<br><br>During an interview on 4/23/19 at 11:47 AM A6 stated, the aides are short staffed and they don't want to wait on you. The other day we waited just about all day, they come in just before the shift change and they say we only got 3 (CNA'S). They need more help. If you ring that bell they walk by they see the light but they will stand across the hall and they will not do a thing.<br><br>4/24/19 at 9:31 AM - During a Resident Council meeting the following anonymous statements were given:<br><br>A7 stated, We do not get help without waiting. Some have waited 1 or 2 hours. They turn call bells off before they go into the room. I have heard residents say that they (staff) turn the call bell off and never come. The call bells go off so long, you can hear at nurse's station, and hear it change sound because it's rang for a certain time. They will have a short attitude when they finally answer you .There are not enough aides, they called more staff in, knowing the survey team would be here soon. There are 6 aides (total) on night shift lately .Also they have split shifts, an aide comes in at 7:00 PM and it is not working . 3-11 shift is a big concern with staffing. They work short all the time; there are not enough aides.<br><br>A8 stated that he/she has rang the call bell in the bathroom for help with bathing . worries he/she could have fallen and would have to wait the same long time for help. A8 further explained that staff have left people in the shower while they do another task and it takes a long time to come back. A8 doesn't want to be left alone in shower. Especially on Unit 2. Even on shower days, it's hard to get a shower. We've been told we can have them whenever we want, but it doesn't work like that cause when we ask they say they can't do it, they're (they are) short of time. A8 reported the CNA assigned today knew about the resident council meeting today and would not give the scheduled shower due to (he/she) won't have time, other than this morning and didn't offer to give shower early/later.<br><br>A9 stated his/her roommate has fallen and didn't get help promptly after using call bell.<br><br>A10 reported some residents don't get to activities they'd enjoy because they are not helped out of bed and dressed in time. A10 then stated it was not fair that residents miss activities, or come in their pajama's, because aides haven't helped them get ready.<br><br>A11 stated a CNA was short with me one night when I only asked for help twice in one night.<br><br>(continued on next page) |

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|---|---|---|---|
| | 085015 | A. Building<br>B. Wing | 05/03/2019 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 4/24/19 at 1:38 PM, A12 stated that wait times for assistance were half an hour or more. I have peed on the floor trying to get to bathroom.<br><br>4/30/19 - 6:00 PM An eMAR nursing note documented R16 was not turned and repositioned every two hours because the CNA stated that he/she can not turn R16 [alone] so he/she did not turn R16.<br><br>During an interview on 5/3/19 at 8:49 AM with E2 (DON), it was confirmed that the facility had several openings for direct care staff, E2 stated we have CNA and licensed nurse positions . Two full time and two part/time nurse positions; Eight full time and four part time CNA positions. E2 stated that the vacant positions were primarily on the evening shifts. During this same interview, E2 confirmed that the daily direct care staff assignments did not reflect the ratio's of direct care staff to resident's, documented as necessary in the Facility Assessment and stated those numbers are based on full census and full staff. The facility census the first day of the survey was 108 or 87% full. When asked if the level of assistance required, acuity and any other resident care needs were a factor in the assignment of direct care staff to resident ratios, E2 stated it does for the Transitional Care Unit.<br><br>5/3/19 at 9:07 AM - During an interview with E9 (LPN), it was revealed that the facility did not have a restorative aide and that the aides working on the floor must complete the range of motion (straightening / moving arms and legs to prevent contractures). We need to have enough staff to do the range of motion.<br><br>5/3/19 at 9:10 AM - During an interview with E10 (CNA) it was revealed that the restorative aide position had been vacant around 4-6 weeks.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>35205<br><br>Based on record review and interview it was determined that the facility failed to perform a blood test to monitor the effectiveness of a medication for one (R6) out of five sampled residents for medication review. Findings include:<br><br>Review of R6's clinical record revealed:<br><br>9/18/17 - Physicians' orders included a Vitamin D blood test to be completed yearly with a start date of 2/1/18.<br><br>2/8/18 - A vitamin D test result was 53 (normal range 30-100).<br><br>9/18/18 - Physicians' orders included Vitamin D to be given twice a day.<br><br>April, 2019 - Review of R6's lab results found no evidence that a Vitamin D blood test was completed in February 2019.<br><br>4/29/19 (9:52 AM) - An interview with E30 (Unit Clerk) revealed that usually six months of lab results were kept in the chart and older ones were thinned out. E30 said he/she would check the purged record.<br><br>4/29/19 (approximately 10:40 AM) - E30 (Unit Clerk) provided the surveyor with lab test results from R6's purged record. Review of these records lacked a Vitamin D blood test from February 2019.<br><br>4/29/19 (1:05 PM) - An interview with E2 (DON) revealed that R6 was hospitalized in February 2019 and the vitamin D blood test was not re-ordered upon return to the facility and was not done.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35959<br><br>Based on observation and interview it was determined that the facility failed to ensure drugs in one out of two medication carts reviewed were maintained within their expiration date. Findings include:<br><br>An observation on [DATE] at 11:27 AM of an Unit 1 medication cart revealed two expired seizure medication cards for R27 that expired on [DATE]. One card contained 14 out of 15 capsules and the second card contained 5 out of 15 capsules.<br><br>E28 (RN) immediately confirmed this finding and E28 stated he/she would dispose of the medications.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on [DATE] during the exit conference beginning at 11:15 AM. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>20835<br><br>Based on observation, record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to provide routine dental services to meet the needs for one (R41) out of one sampled resident reviewed for dental services. Findings include:<br><br>The facility's policy and procedure entitled, Oral Health, with the most recent revision date of 5/1/19, indicated residents oral health will be evaluated as part of the nursing assessment upon admission, annually, and with a change in oral health.<br><br>The facility's policy and procedure entitled, Dental Services, with the most recent revision date of 7/24/18, indicated that the facility would provide or obtain routine and emergency dental services to meet the resident's dental care needs. Routine dental services means an annual inspection of the oral cavity for signs of disease, . minor partial or full denture adjustments .<br><br>Cross refer F641, example #1<br><br>Cross refer F656, example #1<br><br>Cross refer F805<br><br>Review of R41's clinical record revealed:<br><br>11/18/16 - R41 was admitted to the facility.<br><br>2/24/19 - A Nutrition Assessment documented that R41 had both upper and lower dentures. R41 reported that the lower denture fit poorly and R41 was selective of meats he/she consumed.<br><br>2/27/19 - The Quarterly MDS assessment incorrectly documented that R41 did not have any issues with broken or loose fitting dentures.<br><br>Record review lacked evidence that R41 was offered routine dental services to evaluate R41's poor fitting lower denture.<br><br>5/2/19 at approximately 12:45 PM - During meal observation, R41 was observed with a sandwich consisting of three pieces of luncheon meat. R41 verbalized to the surveyor that he/she cannot chew the luncheon meat due to the poor fitting lower denture. R41 verbalized he/she was uncertain when the last time was he/she had routine dental services, but was interested in obtaining a new lower denture.<br><br>5/2/19 at approximately 3:00 PM - An interview with E22 (DSS) revealed he/she was not aware of R41's poor fitting lower denture and R41's desire for a new denture.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>20835<br><br>Based on observation, record review, and interviews, it was determined that the facility failed to provide food prepared in a form designed to meet R41's individual needs. Findings include:<br><br>Cross refer F791<br><br>Review of R41's clinical record revealed:<br><br>11/18/16 - R41 was admitted to the facility.<br><br>5/2/19 - A physician's order for regular, liberalized diet, chopped meat texture.<br><br>5/2/19 at approximately 12:35 PM - Review of R41's meal ticket documented a regular, liberalized, ground meat diet.<br><br>5/2/19 at approximately 12:45 PM - During meal observation, R41 was observed with a sandwich consisting of three pieces of luncheon meat. R41 verbalized to the surveyor that he/she cannot chew the luncheon meat due to the poor fitting lower denture.<br><br>5/2/19 at approximately 12:51 PM - An interview with E23 (DDS) revealed that nursing staff informs the dietary staff of the prescribed diet for each of the residents. E23 verbalized that R41 was served the diet as requested by nursing staff.<br><br>5/3/19 at approximately 10:30 AM - During an interview with E2 (DON), the above observations were reviewed and E2 confirmed that R41 was ordered to have all meats served in a ground form.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>35205<br><br>Based on observation and interview, it was determined that the facility failed to store clean serving dishes in a sanitary manner and failed to prepare food in accordance with professional standards. Findings include:<br><br>1. Storage of clean serving trays.<br><br>4/23/19 (starting at 6:25 AM) - The initial kitchen tour observation revealed that clean serving dishes were stored upside down:<br><br>- two small stainless steel serving trays had moisture in between them; and<br><br>- three medium sized stainless trays had an oily liquid substance along the outer rims.<br><br>E14 (Cook) immediately confirmed the findings and placed the serving trays in the dishwashing area to be rewashed.<br><br>2. Contamination during food preparation.<br><br>4/23/19 (6:35 AM) - Observed E14 (Cook) don (put on) a pair of single-use, disposable gloves and placed 4 pieces of bread on the toaster. E14 then sprayed the grill with a can of oil spray then picked up a large jug of oil, twisted off the lid and poured some on the grill, contaminating his/her gloved hands by touching the two containers. E14 rearranged two pieces of bread on the toaster with his/her contaminated gloved hands. When the toast was done, E14 picked up the 4 pieces of toast and placed several pieces of cheese on them using his/her contaminated gloved hands. E14 did not remove the gloves, perform hand hygiene and don a new pair of gloves prior to touching food items.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>20835<br><br>Based on record review and interview, it was determined that the facility failed to ensure, that for two (R45 and R16) out of 23 residents sampled for investigations, their records were accurate, in accordance with accepted professional standards and practices. Findings include:<br><br>1. Review of R45's clinical record review revealed:<br><br>8/24/18 - Admission Record documented diagnoses including ALS.<br><br>2/26/19 - A Neurological Consultation, documented that R45 did not have ALS and was diagnosed with olivopondrocerebellar degeneration (OPCD). This consultation documentation included the initial of the medical provider, E8 (NP).<br><br>There was lack of evidence that the facility updated R45's diagnosis by deleting ALS and included OPCD.<br><br>5/2/19 at approximately 10:42 AM - An interview with E24 (ADON) confirmed that the facility failed to ensure R45's diagnosis list was accurate.<br><br>35205<br><br>Cross Refer F 609, Example 1<br><br>2. Review of R16's clinical record revealed:<br><br>10/28/16 - A care plan for potential for skin breakdown included the intervention to turn and/or reposition and check skin every 2 hours or as specified by the plan of care.<br><br>4/26/19 - The Annual MDS Assessment identified that R16 was totally dependent and required two staff for repositioning in bed.<br><br>5/2/19 (8:50 AM) - The surveyor discovered several eMAR nursing notes that R16 was not turned due to lack of a second staff member, but CNA documentation included that R16 was turned.<br><br>5/2/19 (3:08 PM) - During an interview E2 (DON) provided employee statements from an allegation of neglect investigation. Review of the information revealed that E21 (CNA) documented that R16 was turned every 2 hours although the resident was not turned. The CNA record did not accurately reflect the care that R16 received.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>35205<br><br>Based on record review and interview it was determined that the facility failed to ensure the appropriate use of an antibiotic for one (R6) out of five residents sampled for infection control review. Findings include:<br><br>Review of R6's clinical record revealed:<br><br>8/14/18 - A NP note documented that R6 had pain with urination, urine testing was ordered and R6 would follow results.<br><br>8/15/18 - The urinalysis result was abnormal with many bacteria. E8 (NP) initialed and dated the test result on 8/15/19.<br><br>8/15/18 - A physicians' order was written for an antibiotic to be given twice a day for seven days.<br><br>8/16/18 - The urine culture test showed more than three organisms, indicates contamination. Recommend repeat culture if clinically indicated. E8 (NP) initialed and dated the test result on 8/16/19.<br><br>Nursing progress notes documented:<br><br>- 8/16/18 (3:07 AM): had not complained of any difficulties with urinating. Urine is a little concentrated and is dark yellow in brief and on bedpan.<br><br>- 8/16/18 (1:59 PM) - requested to stay in bed today .denies pain or discomfort.<br><br>- 8/16/18 (6:47 PM): No c/o (complaint of) painful urination and urine is yellow and non cloudy.<br><br>- 8/17/18 (12:56 PM): denies any flank pain / dysuria (pain with urination).<br><br>August, 2018 - eMAR revealed that R6 received the full seven day course of the antibiotic based on results from a contaminated urine culture.<br><br>4/29/19 (after lunch) - E2 (DON) stated that the nursing notes indicated that R6's urine was clear and the resident had no pain with urination on 8/16/18 and was not sure why the antibiotic had continued.<br><br>5/1/19 (10:35 AM) - During an interview with E8 (NP) to review R6's treatment with an antibiotic, E8 looked at his/her electronic calendar and said, I not here that day and added I want to fix whatever I contributed to.<br><br>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. |