STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135058	A. Building B. Wing	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a) advanced directives were in residents' care plans, and b) the residents' medical records or a copy of the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 1 of 11 (#3) residents reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not honored should the resident be unable to communicate them to a doctor. Findings include: 1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease and heart disease. Resident #3's quarterly MDS assessment, dated 7/6/18, documented she was cognitively intact. Resident #3's Idaho Physician Orders for Scope of Treatment (POST), dated 6/22/17, documented she wished to be Do Not Resuscitate (DNR) and comfort measures only. Resident #3's medical record did not include documentation of advance directives, or documentation advance directives were discussed with her. b. Resident #3 did not have a care plan area addressing her POST and or wishes. On 10/11/18 at 8:29 AM, the LSW stated she was unable to locate an advanced directive for Resident #3. The LSW stated the advanced directives were not in the care plans currently. The LSW stated the corporate had made the decision to not place advanced directives in residents' care plans. The LSW stated the facility would add advanced directives to the care plans.

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36314 Based Review of the facility's policy titled, Notification of Change, dated 11/2016, directed the staff as follows: A facility must immediately . consult with the resident's physician . when there is: . 2. A significant change in the resident's physical, mental or psychosocial status . 1. Resident #30 was admitted to the facility on [DATE], and discharged to the hospital on 8/14/18, and readmitted him on 8/16/18. Resident #30's diagnoses included status-post laminectomy (back surgery) for a ruptured disk, pain, atherosclerotic heart disease (ASHD- also known as coronary artery disease),fractures of thoracic (mid-back) and lumbar (lower back) vertebrae, lumbar spinal stenosis (narrowing of the spinal canal) with neurogenic claudication (pain and cramping in the lower back, buttocks, hips and legs), and nausea with vomiting. Resident #30's Physician Orders for July 2018 through September 2018, documented the resident's medications included: Fentanyl Patch 72-hour, 12 micrograms (mcg)/hour [a narcotic pain medication in a topical patch form that is applied to the skin and delivered in a time-released manner], apply one patch transdermal, one time a day, every three days for pain. (ordered 08/02/18 and discontinued on 09/19/18). Carvedilol 6.25 mg two times a day for hypertension, ordered 7/31/18. Levothyroxine 100 mcg one time a day for hypothyroidism, ordered 08/01/18. Resident #30's History and Physical Evaluation, dated 8/22/18 at 1:20 PM, documented his attending physician saw the resident at the facility and documented the following findings under Review of Systems: Constitutional Negative [for] . Fatigue, . Malaise and Weight Loss . GI [gastrointestinal] Negative [for] Abdominal pain, . Decreased appetite, . Nausea and Vomiting. A quarterly MDS assessment, dated 8/24/18, documented Resident #30 was cognitively intact with mild depression. The MDS documented Resident #30 required extensive assistance of two or more persons for bed mobility, transfer, dressing, and toileting, did not walk in or out of his room, and required extensive assistance of one to two or more persons for wheelchair mobility, but could eat with setup assistance and supervision. Review of Resident 30's care plan indicated the staff developed the following Focus areas, all initiated on 08/01/18: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	a. The care plan area addressing Resident #30's altered cardiovascular status, dated 8/1/18, documented he had a history of coronary artery disease, hypertension, hyperlipidemia [high cholesterol], and Hx [history] of CABG [coronary artery bypass graft surgery]. The Interventions documented staff were to monitor, document, and report any signs and symptoms of heart related concerns, included nausea and vomiting to the physician. b. The care plan area addressing Resident #30's hypothyroidism, dated 8/1/18, documented the staff were to report signs and symptoms of hypothyroidism such as low blood pressure, decreased breathing, decreased body temp, unresponsiveness; fatigue, impaired memory, and depression. c. The care plan area addressing Resident #30's chronic neuropathy pain [nerve-related pain] and acute back pain, dated 8/1/18, documented he had a T12 [thoracic spine, 12th vertebrae] compression Fx [fracture] with disc retropulsion [herniation] with surgical repair. The interventions documented staff were to observe for signs of nausea or vomiting and report to the physician any occurrences. Resident #30's Progress Notes from 09/01/18 through 09/22/18 documented the following: - On 9/1/18 at 11:02 PM, Resident #30 had post-op back surgery and he was to wear a back brace while up in his wheelchair. The note documented Resident #30 denied pain or discomfort and he was alert and oriented. - On 9/2/18 at 8:17 PM, Resident #30 was administered ondansetron HCl (hydrochloride) (Zofran- an anti-nausea medication) 4 milligrams (mg) due to nausea with vomiting. - On 9/2/18 at 11:48 PM, Resident #30 experienced emesis [vomiting] episode this shift, Zofran administered and was effective. - On 9/3/18 at 3:08 AM, Resident #30 was administered Zofran 4 mg due to nausea. - On 9/3/18 at 1:17 PM and at 9:54 PM, and on 09/04/18 at 10:48 PM, the nurses documented Resident #30 was up in his wheelchair with his back brace on, was alert and oriented, participated with PT and OT, and denied pain or discomfort. - On 9/5/18 at 1:09 PM, Resident #30 refused both breakfast and lunch. The Progress Notes did not reflect follow up documentation by the nurse or communication with the physician of the resident's change in status. - On 9/5/18 at 1:33 PM, the LSW met with Resident #30 1:1 and discussed his recent lack of activity and not getting out of bed and his lack of desire to get up and use the restroom. The note documented Resident #30 did not feel up to it. The Progress Notes did not reflect follow up documentation by the LSW or communication with nurses or the physician of the resident's change in status. - On 9/5/18 at 11:02 PM and on 9/6/18 at 11:28 PM, the nurses documented the resident was alert, verbal, oriented x 2, up to his wheelchair with his back brace on, took his medications, and denied pain or discomfort. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	- Resident #30's MAR documented on 9/14/18, from 4:28 PM through 4:32 PM, Resident #30 was not administered several medication due to nausea and emesis. - On 9/14/18 at 5:44 PM, Resident #30 had a substantial amount of emesis after morning medications. The note documented he did not have much of an appetite for the rest of the day. The note documented his vital signs were obtained and were 88/56 for blood pressure, pulse 59, [and] O2 [oxygen] 94%. The note documented his vital signs were rechecked near dinner time and his [blood] pressure was 102/54, pulse was 70, O2 95%, respirations 16, [and] temp of 96.0. The note documented Resident #30's skin was cold to touch and he was pale. The Progress Notes did not reflect follow up documentation by the nurse or communication with the physician of the resident's change in status. - On 9/15/18 at 4:48 PM, Resident #30's carvedilol (a heart medication) was Held for blood pressure 98/49. - On 9/16/18 at 5:19 PM, Resident #30 experienced episodes of vomited about 5 minutes after evening medications were administered. The note documented he was feeling fine today and his BP was 120/53. - On 9/17/18 at 1:44 PM, Resident #30 remained in bed for most of the day sleeping/resting. The note documented he has not complained of any nausea or had any emesis. - On 9/17/18 at 2:34 PM, Resident #30 was discharged from physical therapy's services. The note documented he did not feel up to participating lately. The Progress Notes from 09/15/18 through 09/17/18 did not reflect follow up documentation with the physician of the resident's change in status. The Progress Notes documented the nursing staff did not document an assessment of Resident #30's medical status from 09/19/18 at 3:34 PM until 09/22/18 at 2:15 AM. - On 09/22/18 at 2:15 AM, Resident #30 experienced an emesis episode at approximately 1:20 AM. The note documented Resident #30 was responsive to verbal and tactile stimuli and continued to vomit while being cleaned up by staff. The note documented his vital signs were taken at this time and his blood pressure was 35/30, pulse 60, temperature 98.3, respirations 10, oxygen saturation 48 percent. The note documented oxygen was applied via nasal cannula while EMR [Emergency Medical Response] were notified. The note documented the responsible party [name] was notified of Resident #30's decline. The note documented his vitals were obtained again and they were BP 58/32, pulse 63, sats [oxygen saturation] 68. The note documented the EMR arrived and Resident #30's breathing had become shallow and his eyes were glazed and fixed. The note documented the EMR was unable to retrieve a pulse. The note documented at 2:00 AM Resident #30 was pronounced dead by EMR staff and the DNS and physician were notified. On 10/12/18 at 1:46 PM, LPN #1 stated that on 9/14/18, he was in facility orientation with and thought he notified the RN (registered nurse) working with him that day of Resident #30's condition but could not recall the name of the RN. LPN #1 stated he did not notify Resident #30's physician of the change in the resident's condition. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 10/12/18 at approximately 2:00 PM, the DNS stated that Resident #30 had exhibited episodes of nausea and vomiting prior to his back surgery, but none of the staff notified the physician when the resident exhibited additional episodes of nausea and vomiting, decreased appetite and intake, refusal of therapy services, and preference to stay in bed. The DNS stated she expected the staff to notify the physician of any change in a resident's condition. 37265

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 36314 Based on interview and record review, the facility failed to ensure the staff provided 2 of 3 sampled residents (#23, #28) discharged from Medicare Part A services, with contact information for their Quality Improvement Organization (QIO) in the event either resident wished to file an appeal of the determination. Findings include: 1. Review of Resident 23's Notice of Medicare Non-Coverage (NOMNC) (a mandatory notice issued by the facility that informs the resident or the resident's representative when all Medicare Part A covered services end for coverage reasons, and provides information on the right to appeal the determination), indicated that Medicare Part A coverage of the resident's Occupational Therapy/Physical Therapy services would end on 9/7/18. Under the heading, How to Ask for an Immediate Appeal, the notice read, You must make a request to your Quality Improvement Organization (also known as a QIO) . Call your QIO at: [blank line] to appeal, or if you have questions. Underneath the blank line, the form instructed the staff to, Insert QIO name, toll-free number of QIO, and TTY (Teletypewriter- a dialing device used by those who are deaf or very hard of hearing) number. The staff failed to provide the resident's QIO contact information in the event the resident wished to appeal the determination. 2. Review of Resident 28's NOMNC, indicated that Medicare Part A coverage of the resident's Physical Therapy/Occupational Therapy services would end on 7/30/18. Under the heading, How to Ask for an Immediate Appeal, the notice read, You must make a request to your Quality Improvement Organization (also known as a QIO) . Call your QIO at: [blank line] to appeal, or if you have questions. Underneath the blank line, the form instructed the staff to, Insert QIO name, toll-free number of QIO, and TTY (Teletypewriter- a dialing device used by those who are deaf or very hard of hearing) number. The staff failed to provide the resident's QIO contact information in the event the resident wished to appeal the determination. On 10/11/18 at 8:25 AM, the LSW stated she gave the residents their NOMNC notices, but the facility's Business Office always filled in the QIO information on the forms. The LSW stated since neither Resident #23 nor Resident #28 expressed a desire to appeal the determinations, she did not think the QIO contact information was required.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints, including floor mat alarms and Wanderguards, unless needed to treat the resident's medical symptoms. This was true for 1 of 3 (#27) residents reviewed for restraints. This deficient practice created the potential for harm to residents, including increased the risk of falls, fear movement may set off an alarm, and diminished sense of dignity. Findings include: 1. Resident #27 was admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbances and Parkinson's disease. A quarterly MDS assessment, dated 9/19/18, documented Resident #27 had a moderate cognitive impairment and required extensive to limited assistance of 1-2 staff members for all cares. The MDS documented she had exhibited no behaviors and she used a restraint daily of a floor mat. The care plan area addressing Resident #27's falls, revised 9/6/18, documented Resident #27 required an alarming mat at the side of her bed which alerted staff when Resident #27 attempted to self-transfer out of bed. On 10/9/18 from 2:19 PM through 2:23 PM, Resident #27 was observed in her recliner chair with a floor mat under the chair. Resident #27 was observed in bed with the floor mat in place on 10/11/18 at 5:50 AM as well. Resident #27's clinical record did not contain an assessment of the medical need for the floor mat or a consent. On 10/10/18 at 4:28 PM, the DNS stated the facility did not know they had to assess floor mats as possible restraints. The DON stated they had not completed assessments for Resident #27's floor mat.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on observation, staff interview, and record review, it was determined the facility failed to ensure a resident who was no longer at risk for elopement were reassessed for devices to prevent residents from leaving the facility, such as a Wanderguard. This was true for 1 of 1 (#1) residents reviewed for elopement risk. This deficient practice created the potential for harm to residents, including diminished sense of dignity. Findings include: 1. Resident #1 was admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbances. A quarterly MDS assessment, dated 7/3/18, documented Resident #1 had a severe cognitive impairment and required extensive assistance of 1-2 staff members for all cares. The MDS documented she had exhibited no behaviors of wandering and she used a restraint daily of a Wanderguard. The care plan area addressing Resident #1's potential for elopement, revised 12/8/16, documented Resident #1 required a personal Wanderguard to her wrist which alerted staff to her movements. On 10/9/18 from 12:33 PM through 3:22 PM, Resident #1 was observed positioned in her wheelchair in the activities room with a Wanderguard clipped on the backside of her wheelchair. Resident #1 was observed positioned in her wheelchair on 10/10/18 at 10:21 AM through 1:55 PM in her wheelchair in the activity room with the Wanderguard in place. Resident #1's clinical record did not contain an assessment of the medical need for the Wanderguard or a consent. On 10/11/18 at 10:42 AM, the DNS stated the facility did not know they had to assess Wanderguards as possible restraints. The DON stated they had not completed assessments for Resident #1's Wanderguard.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36314 Based on interview, record review, and review of the facility's policy and procedure, the facility failed to ensure the staff developed person-centered care plans for 2 of 14 residents (#5 and #8), selected for review. The care plans failed to include individualized, non-pharmacological interventions, based on the residents' assessed social history and activity preferences, for the staff to implement to help relieve the residents' expressions of distress and/or to promote their highest practicable physical, mental, and psychosocial well-being. Findings include: The care plans for residents with demential not utilize information from their Activity Interest Data Collection Tool to formulate individualized, non-pharmacological care plan interventions as follows: 1. Resident #5 was admitted to the facility on [DATE], with diagnoses which included vascular dementia with behavioral disturbance. A quarterly MDS assessment, dated 7/10/18, documented: a) Resident #5 was severely cognitively impaired and exhibited continuous inattention and disorganized thinking. b)Resident #5 exhibited physical and verbal behaviors toward others, and behaviors not directed toward others on one to three days of the assessment's seven-day look-back period. c)Resident #5 required extensive assistance of two or more persons for transfers. d) Resident #5 received antipsychotic medication on all seven days of the assessment's seven-day look-back period. The annual MDS assessment, dated 04/16/18, documented Resident #5 preferred activities included: Reading books, newspapers, and magazines, listening to music, being around animals such as pets, doing things with groups of people, spending time outdoors, and participating in religious activities or practices. Resident #5's Activity Interest Data Collection Tool, dated 05/19/17, documented Resident #5's interests included: crafts, poetry, listening to music, singing, painting, crocheting/knitting/tatting, needlework/quilting/sewing, tending garden/plants, television, movies, checkers, chess, board games, cards, bingo, word games/trivia, books, educational classes, newspaper, magazines, discussion, reminisce, bowling, dancing, walking, humor, talking/conversing, phone use, Bible study, devotions, worship services, animals/pets, traveling, and volunteer activities. The assessment also indicated the resident's favorite color was blue, that she liked to try things that are different and visiting with others, and had worked as a waitress and dishwasher in restaurants in the past. The care plan area addressing Resident #5's impaired cognitive function, dated 2/25/18, documented she had vascular dementia with behavioral disturbances and moderate cognitive impairment, severe short term memory deficits, difficulty understanding others, difficulty expressing needs [and] wandering. The interventions directed the staff to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Monitor/document/report to heath care provider any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, [and] mental status (initiated 05/29/17). * Reminisce with [resident's name] using photos of family and friends (revised 05/29/17). *[Resident's name] needs supervision/assistance with all decision making (revised 05/29/17). * Ask yes/no questions in order to determine [resident's name] needs (revised 05/29/17). * Present just one thought, idea, question or command at a time (initiated 05/29/17). * Break tasks into one step at a time (initiated 05/29/17). * Cue, reorient and supervise as needed (initiated 05/29/17). * Redirect/reassure as needed (initiated 05/29/17). Engage resident in simple, structured activities that avoid overly demanding tasks such as coffee time, Bible study, devotions, discussion groups, special events, going outside, and sensory stimulating projects as tolerated (revised 07/10/18). Dementia/impaired thoughts: Attempt non-pharmacological interventions: 1:1 visits, cue remind [sic] and reorientate [sic] as needed (revised 03/13/18). i. The care plan area addressing Resident #5's antipsychotic medication therapy, dated 2/15/18, documented she was on the medication related to vascular dementia with behavioral symptoms, tearfulness, and excessive wandering. The interventions directed the staff to: Behavior #1,Tearfulness: 1 :1 interaction. Behavior #2: Wandering: Offer to take [resident's name] for a walk to divert attention. Assess for toileting, wander guard to left wrist (revised 07/10/18). Monitor for a significant decline in function and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear, and not bathing leading to skin breakdown or infection) (initiated 07/19/17). Monitor for behavioral symptoms that present a danger to the resident or others. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed (revised 07/19/17). Monitor for symptoms that are significant enough that the resident is experiencing inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end of life. or crying) (no date of initiation or revision). Document target behavior episodes. side effects, and non-pharmacological interventions used q [every] shift (revised 08/09/17). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff did not utilize information from Resident 5's Activity Interest Data Collection Tool to formulate individualized, non-pharmacological care plan interventions for the staff to implement in the event Resident 5's expressed distress, or to help promote an optimal state of physical, emotional, and psychological well-being. 2. Resident #8 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease and a secondary diagnosis of dementia with behavioral disturbance. A quarterly MDS assessment with an ARD, dated 08/02/18, documented Resident #8 was severely cognitively impaired and required extensive assistance of one person for transfers. A significant change in status MDS assessment, dated 02/03/18, documented Resident #8's preferred activities were reading books, newspapers, and magazines, listening to music she likes, keeping up with the news, going outside to get fresh air when the weather is good, and participating in religious services or practices. Resident #8's Activity Interest Data Collection Tool, dated 07/30/18, documented Resident #8 was interested in poetry, listening to music, singing, playing the trumpet, crocheting/knitting/tatting, needlework/quilting/sewing, landscaping and lawn work, tending garden/plants, television, movies, checkers, chess, board games, cards, bingo, word games/trivia, jigsaw puzzles, books, computer, newspaper, magazines, letter writing, discussion, reminisce, bowling, dancing, walking, exercise, humor, talking/conversing, phone use, Bible study, devotions, worship services, communion, animals/pets, traveling, and volunteer activities. The assessment also indicated the resident liked bright colors, sweets, and hand work, enjoyed being with others, and was a teacher for first through eighth grades. Review of Resident 8's care plan, indicated the staff developed the following care plan Focus areas: i. The care plan area addressing Resident #8's impaired cognitive function, dated 8/24/17, documented she had dementia without behavioral disturbances, short and long term memory deficits, and poor safety awareness. The interventions directed the staff to: Monitor/document/report to heath care provider any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, [and] mental status (initiated 08/03/17). Communication: Reduce any distractions- turn off TV, close door, etc. (revised 08/24/18). Present just one thought, idea, question or command at a time (initiated 08/04/17). Invite [Resident #8] to Friendship circle, popcorn group, musical events, religious events, and/or other leisure activities of interest (revised 04/24/18). Dementia/impaired thoughts: Attempt non-pharmacological interventions: 1:1 visits, assist to activities, reminisce about teaching school, call daughter [name] revised 08/10/17). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. The care plan area addressing Resident #8's communication problem, dated 8/16/17, documented she had dementia without behavioral disturbance as evidenced by short and long term memory deficits, needing information repeated, and step by step instructions. The interventions directed the staff to: Encourage her to continue stating thoughts even if she is having difficulty. Focus on a word or phrase that makes sense or responds to the feeling she is trying to express (revised 08/16/17). Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed (initiated 08/15/17). Monitor for and document changes in [Resident #8's] ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend (revised 08/16/17). Monitor/document/report to health care provider PRN [as needed] changes in: ability to communicate and potential contributing factors for communication problems (initiated 08/15/17). Ensure availability and functioning of adaptive communication equipment: hearing aids; assist to place and remove (revised 08/22/18). Use communication techniques which enhance interaction: allow adequate time to respond, repeat as necessary, do not rush; request feedback/clarification from the [sic] [Resident #8] to ensure understanding, face when speaking and make eye contact, turn off TV as needed to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues (revised 08/24/17). Be conscious of [Resident #8's] location when in groups, activities, [and the] dining room to promote proper communication with others (initiated 08/15/17). Use effective strategies: [Resident's name] has an orange journal in her room for family/friends/staff to write reminders, especially that her daughter has visited in order to enhance communication and assist with remembering events (revised 08/15/17). The resident prefers to be called [Resident #8's name] (revised 08/16/17). The staff did not utilize information from Resident 8's Activity Interest Data Collection Tool to formulate individualized, non-pharmacological care plan interventions for the staff to implement to help promote an optimal sense of physical, emotional, and psychological well-being for Resident 8. During an interview on 10/11/18 at ____ , the MDS Coordinator stated the LSW was responsible for the development of the care plans and interventions related to dementia and/or behavioral symptoms but added that she thought the care plans for residents with dementia included person-centered interventions. During an interview on 10/12/18, at ___, the LSW stated she was responsible developing the psychosocial section(s) of the residents' care plans and had begun a process for ensuring the residents' care plans included person-centered interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Care Plan, revised 11/2016, indicated the following: Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36314 Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 3 of 14 residents (#1, #6, #14) reviewed for standards of practice. Resident #1 and #14 had the potential for harm when they were not repositioned routinely to prevent potential skin impairments. Resident #6 had the potential for harm when he received blood pressure lowering medications when he was experiencing low blood pressures. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: 37265 The facility's Positioning Policy and Procedure, dated 10/17, documented staff would reposition residents to reduce their risk of developing pressure ulcers. 2. Resident #14 was admitted to the facility on [DATE], with diagnoses which included bilateral osteoarthritis of the knee, pain, idiopathic peripheral autonomic neuropathy, peripheral vascular disease, and degeneration of the lumbar disc in the back. A quarterly MDS assessment, dated 8/9/18, documented Resident #14 was cognitively intact and she required extensive assistance of one to two staff members with all cares except eating. The care plan area addressing Resident #14's ADL care, revised 6/7/18, documented Resident #14's required 1 staff members assistance with bed mobility and transfers. Resident #14's Positioning Assessment, dated 9/3/18, documented she was incontinent of bladder and required extensive assistance with all transfers and assist with bed mobility. The assessment documented Resident #14 was obese and had frequent recurring rashes to her groin and pannus area. The assessment documented she was at risk for skin breakdown and her skin was fragile. Resident #14 was not repositioned consistently as follows: *On 10/11/18 at 10:44 AM, the DNS stated the staff were instructed to document repositioning of residents in their chair and beds under the bed mobility section of the charting system. The DNS stated the staff were to document each occurrence of repositioning they provided to residents. The September 2018 ADL Bed Mobility record documented the following: - There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 day shift, except once on 9/1/18-9/3/18, 9/8/18, 9/9/18, 9/14/18-9/17/18, 9/20/18-9/25/18, and 9/28/18-9/30/18. - There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 evening shift, except once one evening shift of 9/5/18, 9/6/18, 9/9/18, 9/19/18, 9/25/18, and 9/30/18. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 night shift, except once per shift on 9/2/18, 9/6/18-9/14/18, 9/19/18, 9/22/18-9/24/18, and 9/27/18 and twice per shift on 9/1/18, 9/4/18, 9/15/18, 9/17/18, 9/20/18, 9/25/18, and 9/29/18, and three times per shift on 9/28/18. The 10/1/18 through 10/10/18 ADL Bed Mobility record documented the following: - There was no documented evidence she was turned and/or repositioned between 10/1/18 through 10/10/18 day shift, except once on 10/1/18, 10/5/18, 10/7/18, and 10/8/18. - There was no documented evidence she was turned and/or repositioned between 10/1/18 through 10/10/18 evening shift. - There was no documented evidence she was turned and/or repositioned between 10/1/18 through 10/10/18 night shift, except once per shift on 10/1/18, 103/18, and 10/4/18 and twice per shift on 10/2/18, 10/5/18-10/9/18. On 10/9/18 at 3:48 PM, Resident #14 was observed positioned in her wheelchair in her room. Resident #14 stated staff did not often reposition her at night or during the day. Resident #14 stated staff would place her in her bed and not move her until she woke in the morning unless she called for assistance to go the restroom. Resident #14 stated she did not want to bother staff with assisting her to reposition and stated she was aware of the risk of skin breakdown. Resident #14 was observed positioned in her wheelchair on 10/10/18 at 8:46 AM through 1:55 PM and on 10/11/18 from 5:51 AM through 11:22 AM in her wheelchair in her room. On 10/11/18 at 6:09 AM, Resident #14 was observed positioned close to the edge of the left side of her bed, on her left side with her legs bent at the knees and hanging over the edge of the bed. Resident #14 was observed grasping the hand rail tightly and her face was pressed close the rail. Resident #14 stated to CNA #3, I have been hanging here like this since 4 in the morning, please help. CNA #3 hurried to Resident #14's aide and assisted her with positioning. On 10/11/18 at 11:22 AM, the DNS stated residents should be assisted with positioning minimally every 2-3 hours. The DNS stated the documented did not show this was being completed. 3. Resident #1 was admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbances, anxiety, depression, borderline personality disorder, and pseudobulbar affect. A quarterly MDS assessment, dated 7/3/18, documented Resident #1 had a severe cognitive impairment and required extensive assistance of 1-2 staff members for all cares. The care plan area addressing Resident #1's ADL care, revised 6/6/16, documented Resident #1 required two staff members assistance with bed mobility and transfers. Resident #1 was not repositioned consistently as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/18 at 10:44 AM, the DNS stated the staff were instructed to document repositioning of residents in their chair and beds under the bed mobility section of the charting system. The DNS stated the staff were to document each occurrence of repositioning they provided to residents. The September 2018 ADL Bed Mobility record documented the following: - Resident #1 was repositioned/turned once per shift on the day shift between the dates of 9/1/18 and 9/29/18. - Resident #1 was repositioned/turned once per shift on the evening shift between the dates of 9/1/18 and 9/30/18. - There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 night shift, except once per shift on 9/1/18, 9/3/18-9/5/18, 9/8/18-9/10/18, 9/13/18, 9/18/18, 9/19/18, 9/22/18-9/24/18, and 9/27/18-9/30/18 and twice per shift on 9/25/18. The 10/1/18 through 10/10/18 ADL Bed Mobility record documented the following: - Resident #1 was repositioned/turned once per shift on the day shift between the dates of 10/1/18 and 10/10/18 and twice per shift on 10/2/18, 10/4/18, and 10/5/18. - Resident #1 was repositioned/turned once per shift on the evening shift between the dates of 10/1/18 and 10/10/18. - Resident #1 was repositioned/turned once per shift on the night shift between the dates of 10/1/18 and 10/10/18. On 10/9/18 from 12:33 PM through 3:22 PM, Resident #1 was observed positioned in her wheelchair in the activities room. Resident #1 was observed positioned in her wheelchair on 10/10/18 at 10:21 AM through 1:55 PM in her wheelchair in the activity room. On 10/11/18 at 11:22 AM, the DNS stated residents should be assisted with positioning minimally every 2-3 hours. The DNS stated the documented did not show this was being completed. 4. Resident #6 was admitted to the facility on [DATE], with diagnoses which included hypertension. According to the 2018 Nursing Drug Handbook, those receiving Amiodarone HCL, an antiarrhythmic (heart medicine), should have their BP and heart rate monitored frequently. An annual MDS assessment, dated 7/12/18, documented Resident #6 was cognitively intact. The care plan area addressing Resident #6's hypertension, revised 9/18/18, documented staff were to monitor Resident #6 for signs of low blood pressure. Resident #6's Physician Orders included: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Amiodarone HCL 200 mg in morning for cardiac, ordered 9/25/16 and discontinued 10/9/18. - Hold BP medicine and therapy for BP of 90/60 or below after attempting to hydrate with 500 cc of fluids, ordered 1/25/18 and discontinued 10/9/18. - Amiodarone HCL 200 mg in morning, hold BP medicine and therapy for BP of 90/60 or below after attempting to hydrate with 500 cc of fluids, ordered 10/9/18. Resident #6's 9/1/18 through 10/1/18 MAR documented he was administered his Amiodarone HCL 200 daily and the medication was not held on any day. Resident #6's Vital Sign Report 9/1/18 through 10/11/18 documented he experienced multiple BPs below 90/60 and the staff did not hold the BP medication as ordered by the physician. Examples included: - 9/25/18-90/39 - 10/1/18-93/39 - 10/8/18- 88/43 - Resident #6's BP was not assessed prior to giving the medication on the following mornings 9/3/18, 9/9/18, 9/13/18, 9/15/18, 9/24/18, 9/29/18, and 9/30/18. On 10/11/18 at 12:05 PM, the DNS stated the nursing staff should hold a medication of a residents BP was low from either number the systolic or the diastolic. The DNS stated this was not done on Resident #6's medication. The DNS stated if a CNA obtained the vital for the nurse and the number was low she was expecting the staff to recheck the BP to ensure the BP was indeed low.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on observation, record review and staff interview, it was determined the facility failed to ensure residents did not develop avoidable pressure ulcers. This was true for 1 of 2 residents (#25) reviewed for pressure ulcers. Resident #25 was harmed when she developed 2 pressure ulcers. Findings include: The facility's Wound and Pressure Ulcer Management Policy and Procedure, dated 1/17, documented the facility followed protocols and procedures consistent with the Agency for Healthcare Research and Quality (AHRQ), the American Medical Director Association (AMDA), and the Society for Post-Acute and Long-Term Care Medicine. The facility's Positioning Policy and Procedure, dated 10/17, documented staff would reposition residents to reduce their risk of developing pressure ulcers. The 2014 guidelines for staging wounds, from the National Pressure Ulcer Advisory Panel, Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, documented a Stage I pressure ulcer was defined as nonblanchable (Skin that remains red in color after pressure was applied.) intact redness to skin over a bony area. The guidelines documented a Stage II wound was partially skin thickness loss (A Wound that affects the top two layers of the skin.) with red and or pink in the wound bed without slough (A mass of dead tissue that separates from a wound bed.). The guidelines documented a Stage III wound was full skin thickness loss (A wound that affected the layers of skin and into the subcutaneous tissue of fat.) with possible slough present in the wound bed, however, the base of wound is visible. The guidelines documented a Stage IV wound was a full thickness tissue loss with exposed muscle, bone, or tendon. The guideline documented slough or eschar could be present in parts of the wound bed. The guideline documented an unstageable wound was of unknown depth due to the base of the wound covered by slough or eschar. Resident #25 was admitted to the facility on [DATE], with diagnoses which included difficulty walking, muscle weakness, and pain. The care plan area addressing Resident #25's pressure ulcer, initiated 4/14/17, documented Resident #25 had a stage II pressure injury to her coccyx and a Deep tissue injury (DTI) to her buttock. The care plan documented she was risk related to incontinence, impaired mobility, and a history of dermatitis. The care plan documented staff were to encourage Resident #25 to lift her buttock off of her wheelchair seat a minimum of twice per shift. (The facility had two shifts.) The care plan documented Resident #25 was to receive wound care per orders and staff were to encourage her to lay down for pressure relief during the day. Resident #25's clinical record contained Weekly Skin Observation Assessments between the dates of 5/1/18 and 10/10/18. The assessments were completed weekly and PRN. Resident #25's Weekly Skin Observation Assessment, dated 5/8/18, documented her skin was intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #25 developed and/or re-developed a Stage III pressure ulcer to her coccyx in September 2018, and the facility did not treat, implement interventions, and assess her pressure ulcer when the skin impairment was first discovered in May 2018. Examples include: i. Resident #25's Weekly Skin Observation Assessment, dated 5/15/18, documented Resident #25 had a new area to her coccyx which was red with fragile skin noted. The assessment did not document if the skin was blanchable or provided measurements for the area. Resident #25's clinical records did not contain a Wound Data Collection, dated 5/15/18, describing the skin impairment. Resident #25's May 2018 MAR or TAR and physician's orders did not contain treatment orders for the skin impairment found in May on her coccyx. Resident #25's Weekly Skin Observation Assessment, dated 6/9/18 and 6/12/18, documented Resident #25's coccyx had healing buttocks wound and was healing. The assessments did not document if the skin was blanchable or provided measurements for the area. Resident #25's clinical records did not contain a Wound Data Collection or a progress note, dated 6/9/18 and 6/12/18, describing the skin impairment. Resident #25's Positioning Assessment, dated 6/25/18, documented her Braden score was a 16 which placed her at risk for skin breakdown and she had no current skin breakdown. A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #25's skin was intact, and she did not have a pressure ulcer. Resident #25's Positioning Assessment, dated 9/18/18, documented she was incontinent of bowel and bladder and required assistance with bed mobility and transfers. The assessment documented her skin was in good condition. This assessment was not consistetnt with the 9/18/18 weekly skin observtion assessment or progress notes. ii. Resident #25's Weekly Skin Observation Assessment, dated 9/18/18, documented Resident #25's coccyx had a Stage III pressure injury to her coccyx. The assessment documented the facility changed out the cushion on her wheelchair and planned to reposition her every 3 hours. A Progress Note, dated 9/18/18, documented Resident #25 was found to have a Stage III pressure injury to her coccyx after being assisted in the shower. A Progress Note, dated 9/20/18, documented Resident #25's wound was assessed, and the dressing was changed. The note documented Resident #25's wound bed did not have slough, no evidence of subcutaneous fat, or full thickness tissue loss. The note documented the wound was a Stage II. Resident #25's Wound Data Collection, dated 9/20/18, documented Resident #25 had a previously identified stage II wound to her coccyx, measuring 1.5 cm by 0.5 cm. The assessment documented the wound was pink and intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #25's Wound Data Collection assessments for her coccyx were completed between the dates of 9/20/18 and 10/11/18 by 11 different nurses. Thedocumentation of the characteristics of the wound was incomplete and inconsistent as follows: *On 9/27/18 Resident #25's wound worsened in size to 2.5 cm by 1 cm and 0.5 cm in depth. *The 9/27/18 assessment documented the wound remained a Stage II wound and the wound bed had 90% slough covering the surface with 5% granulation tissue [pink or beefy red moist tissue]. (The national standards documented slough present would not be a Stage II wound, but an unstageable wound.) * On 9/29/18 Resident #25's wound was documented as worsening in size to 3 cm by 2 cm by 1 cm, no staging documented. * The 9/29/18 assessment documented 5% granulation and no other tissue type documented. * The 9/30/18 assessment documented the wound size remained the same, however there was 5% eschar in the wound bed, no staging documented. *On 10/2/18 the assessment documented the wound was 2.5 cm by 1.5 cm by 0.1 with 100% slough in the wound bed, no staging documented. (The depth of a pressure ulcer cannot be determined when the wound bed is covered by slough 100%.) * The 10/2/18 assessment documented the pressure ulcer was worsening. *On 10/3/18 the assessment documented the wound was a Stage III pressure ulcer, measuring 2.5 cm by 1. 5 cm by 4 cm deep, with 85% slough covering the wound bed, 10% epithelialized tissue (new skin tissue), and 5% granulation tissue. (The depth of a pressure ulcer cannot be determined when the wound bed is covered by slough or eschar.) A day later on 10/4/18 the Stage III pressure ulcer was documented as measuring 2.5 cm by 1.5 cm by 0.5 cm deep with 80% slough in the wound bed. (The wound healed 3.5 cm in one day according to the assessment.) Five assessments on 10/6/18, 10/7/18, 10/9/18, 10/10/18, and 10/11/18 following 10/4/18 documented the presence of slough in the wound bed. The 9/28/18, 10/5/18, and 10/8/18 assessments did not document an assessment of the wound bed to include the presence of granulation tissue, slough, eschar, or epithelial tissue. The wound was last measured on 10/10/18 as 2 cm by 1.5 cm by 2 cm deep as a Stage III pressure ulcer. Resident #25's September 2018 MAR documented staff were to cleanse her stage II Pressure Ulcer wound with [NAME] sterile saline solution and apply foam border adhesion dressing or alginate hydrocolloid dressing every 3-5 days and PRN, beginning 9/21/18 and discontinued 10/6/18. This was ordered three days after the wound was discovered. The order was not specific to the location of the pressure ulcer. The dressing was changed as ordered with the exception of 9/21/18. b. Resident #25 developed and/or re-developed a skin impairment in September 2018 on her left buttocks, and the facility did not treat and implement interventions to her left buttocks when the skin impairment was first discovered in May 2018. Example includes: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	i. Resident #25's Weekly Skin Observation Assessment, dated 5/19/18, documented Resident #25 had a recurrent area to her left buttock that was a stage II. The assessment document the wound was an open area approximately 0.5 cm by 1 cm that was previously scabbed over. Resident #25's Wound Data Collection, dated 5/19/18, documented Resident #25 had new wound to her left buttock, measuring 0.5 by 0.5 cm by 0.25 cm deep. The assessment documented the wound was reopened. The assessment did not document an assessment of the wound bed characteristics. Resident #25's Wound Data Collection, dated 5/26/18, documented Resident #25's wound to her left buttock, measured 0.5 by 0.5 cm. The assessment documented the wound bed had 100% epithelial tissue present in the wound bed. Resident #25's May 2018 MAR or TAR and physician's orders did not contain treatment orders for the skin impairment found in May on her left buttock. ii. Resident #25's Weekly Skin Observation Assessment, dated 9/18/18, documented Resident #25 had a deep tissue injury to her left buttock. The assessment documented the facility changed out the cushion on her wheelchair and planned to reposition her every 3 hours. A Progress Note, dated 9/18/18, documented Resident #25 had a deep tissue injury to her left buttock. The note documented Resident #25 was being assisted into her wheelchair by two staff members when Resident #25's stated her legs were tired and began to sit down. The note documented Resident #25's legs were tired and gave out on her and she was lowered to the floor. The note documented Resident #25's deep tissue injury may have come from this incident as she hit her buttock on the arm rest of the wheelchair. Resident #25's Wound Data Collection, dated 9/20/18, documented Resident #25 had a previously identified deep tissue injury wound to her left buttock, without measurements. The assessment documented Resident #25's left buttocks had a bruised area. Resident #25's Wound Data Collection assessments for her left buttock were completed between the dates of 9/20/18 and 10/4/18 by 3 different nurses. The documentation of the characteristics of the wound and wound size, were inconsistently documented between nurses as follows: * On the 9/20/18, 9/22/18, 9/23/18, and 9/28/18, Resident #25's wound was not documented as measured. *The 9/23/18 assessment documented the wound bed had 3 small areas open. *The 9/24/18 assessment documented the wound was open and measured 1 cm by 1 cm with 65% granulation and 35% epithelial tissue. * On 9/27/18 Resident #25's wound was documented as worsening in size to 1.5 cm by 3 cm, with 100% granulation tissue. The 9/27/18 assessment documented the area was no longer bruised, but there were two open areas present. (continued on next page)

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Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*The 10/4/18 assessment documented the deep tissue injury was 0.5 cm by 0.5 cm with 95% epithelial tissue present. This was the last assessment of the wound. Resident #25's clinical record did not document when her left buttock wound resolved. Resident #25's September 2018 MAR or TAR and physician's orders did not contain treatment orders for the skin impairment found in September on her left buttock. c. Resident #25 developed new a skin impairment on her left gluteal fold and the facility did not implement interventions or consistently assess the wounds. Example includes: Resident #25's Weekly Skin Observation Assessment, dated 10/2/18, documented Resident #25 had an abrasion to her left gluteal fold. The assessment did not document a size of the wound. Resident #25's Wound Data Collection, dated 10/3/18, documented Resident #25 had previously identified wounds to her left gluteal fold. The assessment documented there were three areas that were connecting with excoriated (rubbed off skin) skin. The assessment documented one area was 1 cm by 0.5 cm by 0.2 cm deep. The assessment documented the biggest wound had slough present in the wound bed and one wound appeared to be a Stage I. The assessment documented there was 85% slough present in the wound bed. A Progress Note, dated 10/3/18, documented Resident #25 had three sores located on her coccyx, right [NAME], and crease of buttock and leg on the right hand side. The 3rd sore is a cluster of satellite open areas with one main area measuring 1 cm x [by] 0.5 cm. Resident #25's Wound Data Collection, dated 10/4/18, documented Resident #25 had previously identified wounds to her left gluteal fold. The assessment documented there were three areas, measuring 1 cm by 1.5 cm with 85% slough present in the wound bed. The assessment documented there was a 3 cm by 3 cm excoriated area surrounding the open area. The assessment documented the other two area look like potential problem. The assessment documented there was 85% slough present in the wound bed. Resident #25's clinical record did not contain documentation of the progression of the three areas to the left gluteal folds or documentation of further assessments after 10/4/18. Resident #25's October 2018 MAR or TAR and physician's orders did not contain treatment orders for the three areas of skin impairment found in October on her left gluteal fold. d. Resident #25 was not repositioned consistently and every 3 hours as follows: On 10/11/18 at 10:44 AM, the DNS stated the staff were instructed to document repositioning of residents in their chair and beds under the bed mobility section of the charting system. The DNS stated the staff were to document each occurrence of repositioning they provided to residents. The DNS stated the staff were to reposition Resident #25 mininally every 3 hours. The September 2018 ADL Bed Mobility record documented the following: - There was no documented evidence she was turned/repositioned between 9/1/18 through 9/18/18 day shift, except once on 9/7/18 and 9/15/18. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- There was no documented evidence she was turned/repositioned between 9/1/18 through 9/18/18 evening shift, except once one evening shift on 9/5/18 when she was documented as she was able to do it herself. - There was no documented evidence she was turned/repositioned between 9/1/18 through 9/18/18 night shift, except once per shift on 9/1/18, 9/4/18, 9/5/18, 9/10/18, and 9/18/18 and twice per shift on 9/3/18. The ADL sheet documented Resident #25 was able to provide bed mobility independently once per shift on 9/1/18, 9/6/18, 9/10/18, 9/12/18, 9/13/18-9/15/18 and twice per shift on 9/7/18, 9/8/18, and 9/16/18. * The bed mobility between 9/19/18 through 9/30/18 day shift documented she was repositioned the following hours a day: - 9/19/18- Resident #25 was repositioned at 8:28 AM and again at 3:54 PM (7 1/2 hours). - 9/20/18- Resident #25 was repositioned at 1:10 AM and again at 12:20 PM (9 hours). - 9/22/18- Resident #25 was repositioned at 12:51 AM and again at 6:00 AM (5 hours). Resident #25's ADL documentation documented similar findings for the remainder of September 2018. The 10/1/18 through 10/11/18 ADL Bed Mobility record documented the following: -10/9/18- Resident #25 was repositioned at 1:33 PM and again at 7:21 PM (6 hours). - 10/10/18- Resident #25 was repositioned at 8:02 AM and again at 1:18 PM (5 hours) and at 2:43 PM and again at 7:34 PM (5 hours). - 10/11/18 Resident #25 was repositioned at 6:15 AM and again at 10:01 AM (4 hours). Resident #25's 10/1/18 through 10/8/18 ADL documentation documented similar findings. On 10/9/18 from 2:15 PM through 4:33 PM, Resident #25 was observed positioned in her wheelchair located in the activity room by the window without staff offering to reposition her or staff providing assistance with repositioning. Resident #25 was observed positioned in her wheelchair on 10/10/18 at 8:38 AM through 12:25 PM, on 10/10/18 at 1:58 PM, and on 10/11/18 from 6:54 AM through 10:01 AM, and 10:15 AM through 11:45 AM, and 12:50 PM through 3:25 PM. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/11/18 at 6:10 AM, Resident #25's wound care was observed. RN #1 was observed instructing CNA #1 to assist Resident #25 onto her left side from her back while in bed. CNA #1 rolled Resident #25 onto her left side and Resident #25 began to immediately cry out, Oh, oh! That hurts! CNA #1 reassured Resident #25 that she would not let her fall and adjusted her legs to try and help ease her pain. CNA #1 unfastened the brief on Resident #25's right hip and pulled it down to reveal an intact foam dressing at the midline of her coccyx. RN #1 began to remove the dressing and Resident #25 again cried out in pain and complained of pain. RN #1 continued to dispose of the old dressing and then used her gloved right hand to hold up Resident #25's right buttock to view the pressure ulcer. The pressure ulcer was observed located in the midline of Resident #25's coccyx at the top of the gluteal fold. The pressure ulcer measured approximately the size of a quarter with a depth of approximately 1.5 cm. The wound bed had a pale-yellow appearance with 30% stingy slough present that was moveable after cleansing. The wound was observed with no signs of infection, exudate, eschar, or tunneling of the pressure ulcer, but also no signs of granulation tissue, or re-epithelization. Wound margins were well-defined, with no undermining noted. The peri-wound skin was observed light pink in color with no signs and symptoms of irritation or infection, and no odors were noted. RN #1 disposed of the old dressing and she picked up a can of saline wound cleanser and sprayed the wound bed with a wound cleanser. RN #1 patted the pressure ulcer dry with a sterile 4 x 4 and removed her gloves, sanitized her hands, and re-gloved. While RN #1 was cleansing the wound Resident #25 continued to complain of pain and cry out, That hurts. RN #1 covered Resident #25's pressure ulcer with a cut small piece of oil emulsion dressing, and with a self-adhering antimicrobial foam dressing. On 10/11/18 at 10:44 AM, the DNS stated the wounds to Resident #25's coccyx and buttock were both found in September 2018. The DNS stated the September 2018 assessment documented the wounds being previously identified was a mistake. The DNS stated she was unsure where that information came from. The DNS stated she was unsure what the wounds found in May 2018 were and she suspected these wounds healed and resolved without facility staff documenting resolution dates and updating the care plan. The DNS stated the staff should be completing a Wound Data Collection assessment when they resolve a wound. The DNS stated staff should notify her when new skin areas were found. The DNS stated she could see there was inconsistency with the documentation of the wounds. The DNS stated the facility did not have a wound certified nurse for wound care and all nurses on the floor completed wound assessments. The DNS stated the staff should be repositioning Resident #25 minimally every 3 hours, and she could see this was not documented as completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on staff interview and record review, it was determined the facility failed to ensure mechanical transfer sling was the correct size to reduce potential injuries. This was true for 1 of 5 residents (#25) reviewed for supervision and accidents. These failed practices placed residents at risk of bone fractures and other injuries related inapproprite use of a mechanical lift. Findings include: Resident #25 was admitted to the facility on [DATE], with diagnoses which included difficulty walking, muscle weakness, and pain. A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #25's experienced 1 fall since the last assessment. The care plan area addressing Resident #25's risk for falls, revised 6/6/18, documented Resident #25 was at risk of falling related to impaired mobility, a history of falls, weakness, and Alzheimer's. On 10/11/18 at 6:28 AM, Resident #25 was observed sitting in her wheelchair with CNA #1 assisting her with her morning cares. While CNA #1 wheeled Resident #25 into the bathroom, Resident #25 was crying out, Ow, ow, ow, ow. CNA #1 proceeded to position Resident #25's wheelchair in the bathroom doorway, and asked Resident #25 stand up and reach for the assist bar on the wall by the toilet. Resident #25 was observed trying to stand up and stated, Nope, I can't stand. Oh, it hurts so bad. It's hurting can you hold my feet. Its hurting so bad. My legs hurt, my whole-body hurts, God, that hurts. Resident #25 asked CNA #1 to please use the Hoyer lift. CNA #1 left the room to obtain a mechanical lift. On 10/11/18 at 6:32 AM, CNA #1 returned with a sit-to-stand mechanical lift and placed a body sling around Resident #25's torso, just below her breasts. The CNA asked her to place her feet on the machine's foot plate, and hold onto the lift bars, which she did. Then CNA #1 lifted Resident #25 off her wheelchair and asked her to stand so she could remove her incontinence brief. While Resident #25 was being lifted in the air she said, Hurry, it hurts, ow, hurry it hurts. CNA #1 removed the soiled brief. Resident #25 stated she needed to sit down, and she was going to fall. CNA #1 stated she was almost done and assisted Resident #25 onto the toilet. Then the CNA removed the sling while Resident #25 used the toilet. After Resident #25 used the toilet and CNA #1 provided pericare, the CNA assisted her with applying a clean brief and clean pants. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/18 at 6:48 AM, CNA #1 was observed as she applied the sit-to-stand sling around Resident #25's torso, just below her breasts, and asked her to place her hands on the lift bars. The sling was slightly loose. As Resident #25 was raised up she cried out, Ow, ow, ow, hurry, I'm going to fall, it hurts, it hurts, it hurts. As CNA #1 continued to move Resident #25 from the bathroom toward to her wheelchair, approximately 8 feet away, Resident #25 began to slide down into a sitting position, as the loose sling slid under her underarms, the strap/belt of the sling slid into her mouth gagging her, and the back of the sling curled up over her head. As CNA #1 continued to move Resident #25 towards the wheelchair, her legs were bent at a 45-degree angle and her buttocks was below the seat of the wheelchair. CNA #1 had to raise the sit-to-stand lift high enough in order to place Resident #25's bottom on the front part of her wheelchair seat. Then CNA #1 went around behind Resident #25 and pulled Resident #25's pants as leverage to position her all the way onto her wheelchair seat. Resident #25 appeared frightened, her eyes were opened wide and the sling stap was still in her mouth. When CNA #1 removed the sling Resident #25 relaxed into her wheelchair and sighed deeply. On 10/11/18 at 6:50 AM, CNA #1 was observed notifying RN #1 that Resident #25 was acting different this morning. CNA #1 stated Resident #25 could not brush her own teeth and was different. RN #1 asked CNA #1 to take Resident #25's vitals and RN #1 would assess Resident #25's blood sugar. On 10/11/8 at 6:54 AM, RN #1 and CNA #1 checked Resident #25's blood sugar and vital signs, Resident #25's results were within normal limits. On 10/11/18 at 7:21 AM, CNA #1 stated Resident #25 was fearful of the sit-to-stand machine and she noticed it about 1 week ago. CNA #1 stated Resident #1 was afraid of falling. CNA #1 stated the facility had two-person Hoyer lifts they could use with a bed side commode for residents. CNA #1 stated Resident #25 started trying to sit down more yesterday and she was close to falling when CNA #1 assisted her on the edge of the bed. CNA #1 stated she had not told anyone about the incident yet. CNA #1 stated she had told RN #1 that Resident #25 was acting differently. CNA #1 stated she had not told the RN about Resident #25's sit-to-stand sling and Resident #25 biting the strap or her legs giving out on her or the incident on the previous day. CNA #1 stated she could have given the RN more information and she would. CNA #1 stated she thought Resident #25 was afraid of the sit-to-stand lift and falling because she had more falls recently. CNA #1 stated She could usually talk Resident #25 into using the lift and calm her down, she stated she was not sure what happened these last couple days. The care plan did not direct staff to use the sit-to-stand lift to transfer the resident between surfaces. On 10/11/18 at 10:44 AM, the DNS and the IDNS stated they would expect staff to report changes in a residents' condition to the nurse as soon as possible. The DNS stated the CNA #1 did talk to the RN after the surveyor spoke with the Aide. The DNS stated Resident #25 would be evaluated by therapy for strength for the most appropriate transfer and she would be placed on the fall committee. The DNS stated if the CNA noticed a change in Resident #25's ability to transfer on 10/10/18 she should have notified nursing.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on observation, staff and resident interview, and review of residents' clinical records, it was determined the facility failed to ensure a method for evaluating the effectiveness of residents' pain management plans was in place. This was true for 1 of 5 residents (#25) reviewed for pain. Resident #25 was harmed when she experienced increased pain during cares and a dressing change and the facility did not identify and treat it. Findings include: The facility's Pain Management Policy and Procedure, dated September 2012, documented when a resident was identified to be in pain a registered nurse would assess the residents current pain level and offer non-pharmacological interventions and provide medication interventions as needed. Resident #25 was admitted to the facility on [DATE], with diagnoses which included difficulty walking, muscle weakness, and pain. A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #25's did not have pain. The care plan area addressing Resident #25's chronic pain, revised 6/6/18, documented Resident #25 had generalized pain and could verbalize her pain. The care plan area addressing Resident #25's pressure ulcer, initiated 4/14/17, documented Resident #25 had a Stage II pressure injury to her coccyx and a DTI to her buttock. Resident #25's Physician Orders Included the following: * Staff were to monitor her pain every shift, ordered 5/16/18. * 650 mg of Tylenol by mouth every 6 hours PRN for pain, ordered 7/27/17. Resident #25 did not have orders for scheduled pain medications. The Wound Data Collection Assessments from 9/20/18, 9/24/18, 9/30/18, 10/3/18, 10/4/18, 10/6/18, 10/7/18, and 10/11/18 documented Resident #25 complained of pain during the dressing changes. Resident #25's Weekly Skin Observation Assessment, dated 9/18/18, documented Resident #25 had a deep tissue injury to her left buttock. The assessment documented the facility changed out the cushion on her wheelchair and planned to reposition her every 3 hours. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	On 10/11/18 at 6:10 AM, Resident #25's wound care was observed. RN #1 was observed instructing CNA #1 to assist Resident #25 onto her left side from her back while in bed. CNA #1 rolled Resident #25 onto her left side and Resident #25 began to immediately cry out, Oh, oh! That hurts! CNA #1 reassured Resident #25 that she would not let her fall and adjusted her legs to try and help ease her pain. CNA #1 unfastened the brief on Resident #25's right hip and pulled it down to reveal an intact foam dressing at the midline of her coccyx. RN #1 began to remove the dressing and Resident #25 again cried out in pain and complained of pain. RN #1 continued to dispose of the old dressing and then used her gloved right hand to hold up Resident #25's right buttock to view the pressure ulcer. RN #1 disposed of the old dressing and she picked up a can of saline wound cleanser and sprayed the wound bed with a wound cleanser. RN #1 patted the pressure ulcer dry with a sterile 4 x 4 and removed her gloves, sanitized her hands, and re-gloved. While RN #1 was cleansing the wound Resident #25 continued to complain of pain and cry out, That hurts. While the wound care was being provided, Resident #25 stated the pain was located in, My back, and from the wound when they clean it. Resident #25 stated staff had not provided pain medication prior to wound care nor offered. Resident #25 stated, No, but that would probably help. On 10/11/18 at 6:27 AM, RN #1 was observed leaving Resident #25's room. RN #1 stated she had just given Resident #25 Tylenol for pain. On 10/11/18 at 6:28 AM, Resident #25 was observed sitting in her wheelchair with CNA #1 assisting her with her morning cares. While CNA #1 wheeled Resident #25 into the bathroom, Resident #25 was crying out, Ow, ow, ow, ow. CNA #1 proceeded to position Resident #25's wheelchair in the bathroom doorway, and asked Resident #25 stand up and reach for the assist bar on the wall by the toilet. Resident #25 was observed trying to stand up and stated, Nope, I can't stand. Oh, it hurts so bad. It's hurting can you hold my feet. Its hurting so bad. My legs hurt, my whole body hurts, God, that hurts. Resident #25 asked CNA #1 to please use the Hoyer lift. CNA #1 left the room to obtain a mechanical lift. On 10/11/18 at 6:32 AM, CNA #1 returned with a sit-to-stand mechanical lift and placed a body sling around Resident #25's torso, just below her breasts. The CNA asked her to place her feet on the machine's foot plate, and hold onto the lift bars, which she did. Then CNA #1 lifted Resident #25 off her wheelchair and asked her to stand so she could remove her incontinence brief. While Resident #25 was being lifted in the air she said, Hurry, it hurts, ow, hurry it hurts. CNA #1 removed the soiled brief. Resident #25 stated she needed to sit down, and she was going to fall. CNA #1 stated she was almost done and assisted Resident #25 onto the toilet. Then the CNA removed the sling while Resident #25 used the toilet. After Resident #25 used the toilet and CNA #1 provided pericare, the CNA assisted her with applying a clean brief and clean pants. On 10/11/18 at 6:48 AM, CNA #1 was observed as she applied the sit-to-stand sling around Resident #25's torso, just below her breasts, and asked her to place her hands on the lift bars. The sling was slightly loose. As Resident #25 was raised up she cried out, Ow, ow, ow, hurry, I'm going to fall, it hurts, it hurts, it hurts. On 10/11/18 at 6:35 AM, RN #1 stated she had not administered pain medications prior to Resident #25's wound dressing change. RN #1 stated she had not spoken with Resident #25's physician about obtaining a pre-treatment pain medication order. RN #1 stated, Giving her [the resident] pain medication at about 5:00 AM every morning would probably work well. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 10/11/18 at 10:45 AM, the DNS stated she would expect the staff to pre-medicate Resident #25 prior to the dressing change. The DNS stated the nurse told her about the resident's complaint of pain during the dressing change and that Resident #25 had not complained of pain during dressing changes in the past. The DNS stated she would expect staff to wait for pain medications to be effective before providing cares and if a resident verbalized pain during the dressing change or cares the staff should stop and try and address the situation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on record review and staff interview, it was determined the facility failed to ensure pharmacy recommendations were followed or addressed by the attending physician. This was true for 1 of 5 residents (#14) reviewed for pharmacy recommendations and had the potential for harm if residents' medications were administered without a clinical rationale. Findings include: Resident #14 was admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbances and depression. A quarterly MDS assessment, dated 8/9/18, documented Resident #14 was cognitively intact and she had minimal signs and symptoms of depression. The MDS documented she had no behaviors. The care plan area addressing Resident #14's depression, revised 9/13/17 documented Resident #14's depression presented by tearfulness, self-isolation, statements of loss of home and possessions, and independence. A Physician's Order, dated 9/13/17, documented Resident #14 received Lexapro 10 mg once daily for depression. Resident #14's 9/1/18 through 10/10/18 MAR documented she was administered her Lexapro as ordered. A pharmacy recommendation form, unsigned by the physician, dated 4/30/18, documented Resident #14's Lexapro was currently at 10 mg daily and Resident #14 had not displayed any signs and symptoms of depression for several months. The form documented the GDR team recommended a trial dose reduction to 5 mg of Lexapro. On 10/11/18 at 11:26 AM, the DNS stated if a resident did not exhibit behaviors for a few months then the committee would make a recommendation to attempt a GDR of the medication. On 10/11/18 at 1:55 PM, the LSW stated she could not find evidence the GDR was attempted for Resident #14's Lexapro. The LSW stated she was not sure why it was not completed. The LSW stated Resident #14 would be reviewed in the next GDR committee meeting.

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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** 37265 Based on interview, record review, and facility policy review, it was determined the facility failed to a) attempt GDR of psychotropic medications b) monitor behavioral symptoms , obtain informed consents for the medications. This was true for 3 of 5 residents (#1, #5, and #25) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents receive unnecessary psychotropic medications which were not adequately monitored. Findings include: 1. Resident #1 was admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbances, anxiety, depression, borderline personality disorder, and pseudobulbar affect (sudden crying/laughing). A quarterly MDS assessment, dated 7/3/18, documented Resident #1 had a severe cognitive impairment and she displayed inattentive and disorganized thinking. The MDS documented she had minimal signs and symptoms of depression and no behaviors such as wandering. The care plan area addressing Resident #1's antipsychotic medication, revised 12/8/16, documented Resident #1 required the medication due to dementia with behavioral disturbances, anxiety disorder, and borderline personality disorder as evidenced by angry out-burst, agitation, crying, and threatening behavior. The care plan area addressing Resident #1's dementia, revised 10/26/17, documented Resident #1 had poor safety awareness, wandered into other residents' personal spaces, and had a history of negative resident to resident interactions. a. A GDR was not attempted for Resident #1's Seroquel as follows: A Physician's Order, dated 8/26/16, documented Resident #1 received Seroquel 25 mg twice daily for anxiety related to borderline personality disorder. Resident #1's Physician Orders included Seroquel 25 mg twice daily for anxiety related to dementia with behavioral disturbances and borderline personality disorder, ordered 8/3/17. Resident #1's 3/1/18 through 10/10/18 MAR documented she was administered her Seroquel as ordered. Resident #1's GDR Review, dated 5/1/18, documented her Seroquel was at 25 mg twice daily and the team discussed the recommendations of a hospice and psych evaluation. The note documented Resident #1 was not appropriate for either evaluation at this time. The note documented the GDR committee would continue to monitor and make recommendations for Resident #1's care. Resident #1's GDR evaluation did not review specific behavior or identify she had been on the Seroquel dose 25 mg twice daily for two years without an attempt at reducing the medication. The review did not evaluate Resident #1 for how many episodes/behaviors of anxiety, wandering, physical or verbal aggression she had experienced during the look back period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/18 at 9:07 AM, the LSW stated she was not sure why Resident #1 was on Seroquel for anxiety with a diagnosis of dementia. The LSW stated Resident #1 cried often, was paranoid of the color red, scared to be alone, could not sleep well at night, and would take a hold of staff members arms and not want to let go. The LSW stated the facility practice was to start residents on Melatonin if they could not sleep to try that first before starting residents on antipsychotic medications. The LSW stated there was no documentation that a GDR trial of Resident #1's Seroquel had been completed. The LSW stated she would discuss Resident #1 in the next committee meeting. On 10/11/18 at 9:57 AM, the LSW stated the medication should be provided for borderline personality disorder and was monitored for other behaviors a few years ago. The LSW stated she added Resident #1 to the GDR review list for next month. The LSW stated she was unsure why Resident #1's diagnosis for the medication had changed to dementia with behaviors. The LSW stated she did not know why Resident #1's Seroquel had not been adjusted since 2016. The LSW stated the GDR committee consisted of the LSW, the pharmacist, the DNS, and the MD as needed. The LSW stated the committee reviewed each resident in the facility on antipsychotic medications each month. The LSW stated she could see the GDR reviews were not specific with identifying and reviewing behaviors a resident was experiencing in order to inform the physician on whether to keep a medication or not. On 10/11/18 at 11:26 AM, the DNS stated residents' psychotropic medications should be start low and go slow to find the appropriate dose after non-pharmacological options have been exhausted. The DNS stated residents require medications when they have psych diagnoses and or were harmful to self or others. The DNS stated the facility could send residents out and could provide some behavioral counseling for residents. The DNS stated the GDR process involved the DNS, SW, Pharmacy, and the MD was involved as needed. The DNS stated they reviewed all psychotropic medications in the building for issues. The DNS stated if a resident did not exhibit behaviors for a few months then the committee would make a recommendation to attempt an GDR of the medication. b. Resident #1's behavior monitors did not match as follows: Resident #1's 3/1/18 through 10/10/18 MAR documented staff monitored Resident #1 for verbal and physical aggression, inconsolable distress/crying, and wandering into other residents' spaces. The MAR documented she experienced the following behaviors. - Verbal or physical aggression directed at others- 9/30/18 - Inconsolable distress/crying- 10/4/18 - Wandering- 7/8/18 Resident #1's 9/1/18 through 10/10/18 ADL Flowsheets documented behaviors witnessed by CNA staff. The CNA staff documented different behaviors from the nursing staff. The following behaviors were monitored by the CNAs. - Physical directed towards other- hitting, kicking, pushing, scratching, grabbing, sexual abuse, biting, and no behavior. Resident #1 was documented to have hit towards others on 9/5/18, 9/8/18, 9/22/18, 9/29/18, 10/3/18, 10/8/18, and 10/9/18. Resident #1 was documented to push others twice on 9/4/18. Resident #1 was documented to scratch at other on 9/4/18. Resident #1 was documented to grab at others once on 9/6/18 and 9/7/18 and twice on 9/9/18. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Verbal directed towards others- threatening others, screaming at others, cursing at others, sexual comments, and no verbal behaviors. Resident #1 was documented as threatening others on 9/20/18. Resident #1 was documented as cursing at others on 9/5/18, 9/8/18, 9/9/18, 9/12/18, 9/22/18, 9/29/18, and 10/3/18. - Behaviors not directed at others- hitting self, scratching self, pacing, rummaging, public sexual act, disrobing in public, throwing or smearing food or bodily waste, screaming, disruptive sounds, exit seeking, and no behaviors. Resident #1 was documented as exit seeking on 9/5/18. - Did the residents reject care- yes or no. Resident #1 was documented to have rejected cares once on 9/4/18, 9/8/18, 9/22/18, 10/3/18, and 10/9/18, and twice on 9/5/18 and 9/9/18. - Had the resident wandered- yes or no. Resident was documented to have wandered on 9/5/18. - Was this the first-time the behavior occurred- yes or no. There were no first-time behaviors documents. The CNAs were not monitoring Resident #1 for crying. On 10/11/18 at 9:07 AM, the LSW stated the CNAs documented residents' behaviors in their system and the system behaviors could not be changed. The LSW stated the CNA behavior monitors were identical facility wide and she would figure out to match the residents' behaviors with the nurses behavior monitors. 2. Resident #25 was admitted to the facility on [DATE], with diagnoses which included depression. A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The care plan area addressing Resident #25's depression, revised 7/11/18, documented Resident #25's depression presented as withdrawing from activities of choice and accusing others of taking her things. Resident #25's Physician Orders included Trazodone 50 mg every evening for depression, ordered 4/24/17. Resident #25's 5/1/18 through 10/10/18 MAR documented she was administered her Trazodone as ordered. Resident #25's clinical record did not contain a consent for the Trazodone. On 10/11/18 at 2:21 PM, the LSW stated she could not locate Resident #25's consent for the Trazodone. The LSW stated the facility noticed a few months ago that consents were not completed and they tried to complete them all. The LSW stated Resident #25 had a care conference planned in a few weeks and she would obtain a consent for the medication at that time. 36314 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident 5's undated Admission Record' and undated Medical Diagnosis form indicated the facility admitted the resident on 05/16/17 with a primary diagnosis of vascular dementia with behavioral disturbance. Review of Resident 5's quarterly Minimum Data Set (MDS), an assessment tool completed by the facility staff used to identify resident care problems and assist with care planning, with an Assessment Reference Date (ARD), the end-point of the evaluation period, of 07/10/18, specified under Section C: Cognitive Patterns, Resident 5 had severely impaired cognitive skills and exhibited continuous inattention and disorganized thinking. Section E: Behavior, indicated the resident exhibited physical and verbal behaviors toward others, and behaviors not directed toward others on one to three days of the assessment's seven-day look-back period. Section N: Medications, indicated the resident received antipsychotic medication on all seven days of the assessment's seven-day look-back period. Review of Resident 5's September 2018 Physician Orders indicated Resident 5 received, Zyprexa (an antipsychotic medication) 10 milligrams (mg) daily at bedtime related to dementia . with behavioral disturbance (ordered on 04/06/18). Further review of the orders indicated the physician decreased the resident's Zyprexa dose to 5 mg daily at bedtime on 09/05/18 for dementia . with behavioral disturbance. The orders also directed the staff to, Monitor the following behaviors: T = tearfulness, P = pacing up and down the hallways, I = physically intrusive in others' personal space every shift for behavioral monitoring (ordered 05/16/18). A review of Resident 5's Medication Administration Records (MARs) from 09/05/18 through 10/11/18 indicated the nursing staff documented Resident 5 exhibited no signs or symptoms of tearfulness, pacing up and down the hallways, or of being physically intrusive on others' personal space. During an interview on 10/12/18, the Social Services Director (SSD) stated Resident 5 used to walk and wander in and out of other residents' rooms, then became too unsteady when walking and began using a wheelchair for locomotion. The SSD stated Resident 5 no longer goes in other residents' rooms, but continues to receive antipsychotic medication.

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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. 37265 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when a staff member was observed in the kitchen without a hair restraint. This affected 12 of 12 residents (#1, #2, #3, #4, #5, #6, #8, #14, #18, #23, #25, and #27) and had the potential to affect the remaining 15 residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease-causing pathogens. Findings include: The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food . On 10/10/18 at 1:30 PM, Cook #1 was observed entering the kitchen, without a hair restraint to cover his hair. On 10/10/18 at 1:35 PM, Cook #1 was observed leaving the kitchen, without a hair restraint to cover his hair, and he was holding a pie. On 10/10/18 at 1:45 PM, the Certified Dietary Manager (CDM) stated she would ensure hair restraints were worn.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 5 of 5 residents (#7, #9, #18, #26, and #27) whose immunization records were reviewed. This created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information in the resident's clinical record. Findings include: 1. Resident #27 was admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbances and Parkinson's disease. Resident #27's Immunization Record documented she received the Pneumococcal Polysacchriade (PPSV23) historically and the Pneumococcal Conjugated (PCV13) on 6/26/18. The immunization record documented consent was obtained for the shots, however, Resident #27's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. 2. Resident #9 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis. Resident #9's Immunization Record documented she received the Pneumovax Dose 1 (PCV13) historically and the Pneumococcal 13-valent Conjugated (Prevnar 13) on 6/27/18. The immunization record documented consent was obtained for the shot, however, Resident #9's clinical record did not contain evidenced of a signed or verbal consent was obtained for the vaccine. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. 3. Resident #7 was admitted to the facility on [DATE], with diagnoses which included weakness and Raynaud's syndrome. Resident #7's Immunization Record documented he received the Pneumococcal Conjugated (PCV13) historically and Pneumococcal Polysacchriade (PPSV23) on the 10/9/18. The immunization record documented consent was obtained for the shots, however, Resident #7's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. 4. Resident #18 was admitted to the facility on [DATE], with diagnoses which included acute respiratory disease, heart failure, and pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18's Immunization Record documented she received the Pneumococcal Polysacchriade (PPSV23) historically and the Pneumococcal Conjugated (PCV13) on 6/26/18. The immunization record documented consent was obtained for the shots, however, Resident #18's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. 5. Resident #26 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease and pain. Resident #26's Immunization Record documented she received the Pneumococcal Conjugated (PCV13) on 6/26/18. The immunization record documented consent was obtained for the shots, however, Resident #26's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. On 10/12/18 at 10:15 AM, the DNS stated she did not have the consent forms for the Pneumococcal immunizations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36314 Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 2 of 12 (#25 and #27) residents reviewed for infection control when staff failed to adequately perform effective hand hygiene during residents' cares and dressing changes. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include 1. During observation of pressure ulcer wound care for Resident #25 on 10/11/18 at 6:10 AM, RN #1 checked the resident's wound care orders and retrieved wound care supplies from the medication cart. RN1 then entered the resident's room and setup a clean field for the wound care supplies. RN #1 sanitized her hands and donned gloves. After CNA #1 positioned the resident to the left side and unfastened the resident's brief, RN #1 removed a dressing from the resident's coccyx (lower back) and discarded the old dressing. Then without first removing her contaminated gloves, sanitizing her hands, and re-gloving, RN #1 picked up a can of saline wound cleanser and sprayed Resident 25's pressure ulcer with the wound cleanser, cleansed the ulcer with a sterile gauze pad, and then patted the ulcer with a clean gauze pad to dry the area. RN #1 then removed her gloves, sanitized her hands, re-gloved, and continued with the application of a new dressing. During an interview on 10/11/18 at 10:45 AM, the DNS stated she expected the nursing staff to remove their gloves, sanitize their hands, and re-glove after removing the old dressing and before cleaning and re-dressing a wound. Upon conclusion of the interview with the DNS, a request was made for the facility's policy and procedure for infection control, hand hygiene/sanitization, and glove use during wound care; however, the policy was not provided prior to the survey's exit conference on 10/12/18. 37265 2. On 10/9/18 at 2:32 PM, CNA #2 was observed assisting Resident #27 to the bathroom. Resident #27 was sitting in a recliner chair and was assisted into her wheelchair to assist with transferring her to the bathroom. CNA #2 wheeled Resident #27 into the bathroom and asked Resident #27 to please stand and use the grab bar on the wall. Resident #27 stood, and CNA #2 removed Resident #27's pants and briefs to finish assisting her onto the toilet. CNA #2 left the bathroom for Resident #27 to complete her task, and when Resident #27 was finished, CNA #2 entered the bathroom, assisted with pericare, and pulled up Resident #27's drawers. CNA #2 assisted Resident #27 into the wheelchair and wheeled her out of the bathroom. CNA #2 removed her gloves and wheeled Resident #27 out into the activity room. Resident #27 was not offered to wash her hands after she finished using the restroom. On 10/12/18 at 11:36 AM, the DNS stated staff should wash their hands before starting cares, apply gloves, then provide pericare, then remove their gloves, sanitize, re-glove, assist with clothing, and then assist the resident with washing their hands.