STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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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 0157 Level of Harm - Minimal harm or potential for 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. 30440 Based on medical and administrative record review and interviews with family and staff it was determined that the facility failed to have an effective system in place to ensure family and guardians were notified in a timely manner as evidenced by: 1) failure to notify the resident's family when the resident was admitted to the hospital and 2) failure to appropriately notify a resident's legal guardian after the resident submitted an allegation of verbal abuse. This was evident for 2 out of 31 residents (Resident #50 and #56) reviewed during stage two of the survey. The findings include: 1) Review of complaint MD00110498 revealed Resident #50 was sent to the hospital on 1/27/17. When the complainant came to facility on 1/29/17 to visit with the resident, the nurse did not know where the resident was. A medical record review was conducted for Resident #50 on 8/14/17. Upon review, there was a note dated 1/31/17 documenting the resident was readmitted to the facility from the hospital. A phone interview was conducted with the complainant on 8/11/17 at 9:00 AM and s/he stated that Resident # 50 was chaperoned to an appointment with the wound doctor sometime in January of this year. While at this appointment the wound doctor found Resident #50 to have an infection and sent him/her to the hospital where he/she was admitted . The complainant went on to say that no one notified him/her of Resident #50 being admitted to the hospital. The complainant further stated that when s/he came into the facility to visit during the afternoon on Sunday 1/29/17, no one knew where the resident was. An interview was conducted with the Nursing Home Administrator (NHA) and Nurse #6 who was present on 8/15/17 at 8:45 AM. The NHA was asked if there was documentation of a nurse assessment and or documentation of Resident #50's admission to the hospital on 1/27/17. Nurse #6 stated Resident #50 went to an appointment at the wound clinic, located at the hospital, in January of this year. Nurse #6 further stated the resident was admitted to the hospital from the wound clinic. The NHA was unable to produce documentation of the resident transfer/admission to hospital. The NHA confirmed that according to the facility's policy, this is to be documented in the resident medical file by the nurse as a SBAR (Situation,Background,Assessment,Recommendation). (continued on next page)

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

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F 0157 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37979 2) A review of the Resident #56's medical record revealed that the resident was granted a court appointed guardian on 9/16/13 due to physical or mental incapacity. On 4/26/17 Resident #56 made an allegation of verbal abuse to facility staff. An investigation was initiated and the incident was found to be unsubstantiated. The facility investigative documentation did not provide any information indicating that the resident's guardian had been notified of the allegation. In interview on 8/10/17, the Director of Nursing (DON) was asked if Resident #56's guardian had been notified of the resident's allegation of verbal abuse. The DON reported that he/she was unable to locate any evidence that indicated that the guardian had been notified of the resident's allegation. On 8/10/17 the DON confirmed with documentation that the resident's guardian had not been notified of the allegations of verbal abuse until 8/10/17.

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all abuse, physical punishment, and involuntary separation from others. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to, 1. Thoroughly complete abuse investigations, 2. Provide education to staff after allegations of abuse were made, 3. Protect residents after the report of an alleged abuse, 4. Ensure that a resident was free from abuse and injury (#1). This was found to be evident for 3 out of 31 residents (#89, #95, and #1) reviewed during stage two of the survey. On August 11, 2017 at 4:32 PM an immediate jeopardy was called by the Office of Health Care Quality related to the facility's failure to have a system in place to thoroughly complete investigations into allegations of abuse, protect residents and to provide education to staff after an allegation of abuse was made. The initial plan to remove the immediacy was given to the survey team (State Surveyors #1, #2 and #3) at 7:25 PM. This plan was not accepted by the survey team and the Office of Health Care Quality. At 8:00 PM another plan to remove the immediacy was given to the survey team and reviewed by the Office of Health Care Quality. After modifications another plan to remove the immediacy was given to the survey team at 8:58 PM. The plan was carried out and the Immediate Jeopardy was removed on 8/11/17 at 9:00 PM. After removal of the immediacy, the deficient practice continued for an actual harm deficiency due to findings of Example #3, at a scope/severity of G level for the remaining residents. On 7/1/17 the facility changed ownership and new abuse policies and procedures were put in place, however as of time of the immediate jeopardy all staff had not yet been in-serviced regarding the new abuse policies and procedures. The findings include: 1. On 8/11/17 review of Resident #89's medical record revealed diagnosis including morbid obesity and bilateral cellulitis (skin inflammation) of the lower extremities. Additional review revealed a Brief Interview Mental Status (BIMS) completed on 4/26/17 with a score of 15/15, meaning the resident is intact cognitively. Review of the facility reported incident MD0011401, investigation documentation revealed that on 5/26/17 Resident #89 reported to the previous Administrator (NHA #2) that on or about 5/23/17 or 5/24/17 s/he had been called a derogatory name by [name of employee] (Staff Nurse #2) and that same nurse had, with her hands, made a fist pounding it into her other hand as if to threaten to hit her/him. The nurse was reported as suspended pending investigation that was initiated on 5/26/17. Review of the residents medical record on 8/11/17 revealed a nursing note from 5/26/17 at 1:30 PM that Resident #89 was alert and oriented x3, was crying and upset about nurse mistreatment that occurred previously on 5/23/17 or 5/24/17 on the 3 PM -11 PM evening shift. The note said the resident requested to speak to the Administrator (NHA #2) and the Unit Manager. The nursing note was updated at 2:00 PM to include that the police were called by the resident to file a complaint of being unsatisfied with service given. (continued on next page)

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/26/17 Resident #89 was ordered a psychiatric consult related to emotional support related to an abuse complaint. This consult was followed-up on 5/31/17 and the Licensed Psychologist noted the following: Specific issues: adjustment related anxiety, multiple medical problems; Additional Information/Recommendations: reported poor appetite for facility food (loss of weight this week) Wounds are better per [his/her] report. Will follow-up. The psychiatric Nurse Practitioner also saw the resident on 5/31/17 and documented the following: For rep Pt reports that staff are not pleasant; Chief C/O [complaint]: adjustment, insomnia; Concerns/Findings: [She/He] to stay here. 'I want that people respect me.' Pt does not want any psych meds at present time. There was no documentation found in either note addressing the specifics of the complaint made by Resident #89 to the facility, therefore it is unclear if the Licensed Psychologist and psychiatric Nurse Practitioner were made aware of these concerns so they could be addressed. Per the facility reported investigation, the employee was suspended on 5/26/17. Review of Nurse #2's time card revealed that she returned to work on 6/2/17 and clocked in at 11 PM, after the facility reportedly completed their investigation. Review of Nurse #2's file and the facility investigation revealed that the facility failed to provide education or abuse training regarding the alleged abuse that occurred around 5/23/17 until 6/12/17. Nurse #2 was noted to continue to work in the facility without receiving additional training regarding abuse until 6/12/17. The Director of Nursing (DON) was interviewed on 8/11/17 10:26 AM regarding the lack of training and she had no further information. At 2:00 PM she verbalized that she had no further information into the investigations. She stated that she was sure further investigations and interviews were completed but was unable to locate them at this time. She also indicated that she had no further information regarding the police being contacted by Resident #89, if they came to the facility or what their findings were. On 8/11/17 at approximately 2:00 PM review of scheduling sheets revealed Nurse #2 had worked the night shift on 8/6/17, 8/7/17, 8/9/17, 8/10/17 and was scheduled to work the night shift on 8/11/17 starting at 11:00 PM. Further review of the final report submitted to the state agency revealed that the facility was unable to substantiate an allegation of abuse as there were no witnesses. It further noted that although Resident #89 was deemed capable and had a BIMS of 15 showing s/he was cognitively intact they documented that s/he was manipulative. Further review of the investigative findings revealed that the resident reported various versions of events to staff. Review of the investigation provided to the survey team did not reveal multiple documented statements from Resident #89 regarding the allegation of abuse. A review of Resident #89's care plan failed to reveal any documentation or care plan regarding manipulative behaviors prior to 6/2/17, after the allegation of abuse occurred. A care plan regarding impaired or inappropriate behaviors related to ineffective coping skills as evidenced by telling different versions of events to different individuals was developed on 5/28/17. The goal for the resident to have less manipulative behaviors was initiated on 6/2/17, although there were no specific manipulative behaviors identified for the staff to monitor. (continued on next page)

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/22/17 at 9:40 AM with the DON revealed that the resident had been non-compliant when it came to physician orders, such as maintaining a fluid restricted diet, but nothing else in the resident's history alerted her regarding false allegations toward staff. Further interview on 8/22/17 at 9:45 AM with the facility DON regarding the investigation revealed that she felt they (the facility) did a thorough investigation at the time and although, per the documentation, they were unable to substantiate the allegation of abuse as there were 'no witnesses,'. She indicated that she and the Administrator (NHA #2) did not feel that Nurse #2 should remain as an employee in the facility, although Nurse #2 did continue to work and was assigned to the resident that made the allegation of abuse against her. Review of staffing sheets revealed that Nurse #2 was assigned to Resident #89 upon her return to work and would continue to be assigned to the resident throughout the remainder of the residents stay in the facility which ended in the middle of June 2017. Review of the Resident #89's psychiatric and psychology notes from visits that occurred after the incident, noted that s/he wanted to be respected and that the staff were unpleasant. There was no documentation of follow up with the resident to see if s/he felt safe and comfortable in the nursing home and staffing environment. Further review of the Nurse #2's employee file revealed that secondary to concerns voiced by employees and managers, the employee 'has a negative attitude and display less than optimal customer service skills.' Additionally, it was noted that a 'Resident (unidentified) verbalized a feeling of discomfort with employee in regard to their continued negative interactions.' An [NAME] (employee assistance program) was recommended by the DON in the presence of Human Resources (HR) at that time on 4/25/17, however, the employee refused and further gave a verbal and written resignation of her position as a unit manager effective in 2 weeks (on 5/9/17) and will assume position of a staff nurse. During an interview with Staff Nurse #3 on 8/11/17 at 3:20 PM revealed that Nurse #3 had multiple interactions with Nurse #2 and she was noted as short with Nurse #3 and continued to be 'loud' with the residents. These findings were reported to the Administrator and Chief Nurse (corporate nurse) on 8/11/17. Interview with the DON on 8/22/17 at 9:40 AM revealed even though Nurse #2 continued to work in the facility after the allegation of abuse, the DON would come in early and follow up with staff that worked with Nurse #2 to see if any further issues or concerns arose. She would also review Nurse #2's nursing notes to see if there were anything concerning. The DON did report that she had to call Nurse #2 on at least one occasion to review a resident's care plan as what was documented did not reflect the resident's needs. Further review of Nurse #2's employee file revealed that she had previous training on abuse on multiple occasions, including as recent as 3/2/17, but no retraining was noted after the incident until the employee had already returned to work. While the facility did not substantiate the allegations of abuse, according to the employees file this was not the first time Nurse #2's behavior towards residents was brought to her and the management's attention. Nurse #2 did not receive re-training until 6/12/17, although abuse training was provided by the facility for all staff starting on 6/2/17. The training the employee received was also regarding reporting abuse, not on the concern as to which she was suspended and the allegation was about. (continued on next page)

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It was noted that Nurse #2 was assigned to Resident #89 upon her return to work and would continue to be assigned to the resident throughout the remainder of the residents stay in the facility which ended in the middle of June 2017. Review of the Resident #89's psychiatric and psychology notes from visits that occurred after the incident, they noted that s/he wanted to be respected and that the staff were unpleasant. There was no documentation of follow up with the resident to see if s/he continued to feel safe and comfortable in the nursing home and staffing environment after 5/26/17. 16218 2. Review of Resident #95's the medical record on 8/11/17 at 2:39 PM revealed resident was admitted on [DATE] with diagnosis that included prostate cancer, hypertension, anemia, urinary retention, and rotator cuff tear. Resident #95 was receiving Remeron (an antidepressant) for appetite. Resident #95's BIMS score was assessed as 15/15 on the 5/25/17 Minimum Data Set (MDS) assessment. Review of the facility investigation documentation for facility reported incident MD00114627 revealed that on 5/30/17 residents were being interviewed, Has staff here abused you? Resident #95 responded, 'yes sometimes when staff members are taking care of me they can be too rough. When I ask them to slow down they say it's just my job, i'm just [not legible] to change you. The employees name is [GNA (geriatric nursing assistant) Staff #4]. This happened when I was in [room number]. On 5/30/17, a psych evaluation was ordered for Resident #95 along with treatment for emotional support related to an abuse complaint. Review of the 5/31/17 psych note revealed the following, 'due to severe weakness not able to [not legible] testify for depression. The pt [patient] wants to eat better suggest to Increase Remeron Refuse to see a psychologist. Recommended increase in Remeron from 7.5 to 15 mg.' Review of the Witness Statement, signed on 5/31/17 by GNA #4 and the Director of Nursing (DON), revealed that the DON asked the GNA about any negative interactions with residents, and if anyone had complained about rough care. The GNA stated no. At the end of the form the following statement was found, Employee was made aware of what the accusation was, and the resident's name was not disclosed. Further review of the facility investigation failed to reveal documentation of a follow-up interview with the resident, although the report sent to the Office of Health Care Quality (OHCQ) referenced that a conversation occurred between the DON and the resident in which the resident stated that it may not be abuse but that s/he does not like the above GNA because she just moves so fast and does not smile. On 8/11/17 at 2:00 PM the DON reported that there should have been follow up interviews. Further review of the facility investigation failed to reveal a date when the investigation was completed. On 8/11/17 at 3:25 PM the DON confirmed that there was no additional documentation found regarding this investigation and no evidence of the date the completed investigation report was sent to OHCQ. (continued on next page)

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The report to OHCQ stated that the allegation of abuse could not be substantiated and that GNA #4 received Customer Service Education. On 8/11/17 review of the GNA #4's employee file revealed documentation of abuse training in August 2016, and training on 6/6/17 for Customer Care: How to enhance your service skills. GNA #4 had been employed at the facility since April of 2014 but there was no evidence of an annual performance review within the past year. On 8/14/17 the DON reported that GNA #4 was suspended until 6/6/17, the day she came in for training only. The DON also reported that GNA #4 returned to work on 6/7/17 but failed to clock in or out on the Timecard for that day. On 6/7/17 GNA Staff #4 was involved in an abuse incident with Resident #1 that was substantiated and the GNA was terminated. (See example 3). 37979 3. Resident #1 was admitted to the facility in April 1998 with diagnoses of multiple sclerosis, right hand contracture, difficulty swallowing, high blood pressure, osteoarthritis, aphasia (language impairment) and unspecified contracture of the ankle. On 6/7/17 Housekeeping Employee #10 reported to his/ her supervisor and the Director of Nursing a witnessed incident of alleged physical abuse carried out upon Resident #1 by Geriatric Nursing Assistant (GNA) #4 that occurred between 11:00 AM and 1:00 PM. The facility investigation documentation contained the witness account, detailed below: The GNA (Geriatric Nursing Assistant) came in the room and the patient was in the wheelchair and the GNA was pushing the patient in the room, but [GNA #4] was pushing him/her so harsh, and tried so hard to push the patient in the room, the patient was like jerking. I thought the wheelchair was going to fall forward. I thought that [GNA #4] was going to push [Resident #1] out of the chair. The patient's feet were bent and twisting. You could see that the patient was hurt. And then [GNA #4] just pushed [Resident #1] in and the patient's shoes came off. The GNA kicked the shoes into the room and slammed the door. You could tell the GNA was very angry. The patient was screaming and crying. On 8/10/17 at 11:25 AM an interview was conducted with Housekeeping Employee #1 who recalled the incident as follows: it was an experience, [GNA #4] was just pushing [Resident #1], it looked like the chair was falling forward, the resident's foot was like bent, it just scared me so bad because his/her foot was bent back and Resident # 1 was screaming and the GNA did it about three to four times and just pushed the resident in the room, the wheelchair hit the bed, and the GNA slammed the door and kept going. I then went straight to my supervisor and let him/her know and one of the girls I work with. The physician was notified of the incident by nursing staff on 6/7/17. The following orders were entered into the medical record: -6/7/17 at 3:16 PM 1: Psychiatric consult for emotional support; -6/7/17 at 4:30 PM: X-ray of bilateral foot and ankle 2 views to r/o (rule out) fracture. (continued on next page)

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record revealed that an X-Ray / Radiology report for Resident #1 was received on 6/7/17. The report found no issues with the left foot. The right ankle x-ray/radiology report read: Findings: the ankle mortise is preserved without fracture or dislocation. There is ankle soft tissue swelling. No foreign body is seen. Impression: Ankle swelling but no fracture. A nursing note entered into Resident #1's medical record on 6/7/17 at 3:45 PM read: Resident sitting up in the wheelchair this shift. Several crying episodes. PRN (as needed) Ativan given with little effect. Ativan is a medication used to treat anxiety. A Nurse Practitioner's Progress Note entered into the medical record on 6/8/17 revealed the addition of a diagnosis of new onset soft tissue swelling. On 6/12/17 a psychiatric consultation was conducted with no new issues noted for Resident #1 and no new orders initiated. The facility initiated an investigation on 6/7/17 and reported the incident to the Office of Healthcare Quality. GNA #4 was suspended pending investigation into the matter. The facility led investigation substantiated that abuse occurred and terminated the employee. The employee was not reported to the Board of Nursing. In interview on 8/10/17 at 11:55 AM the Director of Nursing (DON) stated, I don't know why they did not report her. The previous owners did not want to. They didn't give me a real reason but they mentioned they were fearful of union retaliation. On 8/10/17 at 12:00 PM the findings were discussed with the DON and it was confirmed that facility staff failed to ensure that Resident #1 was free from abuse and injury. As a result of these investigations and the findings listed above, on August 11, 2017 at 4:32 PM an immediate jeopardy was called by the Office of Health Care Quality related to the facility's failure to have a system in place to thoroughly complete investigations into allegations of abuse, protect residents and to provide education to staff after an allegation of abuse was made. The initial plan to remove the immediacy was given to the survey team (State Surveyors #1, #2 and #3) at 7:25 PM. This plan was not accepted by the survey team and the Office of Health Care Quality. At 8:00 PM another plan to remove the immediacy was given to the survey team and reviewed by the Office of Health Care Quality. After modifications another plan to remove the immediacy was given to the survey team at 8:58 PM. The plan to remove the immediacy included, but was not limited to: 1. LPN #2 was removed from the facility schedule and was informed to return to the facility on Monday August 14, 2017 to meet with the Nursing Home Administrator (NHA). Employee will not return to patient care. 2. Facility residents with a BIMS of 8 or greater were interviewed to determine if there were any current concerns regarding safety. Resident with BIMS of 7 or less have had skin assessment by a licensed nurse. Any identified concerns would be investigated and reported as required. QA audit will be completed on the last 30 days of concerns to evaluate if any concern met the definition of a reportable incident. (continued on next page)

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F 0223 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Staff present in facility were educated with the [new ownership name] abuse policy and acknowledgement statement. Ongoing education to ensure 100% of current facility staff to be educated on the [new ownership name] abuse policy. Staff will be provided this education before they will be permitted to provide any further resident service. The NHA will review and compare the employee listing to the documentation of completed in-services to ensure 100% of current employees are educated. 4. Ongoing QA monitoring will be completed by the NHA to validate that incidents and allegations have been properly investigated and that actions have been taken to safeguard the residents. Residents will be monitored by social services weekly for 4 weeks after allegation with respect to psychosocial wellbeing. Any employee that remains employed after an allegation of abuse will be monitored by the NHA or DON weekly for 1 month and then quarterly times three to ensure no trends are identified by repeated concerns. The plan was carried out and the Immediate Jeopardy was removed on 8/11/17 at 9:00 PM. After removal of the immediacy, the deficient practice continued for an actual harm deficiency due to findings of Example #3, at a scope/severity of G level for the remaining residents. On 7/1/17 the facility changed ownership and new abuse policies and procedures were put in place, however as of the time of the immediate jeopardy all staff had not yet been in-serviced regarding the new abuse policies and procedures.

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F 0225 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on the review of facility reported incidents and medical records and interviews with staff it was determined that the facility failed to thoroughly investigate allegations of abuse and further provide concrete and consistent documentation of the facility's reasoning for the determination of abuse being substantiated or not substantiated; and failed to ensure allegations of abuse and injuries of unknown origin were reported and investigated in a timely manner. This was found to be evident for 3 out of 9 residents identified during review of facility reported incidents (Resident #89, #95 and #54) during stage two of the survey. The findings include: 1. On 8/11/17 review of facility report #MD00114101 revealed that on 5/26/17 Resident #89 reported an allegation of abuse regarding Nurse #2. According to the final report submitted to the state agency the facility was unable to substantiate an allegation of abuse as there were no witnesses. It further noted that although Resident #89 was deemed capable and had a BIMS of 15 showing s/he was cognitively intact, they documented that s/he was manipulative. Further review of the investigative findings revealed that the resident reported various versions of events to staff. Review of the investigation provided to the survey team did not reveal multiple documented statements from Resident #89 regarding the allegation of abuse. A review of Resident #89's care plan failed to reveal any documentation or care plan regarding manipulative behaviors prior to 6/2/17, after the allegation of abuse occurred. A care plan regarding impaired or inappropriate behaviors related to ineffective coping skills as evidenced by telling different versions of events to different individuals was developed on 5/28/17. The goal for the resident to have less manipulative behaviors was initiated on 6/2/17, although there were no specific manipulative behaviors identified for the staff to monitor. Interview on 8/22/17 at 9:40 AM with the Director of Nursing (DON) revealed that the resident had been non-compliant when it came to physician orders, such as maintaining a fluid restricted diet, but nothing else in the resident's history alerted her regarding false allegations toward staff. Further interview on 8/22/17 at 9:45 AM with the facility DON regarding investigation into #MD0011401 revealed that she felt they (the facility) did a thorough investigation at the time and although, per the documentation, they were unable to substantiate the allegation of abuse as there were 'no witnesses,' she and the Administrator (NHA#1) did not feel that Nurse #2 should remain as an employee in the facility. Although Nurse #2 did continue to work and was assigned to the resident that made the allegation of abuse against her. The concerns regarding the investigation were reviewed with the Administrator and the Chief Nurse (corporate nurse) on 8/22/17. 16218 (continued on next page)

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F 0225 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #95's the medical record on 8/11/17 at 2:39 PM revealed the was admitted in April 2017 with diagnosis that included prostate cancer, hypertension, anemia, urinary retention, and rotator cuff tear. Resident #95 was receiving Remeron (an antidepressant) for appetite. Resident #95's BIMS (Brief Interview of Mental Status) score was assessed as 15/15 on the 5/25/17 Minimum Data Set (MDS) indicating the resident was cognitively intact. Review of the facility investigation documentation for MD00114627 revealed that on 5/30/17 residents were being interviewed: Has staff here abused you? Resident #95 responded, 'yes sometimes when staff members are taking care of me they can be too rough. When I ask them to slow down they say it's just my job, I'm just [not legible] to change you. The employees name is [GNA Staff #4]. This happened when I was in [room number]. On 5/30/17, a psych evaluation was ordered for Resident #95 along with treatment for emotional support related to an abuse complaint. Review of the 5/31/17 psych note revealed the following: due to severe weakness not able to [not legible] testify for depression. The pt wants to eat better suggest to Increase Remeron Refuse to see a psychologist. Recommended increase in Remeron from 7.5 to 15 mg. Review of the Witness Statement, signed on 5/31/17 by GNA #4 and the Director of Nursing (DON), revealed that the DON asked the GNA about any negative interactions with residents, and if anyone had complained about rough care. The GNA stated no. At the end of the form the following statement was found, Employee was made aware of what the accusation was, and the resident's name was not disclosed. Further review of the facility investigation failed to reveal documentation of a follow-up interview with the resident, although the report sent to the Office of Health Care Quality (OHCQ) referenced that a conversation occurred between the DON and the resident in which the resident stated that it may not be abuse but that s/he did not like the above GNA because she just moves so fast and does not smile. On 8/11/17 at 2:00 PM the DON reported that there should have been follow up interveiws. Further review of the facility investigation failed to reveal a date when the investigation was completed. On 8/11/17 at 3:25 PM the DON confirmed that there was no additional documentation found regarding this investigation and no evidence of the date the completed investigation report was sent to OHCQ. The report to OHCQ stated that the allegation of abuse could not be substantiated and that GNA #4 received Customer Service Education. On 6/7/17 GNA Staff #4 was involved in an abuse incident with Resident #1 that was substantiated and the GNA was terminated. 31985 (continued on next page)

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F 0248 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet the interests and needs of each resident. 30440 Based on administrative record review, interviews with residents and facility staff, it was determined the facility failed to provide activities to meet the specific needs of a resident. This was evident for 1 of 6 residents complaints reviewed during stage two of the survey. The findings include: Medical record review revealed Resident #32's diagnosis included but were not limited to Ankylosing Spondylitis (inflammatory disease that can cause some of the vertebrae of the spine to fuse), Rheumatoid Arthritis (A chronic inflammatory disorder affecting many joints, including those in the hands and feet) and Blindness. Review of complaint #MD00112396 on 8/10/17 revealed multiple concerns surrounding the care of Resident #32. An interview was conducted with Resident #32 on 8/10/17 at 12:50 PM and the resident expressed concerns regarding her/his ability to download books onto his/her Kindle, in audio form. The resident further stated that s/he would like to be able to keep up with the latest discoveries on a science show that s/he previously listened to while at another facility. At the time of the interview, the resident expressed that there were no other concerns that he/she needed assistance with at that time. An interview was conducted with the Nursing Home Administrator (NHA) and Social Services Director (SSD) on 8/14/17 at 3:20 PM and she was made aware of Resident #32's concerns involving downloading books onto his/her Kindle. The NHA told the survey team that s/he would personally assist the resident with downloading the books to the Kindle. The NHA also instructed the SSD to meet with the resident to find out what his/her specific needs were so that they could assist him/her. This is a repeat deficiency from the 2016 annual survey for the same resident.

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F 0278 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment by a qualified health professional. 31985 Based on medical record review and interview with the facility staff it was determined that the facility failed to ensure the information used to complete the quarterly Minimum Data Set (MDS) assessment for activities of daily living, medications received and functional limitations in range of motions was accurate. This was evident for 2 of 31 residents reviewed (Resident #53 and #40) during stage two of the survey. The findings include: The MDS is a federally-mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. 1. On 8/10/17 Resident #53's medical records were reviewed. This review revealed that on 5/22/17 the resident had a quarterly assessment completed. A review of that quarterly assessment Section G functional status under the sub-sections for walk in room and walk in corridor, revealed that the resident was coded by staff as a 7 (activity occurred only once or twice). Eating, toilet use and personal hygiene was coded by staff as a 3, indicating that the resident was extensive assistance. Review of the Balance During Transition and Walking sub section; moving from seated to standing position, walking with assistive device, turning around and facing the opposite direction and moving on and off the toilet, revealed the staff coded the resident as a 2, meaning the resident was not steady and only able to stabilize with human assistance. Further review of the quarterly assessment section N Medications revealed the resident was coded as receiving 7 days of an antianxiety medication. Review of the physician orders and the medication administration records (MAR) revealed the resident was ordered Seroquel which is classified as an antipsychotic. Further review of the physician orders and MAR failed to reveal the resident took any antianxiety medications. During an interview with the geriatric nursing assistant (GNA #13) on 8/10/17 she revealed that she was familiar with the resident and had taken care of the resident for a while. When asked if the resident was able to perform any of the functional status such as walking in the room or corridor, the GNA revealed that the resident was not able to walk. GNA #13 revealed that the resident was totally dependent on staff for eating, toileting and personal hygiene. GNA #13 also revealed that balance during transition and walking did not occur; the resident is not able to stand or walk. During an interview with the MDS coordinator (Nurse #5) this surveyor asked her to review the resident's MARs and ADL sheet, which included documentation by the GNA. The GNA documentation included the resident's functioning status, and the MDS coordinator was asked to speak with the GNA and observe the resident. (continued on next page)

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F 0278 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview with the MDS coordinator on 8/11/17, she revealed that she would be submitting modification to the May quarterly MDS to include changes to section G functional status under the sub-sections for; walk in room, walk in corridor, eating, toilet use and personal hygiene. The MDS coordinator revealed that the code would be changed to a 4 indicating that the resident is dependent on staff. She also revealed that the Balance During Transition and Walking sub section moving from seated to standing position, walking with assistive device, turning around and facing the opposite direction and moving on and off the toilet will be coded as did not occur. The MDS coordinator also revealed that section N would be changed to reveal that the resident had received 7 days of an antipsychotic medication and not an antianxiety. She revealed moving forward she would continue to educate the GNA's on correct coding and inform the other MDS staff that they need to make observations and speak with the GNA's before completing the MDS section G and N. All findings discussed with the Director of Nursing and the Administrator during the survey exit. 16218 2. During stage one of the survey Resident #40 was observed to have a contracture of the arm. On 8/8/17 interview with Nurse #14 confirmed that the Resident had a contracture of the arm. Medical record review revealed a nurse practitioner note, dated 5/4/17 which included: R hand, wrist and elbow contracted. A contracture is a condition of fixed high resistance to passive stretch of a muscle. Review of the 2/24/17 MDS section G0.400 Functional Limitations in Range of Motion assessed the resident as having impairment on one side for both the upper and lower extremities. Review of the 5/27/17 MDS section G0.400 Functional Limitations in Range of Motion assessed the resident as having no impairment on either the upper or lower extremities. This discrepancy between the observation, staff report and February assessment and the May assessment was addressed with the MDS Coordinator (Nurse #5). On 8/14/17 at 10:25 AM the MDS Coordinator confirmed that the May MDS assessment had been an error.

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F 0280 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents the right to participate in the planning or revision of care and treatment. 16218 Based on medical record review, observation and interview it was determined that the facility failed to revise a care plan to reflect the need for specific adaptive equipment to assist with eating. This was found to be evident for one out of 31 resident's reviewed (Resident #40) during stage two of the survey. The findings include: On 8/11/17 review of Resident #40's medical record revealed a care plan for potential nutrition problems which included the intervention, initiated 6/25/16: Provide and serve diet as ordered with adaptive equipment. No specific adaptive equipment was found in the care plan or the physician orders. Further review of the medical record revealed a Registered Dietician (RD) note, dated 5/31/17, which included under Assistive Devices for Meals: divided plate. There was also a notation to: put consult in for adaptive equipment clarification. On 8/11/17 at 12:23 PM the resident was observed in his/her room eating lunch independently, the food was noted to be on a regular plate. Nurse #6 confirmed that there was no specialized equipment on the resident's tray. On 8/11/17 at 12:47 PM review of the therapy notes revealed that the resident was seen by both occupational therapy and speech therapy in June 2017. Review of the discharge summaries failed to reveal any documentation regarding adaptive eating equipment. On 8/11/17 at 1:23 PM surveyor reviewed the 5/31/17 RD note with the current RD (Staff #16) who reported she would investigate. At 2:52 PM the RD reported that a divided plate was included in the meal tracker. The Meal Tracker is a computer system which includes information such as diet order; special requests and adaptive equipment. Review of the Meal Tracker print out for the resident revealed Divided Plate was included under adaptive equipment. On 8/14/17 at 12:19 PM the resident was observed feeding him/herself and a divided plate was noted on the tray. Nurse #17, who was assigned to the resident, was aware that a divided plate was needed. When surveyor reported the observation on Friday that the resident did not have the divided plate, the Nurse reported that GNA #18 had been assigned to the resident on Friday and that GNA #18 normally works on a different unit. On 8/15/17 at 12:19 PM the Certified Dietary Manager (Staff #1) reported that the divided plate was added in January after the Occupational Therapist at that time came and asked why the resident was not receiving the divided plate. On 8/15/17 at 12:53 PM surveyor reviewed with the Administrator the observation on Friday and the concern that the divided plate was not included on the care plan.

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F 0282 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 30440 Based on medical record review and resident interview it was determined the facility failed to follow a resident plan of care for ensuring that the resident received their regularly scheduled medications. This was evident for 1 out of 31 residents (#46) reviewed during stage two of the survey. The findings include: During a resident interview conducted on 8/8/17 at 1:23 PM Resident #46 was asked the question, Do staff include you in decisions about your medicine, therapy, or other treatments? The resident stated, 'the facility runs out of my oxycodone, oxycontin and seroquel (also known as Quetiapine).' Review of physician orders on 8/11/17 for Resident #46 revealed an order for Quetiapine Fumarate ER (extended release) 200 mg (milligrams) 1 tablet by mouth at bedtime for Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and an order for Kadian 80 mg ER by mouth TID (three times a day) for pain. Review of Resident #46's medication administration record (MAR) on 8/11/17 revealed that on June 20, 25, and 26, 2017, the resident did not receive regularly scheduled Kadian 80 mg at 2:00 PM. Further record review revealed that on July 8, 13, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2017, Resident #46 did not receive regularly scheduled Quetiapine 200 mg at 9:00 PM. An interview was conducted with the Director of Nursing (DON) on 8/11/17 at 12:25 PM and she stated that Seroquel was not covered under medicaid and as a result the pharmacy only sends a 5 day supply at a time. The DON further stated they currently have an arrangement with the pharmacy that will allow resident medications to come in a 30 day supply. Cross Reference F 309

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F 0309 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide necessary care and services to maintain or improve the highest well being of each resident . 16218 Based on medical record review and staff interviews it was determined the facility failed to administer regularly scheduled medications to residents according to physician orders as evidenced by staff's failure to access the interim medication supply when the medications had not been delivered by the pharmacy. This was evident for 3 of the 31 residents reviewed (Resident #15, #48, and #46) during stage two of the survey. The findings include: 1. On 8/10/17 review of Resident #15's medical record revealed an order, originally written 4/14/17, for Ativan 0.5 mg to be given every day at 4 PM for anxiety. Review of the July 2017 Medication Administration Record (MAR) revealed that on 7/10/17 the Ativan was documented as not being given due to not being available. Review of the June 2017 MAR revealed documentation that the Ativan was administered as ordered on June 15, 16 and 17, however no documentation was found to account for these doses on the Controlled Medication Utilization Record. The 6/18/17 dose was documented as not given because not in [medication] cart, not in narc book. On 8/10/17 at 12:15 PM this information was reviewed with the Director of Nursing (DON). On 8/11/17 at 9:29 AM the DON reported that on 6/15/17 the nurse accessed the Ativan from the interim supply but that there was no evidence that the nurse obtained the medication on 6/16/17. She went on to report that on the MAR for 6/17/17 it was not a full signature, so then it is considered an omission, but confirmed that even if not signed off as given there was no evidence that the nurse did anything about the fact that the medication was not available. On 8/14/17 surveyor reviewed the concern with the DON regarding the failure to have an effective system in place to obtain regularly scheduled medications. The DON responded that they are working on that. 30428 2. On 8/11/17 review of the medical record for Resident #48 revealed diagnosis including Alzheimer's disease and major depressive disorder. Review of the resident's physician orders revealed an order on 5/2/17 for 1/2 tablet of 25 mg Seroquel BID (twice a day) for dementia with behavioral disturbances. Review of the resident's July medication administration record (MAR) revealed that on 7/16/17, 7/18/17, 7/19/17 at 5 PM and 7/19/17 at 9 AM the residents Seroquel was not signed off. Only on 7/19/17 at 9 AM was a notation made on the back of the MAR that the medication was unavailable. Interview on 8/11/17 at 12:22 PM with the Director of Nursing (DON) and the Chief Nurse (corporate nurse) revealed that certain residents' insurance is only covering a 5 day supply and that may have been the issue why the medication was not available, unlike other medications that are delivered in a 30 day supply. (continued on next page)

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F 0309 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, review of the facility interim box on 8/14/17 at 9:18 AM revealed that Seroquel 25 mg was available in the facility and that staff had access to administer the medication to Resident #48, if the pharmacy had not yet delivered a residents supply. The concerns were reviewed during the survey and again at exit on 8/15/17 with the DON, Administrator and Chief Nurse. 30440 3) During a resident interview conducted on 8/8/17 at 1:23 PM Resident #46 was asked the question, Do staff include you in decisions about your medicine, therapy, or other treatments? The resident stated, 'the facility runs out of my oxycodone, oxycontin and seroquel (also known as Quetiapine).' Review of physician orders on 8/11/17 for Resident #46 revealed an order for Quetiapine Fumarate ER (extended release) 200 mg (milligrams) 1 tablet by mouth at bedtime for Bipolar Disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and an order for Kadian 80 mg ER by mouth TID (three times a day) for pain. Review of Resident #46 medication administration record (MAR) on 8/11/17 revealed that on June 20, 25 and 26, 2017, the resident did not receive Kadian 80 mg at 2:00 PM. On July 8, 13, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2017 Resident #46 did not receive Quetiapine 200 mg at 9:00 PM. An interview was conducted with the Director of Nursing (DON) on 8/11/17 at 12:25 PM and s/he stated that Seroquel is not covered under Medicaid and as a result the pharmacy only sends a 5 day supply at a time. The DON further stated they currently have an arrangement with the pharmacy that will allow resident medications to come in a 30 day supply. On 8/14/17 at 9:00 AM the Nursing Home Administrator (NHA) submitted a copy of the facility's content list for their 2 interim boxes. Quetiapine 25 mg (quantity 6 per interim box) was included on the interim box list. At 11:26 AM on the same date, the Assistant Director of Nursing (ADN) was interviewed and was asked to explain what the interim box is used for. The ADN stated the interim box contains medications that are used for new resident admissions and if medications are needed immediately while awaiting a pharmacy delivery. Resident #46 has orders for 200 mg Quetiapine at 9:00 PM. Based on review of the two interim box lists a total of 300 mg of Quetiapine are kept available.

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F 0317 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent a loss in range of motion among residents who entered the nursing home with a full range of motion, unless it is unavoidable due to resident's clinical condition. 31985 Based on observation, record review and interview with staff it was determined that the facility staff failed to prevent a resident's lower extremity from becoming contracted. This was true for 1 out of 3 residents (Resident #53) reviewed for range of motion during stage two of the survey. The findings include: On 8/10/17 Resident #53's medical record was reviewed, this review revealed that the resident was admitted in 2014 for long term care. Further review of the records revealed that the resident was on hospice. On multiple observation on 8/10/17 the resident was observed each time in bed with the left leg bent up to her/his chest. During an interview with (geriatric nursing assistant) GNA #13 the surveyor asked if the resident was able to straighten her/his leg. GNA #13 replied, 'not really if we try to straighten it out if goes back in that position.' When GNA #13 was asked how long had the leg been bent, and she replied she was not sure. Review of the February 2017 and May 2017 Minimum Data Set (MDS) section G revealed that the resident was not assessed as having any impairment or contractures to the upper or lower extremities. During an interview with MDS coordinator she revealed that based on nursing documentation and physician notes she could not locate any documentation indicating when the resident's left leg became contracted. The MDS coordinator did reveal that she found a note from hospice indicating that the resident was in a fetal position but no documentation indicating contractures. During an interview with the Director of Nursing (DON) on 8/11/17 the surveyor asked if she could locate any documentation to indicate when the resident's left leg started to become contracted. She reported that she was unable to find any documentation indicating when the left leg started to become contracted. During the survey exit the surveyor informed the DON and the Administrator of the concern that the resident was admitted without a contracture and now the left leg was becoming contracted. The DON acknowledged the concerns and said she would contact the physician to inform him of the contracture.

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F 0318 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents with limited range of motion receive appropriate treatment and services to increase range of motion or prevent further decrease in range of motion. 31985 Based on surveyor observation, review of the medical record and interview with facility staff, it was determined the facility failed to provide care and services to prevent the further decline of contractures. This was evident for 1 out of the 3 residents (Resident #53) reviewed for range of motion during stage two of the survey. The findings include: On 8/10/17 Resident #53's medical record was reviewed. This review revealed that the resident was admitted to the facility in January 2014 for long term care. During multiple observations the resident was noted to have a lower extremity contracture. Further observation failed to reveal any splints in use. During an interview with GNA #13 the surveyor asked if any range of motion was being done on the resident, and the GNA replied no. During an interview with the Director of Nursing (DON) on 8/11/17 she confirmed that the resident had contractures and currently was not using any splinting devices nor was the resident receiving range of motion. Range of motion is typically practiced on a joint that is inactive. Staff or therapy may use this exercise on a resident who is paralyzed or unable to mobilize a specific joint. This type of exercise can help prevent stiffness or contracture from occurring. After surveyor intervention and prior to the survey exit the DON provided an order from the physician for a PT (physical therapy) evaluation and treat for contracture splint management.

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F 0323 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 provide adequate supervision to prevent avoidable accidents. 16218 Based on medical record review and interview with staff it was determined that the facility failed to follow a physician order and a care plan intervention to remove fall mats from the resident's room. This was found to be evident for 1 out of 31 residents (Resident #16) reviewed during stage two of the survey. The findings include: Review of Resident #16's medical record revealed that the resident had a history of repeated falls, difficulty walking and diagnosis of dementia. On 8/11/16 review of the medical record revealed a care plan addressing the resident's risk for falls which was updated on 7/31/17 to include: remove fall mats. A corresponding physician order, dated 7/31/17, to discontinue fall mats was also found. On 8/8/17 interview with Nurse #6 revealed that Resident #16 had sustained two falls without injury in the past 30 days (on 7/22/17 and 8/8/17). Review of the nursing notes and incident report for the fall on 8/8/17 revealed that the resident had been found sitting on the floor beside the bed and the fall mat was on the floor. On 8/14/17 the concern regarding the facility's failure to follow the physician orders to discontinue the fall mats was addressed with the Director of Nursing.

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident's 1) entire drug/medication regimen is free from unnecessary drugs; and 2) is managed and monitored to achieve highest level of well-being. 30428 Based on medical record review and interview with facility staff, it was determined that the facility incorrectly gave a resident an antibiotic by inaccurately reading and reporting lab results. This was evident for 1 of 31 residents (Resident #102) reviewed during stage two of the survey. The findings include: Review of the medical record for Resident #102 on 8/14/17 at 11:10 AM revealed that on 9/11/16 the resident was noted with large loose stools. On 9/11/16 the nurse practitioner ordered for a stool sample for clostridium difficile (c-diff, bacterial infection in the colon) and to discontinue the resident's currently ordered Senna (laxative, used to treat constipation). Additionally, on 9/13/16, another nurse practitioner ordered for the residents to start on Flagyl (antibiotic) every 6 hours for 2 weeks for the diagnosis of c-diff. The resident was also moved to a different room and placed on isolation. Review of the resident's lab work revealed a stool sample was sent to the lab on 9/12/16. The result of the stool specimen was reported on 9/14/16 and noted as 'negative.' Again on 9/15/16, the lab reported the culture results as negative. The lab results were signed on 9/15/16 by the physician as notification of the lab results. On 9/15/16 at 1:50 PM the Flagyl was discontinued and the reason documented was, 'does not have c-diff.' Review of the nurse practitioner note who placed the resident on the Flagyl revealed the following, '9/14/16 stool came back positive yesterday, culture negative for any further growth, placed on Flagyl and stool improved.' Note on 9/15/16 documented that 'pt. (patient) was placed on Flagyl on 9/13 for reports of positive results. Today, saw lab results stating that stool was negative.' Review of the resident's labs and medical record failed to reveal any report of positive stool results for c-diff. The concerns regarding Resident #102 were reviewed with the Director of Nursing throughout the survey. No further information was provided to the survey team prior to exit.

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F 0353 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough nurses to care for every resident in a way that maximizes the resident's well being. 16218 Based on medical record review and interview it was determined that the facility failed to have a system in place to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care as evidenced by failure to ensure all nursing staff received training in the use of a wound vac machine after the need for the training had been identified by the Skin Coordinator nurse. This was found to be evident for 1 out of 31 residents reviewed (Resident #105) during stage two of the survey but has the potential to affect all the residents. The findings include: On 8/15/17 review of Resident #105's medical record revealed that the resident had orders for the use of a wound vac in the treatment of a pressure ulcer. A wound vac is a machine that provides negative pressure to assist in the healing of wounds. Review of the In-service Sign In-sheet for the Negative Pressure Wound Therapy System in-service revealed the training took place on 8/9/17. Only 10 nurses signed this sheet to indicate attendance at the training. Review of an employee listing, printed on 8/14/17, revealed that more than 30 nurses are currently employed at the facility. No additional documentation was provided that any additional training's took place after the 8/9/17 in-service. On 8/15/17 at 11:25 AM Nurse #15, who was assigned to work with Resident #105, reported that she had not been to any recent training's regarding the wound vac, but reported the resident had the dressing changed by the night nurse. On 8/15/17 at 11:26 AM Nurse #14, who was also working on the unit, reported that there had been an in-service regarding the wound vac last Wednesday (8/9/17) but that she had not attended. Nurse #14 confirmed that she could be assigned a resident with a wound vac and that she would find someone to show me how to use the device. On 8/15/17 at 11:38 AM interview with the Skin Coordinator (Nurse #6) revealed that she had identified a need for staff education regarding the use of the wound vac and she called for education. She reported she sent a text to every nurse in the building and they all received information that they were suppose to come for the in-service. She went on to report that the nurse educator (Nurse #19) was suppose to follow up with the staff that did not attend the training. Both the Skin Coordinator and the Nurse Educator were given a flash drive with the training material on it. On 8/15/17 at 12:04 PM the Nurse Educator reported that she would have to reschedule the in-service and confirmed that she had a flash drive with the class on it. She went on to report that they have to repeat and repeat because we do not get 100% attendance. When asked about the process for ensuring all required staff received an in-service training, the Nurse Educator reported, we have the list of nurses and check them off. No documentation was provided to indicate the facility had identified staff still in need of the training. (continued on next page)

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F 0353 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/17 at 12:45 PM, the surveyor reviewed the concern with the Administrator that there was an identified training need (for wound vac); a training was completed. However, there are several nurses, including the nurse caring for the resident on 8/15/17, who had not attended the in-service and that there was no identified process in place to ensure all staff receive required in-services.

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F 0371 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Store, cook, and serve food in a safe and clean way. 30440 Based on surveyor observation and interviews with facility staff it was determined the facility staff failed to store food under sanitary conditions. This was evident during an initial tour of the facility's main kitchen and has the potential to affect all resident's who consume food from the kitchen. The findings include: An initial tour of the facility was conducted on 8/8/17 at 8:10 AM with the Dietary Manager (DM) present and the following concerns were identified: -Inside of the refrigerator was an open bag of cole slaw, 2 large open bags of wilted lettuce, and a large container filled with wilted lettuce. None of the items were date labeled. -Inside of the dry storage area was (1) opened 5-lb bag of noodles and 2 (1/2) open bags of noodles that were not date labeled. The DM immediately removed the items from the shelf. The Nursing Home Administrator (NHA) was made aware on 8/9/17 at 10:00 AM

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F 0425 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and emergency drugs through a licensed pharmacist and only under the general supervision of a licensed nurse. 16218 Based on medical record review and interview with staff it was determined that the facility failed to have a system in place to ensure that regularly scheduled medications were available as ordered. This was found to be evident for 2 out of 6 residents (Resident #15 and #46) reviewed for unnecessary medication during stage two of the survey. The findings include: 1. On 8/10/17 review of Resident #15's medical record revealed an order, originally written 4/14/17, for Ativan 0.5 mg to be given every day at 4 PM for anxiety. Review of the July 2017 Medication Administration Record (MAR) revealed that on 7/10/17 the Ativan was documented as not being given due to not being available. Review of the June 2017 MAR revealed documentation that the Ativan was administered as ordered on June 16 and 17, however no documentation was found to account for these doses on the Controlled Medication Utilization Record. The June 18th dose was documented as not given because not in [medication] cart, not in narc book. On 8/10/17 at 12:15 PM this information was reviewed with the Director of Nursing (DON). On 8/11/17 at 9:29 AM the DON reported that there was no evidence that the nurse obtained the medication on 6/16. She went on to report that on the MAR for 6/17 it was not a full signature, so then it is considered an omission, but confirmed that even if not signed off as given there was no evidence that the nurse did anything about the fact that the medication was not available. On 8/14/17 surveyor reviewed the concern with the DON regarding the failure to have an effective system in place to obtain regularly scheduled medications. 30440 2. An interview was conducted with Resident #46 on 8/8/17 at 1:23 PM and the resident reported the facility runs out of several of his/her medications. Resident #46 stated the facility runs out of seroquel, oxycodone and oxycontin. Review of Resident #46's medication administration record (MAR) on 8/11/17 revealed that on June 20, 25, and 26, 2017, the resident did not receive regularly scheduled Kadian (a pain medication) 80 mg at 2:00 PM. Further record review revealed that on July 8, 13, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2017, Resident #46 did not receive regularly scheduled Quetiapine (also known as Seroquel) 200 mg at 9:00 PM. An interview was conducted with the Director of Nursing (DON) on 8/11/17 at 12:25 PM and s/he stated that Seroquel is not covered under medicaid and as a result the pharmacy only sends a 5 day supply at a time. The DON went on to say that they currently have an arrangement with the pharmacy that will allow resident medications to come in a 30 day supply.

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F 0428 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31985 Based on medical record review and interview with staff it was determined that the staff failed to have a system in place to ensure that 1) physician response to the pharmacist recommendations were followed, and 2) that pharmacist recommendations were reviewed/addressed by the physicians in a timely manner. This was evident for 2 of 6 residents (Resident #53 and #15) reviewed for unnecessary medications in stage two of the survey. The findings include: 1. On 8/10/17 Resident #53's medical records were reviewed. This review revealed that the pharmacist had completed the monthly medication reviews and made a written a recommendation to the physician on 7/5/17. This pharmacy review revealed the following: The resident has received very low dose of Seroquel 12.5 mg QHS (every night) for behavior or psychological symptoms of dementia since 2/15/17. Please trial of discontinuation while monitoring for the return of the target symptoms. On 7/26/17 the physician response was she accepted the recommendations and to implement as written and for a psychiatrist consult. Review of the medications administrations records and the consultation notes failed to reveal the facility followed the physician orders to discontinued the Seroquel and obtain a psychiatrist consult. During an interview with the Director of Nursing (DON) and reviewing the pharmacist recommendation the surveyor asked if you reviewed this pharmacist recommendation with the physician response what should staff have done. She replied that on 7/26/17 when the physician wrote the order accepting the recommendations and to implement it and get a psychiatrist consult, staff should have discontinued the Seroquel and put the psychiatric consult in the psychiatrist book. The DON acknowledged that neither order had been carried out. The surveyor asked how often does psychiatric services come to the facility and she replied weekly, she acknowledged that psychiatrist services had been in multiple times but had not seen the resident. All findings discussed at the survey exit. 16218 2. On 8/10/17 review of Resident #15's medical record revealed that the resident is more than [AGE] years old, has resided at the facility for several years with diagnosis that include dementia, depression and anxiety. The resident's medication regimen included Lexapro, an antidepressant medication, which had been increased to 15 mg per day on 4/4/17 based on the psych nurse practitioners recommendation. On 4/5/17 the pharmacist completed a medication review Consultation Report which identified an issue with the increase of the Lexapro due to the maximum geriatric dose being 10mg per day. (continued on next page)

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F 0428 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/17 the psych nurse practitioner (NP) saw the resident for follow up for the increase in the Lexapro. Review of the 4/11/17 psych NP progress note failed to reveal any information to indicate the NP had been made aware of the pharmacist concern regarding the Lexapro dosage. On 4/20/17 the physician acknowledged the pharmacist review and on 4/21/17 the Lexapro dosage was lowered to 10 mg per day and ordered that the resident be seen by psych. This is more than two weeks after the pharmacist had identified the concern. On 5/9/17 psych NP saw the resident. The progress note from this visit revealed: Lexapro was decreased 4/20/17 per pharmacy recommendation No changes in meds today. On 8/10/17 at 11:37 AM the Director of Nursing reported that after she reviews the pharmacy recommendations she gives them to the unit managers with a proposed deadline of one week; if the physician does not come in then expectation is to call physician within a week. Surveyor then reviewed the concern that pharmacy had made a recommendation on 4/5 regarding a psych medication, the resident was seen by psych on 4/12 but the recommendation was not addressed until 4/20, more than two weeks after the recommendation had been made.

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F 0431 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards. 31985 Based on controlled substance count review, review of the facility policy and staff interview, it was determined that the facility failed to maintain accurate records of narcotic medication change of shift reconciliation counts. This was true for 2 of 2 narcotic log books reviewed for completion on the 1st floor and 1 of 2 narcotic books reviewed for 2nd floor. The findings include: The purpose of consistently counting controlled substances, or narcotics, is to monitor narcotic administration and to ensure accountability for all narcotics. Review of Controlled Drug Management policy revealed the following: A complete count of all schedule II-IV controlled drugs is required at the change of each shifts per state regulations. The count must be performed by two licensed nurses. They must sign the shift count page in the controlled substance book to acknowledge the completion of the shift count. The nurses conduct the review simultaneously to maintain accountability and then sign in a controlled substance log to represent their participation. Entries that lack two signatures suggest that the review did not take place with two nurses simultaneously and lacks the credibility of dual signatures. On 8/11/17 at 11:00 AM the controlled drug shift count was reviewed for first floor and second floor This review revealed that the controlled drug count was not consistently counted on each shift on the first and second floor as evidenced by multiple missing signatures for May, June, July and August. Review of 1 west controlled drug count sheet revealed missing signatures on the following days: May 27 and 31, June 1, 5, 10, 11, 16 and 25, July 4, 5, 9, 19 and 27, 2017. Review of 1 east controlled drug count sheet revealed missing signatures on the following days; June 1, 5 and 20, July 5, 21 and 30 and August 1, 2, 9 and 10, 2017. Review of 2 west controlled drug count sheet revealed the following missing signatures: May 15, 16, 26, 27 and 28 and June 1, 2, 8, 12 and 28, 2017. During an interview with the Director of Nursing (DON) on 8/11/17 she acknowledged the concern of the missing signatures from the controlled drug count sheet. She revealed that the nurses are aware that they have to count each. All findings were discussed with the DON and the Administrator during the survey exit. (continued on next page)

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F 0431 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of survey results from the past three years revealed that this is the 4th year in a row that F 431 has been cited as a deficiency.

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F 0441 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a program that investigates, controls and keeps infection from spreading. 16218 Based on review of medical records and interview with the Infection Control Nurse (Nurse #7) it was determined that the facility failed to have a system in place to monitor and document infections and antibiotic usage. This deficient practice has the potential to affect all residents. The findings include: On 8/15/17 review of Resident #15's medical record revealed that the resident had received an antibiotic for more than one week in August 2017. On 8/15/17 at 10:17 AM the Infection Control Nurse (Nurse #7) reported that she has been in this position since 3/30/17. She was unable to provide any documentation regarding Resident #15's use of an antibiotic, although she was able to verbalize knowledge that he had an infection and was receiving an antibiotic. She went on to report that she does not currently have a list of residents with infections and what treatments they are receiving. Nor did she have a list of resident infections and their resolutions. On 8/15/17 when this information was reviewed with the Director of Nursing she was able to produce some of this information but none for April - August of 2017.

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F 0456 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 30440 Based on surveyor observation and interviews with facility staff, it was determined the facility failed to maintain essential kitchen equipment in safe operating condition by failing to maintain the dishwasher with sanitizer within the normal temperature. This was evident during the initial tour of the facility's main kitchen and has the potential to affect all residents who consume food from the kitchen. The findings include: On 8/8/17 at 8:10 AM, an initial tour of the kitchen was conducted with the Dietary Manager (DM). An observation was made of the dishwasher in use, as the DM ran dishes through the machine. The temperature of the dishwasher with sanitizer only reached 117 degrees Fahrenheit. The DM proceeded to run the machine again at 8:15 AM and 8:20 AM with temperature readings of 117 and 118 degrees Fahrenheit. The DM stated to the surveyor that the machine was serviced 2 weeks ago by an outside contractor, and later submitted a copy of the service repair form. The DM placed a call to the facility's outside contractor for a service repair at 8:30 AM. On 8/8/17 at 10:55 AM during an interview with the DM, s/he stated that the dishwasher was repaired. The DM went on to say that the contractor found the booster heater was tripped off and had to be reset. The DM submitted a copy of the report to the survey team. On 8/10/17 at 10:30 AM the dishwasher with sanitizer was observed in use and the temperature was 120 degrees Fahrenheit. The Nursing Home Administrator (NHA) was made aware on 8/8/17 at 8:30 AM at the time of the finding.

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F 0497 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Review the work of each nurse aide every year; and 2) give regular in-service training based upon these reviews. 16218 Based on review of employee files and interviews it was determined that the facility failed to have an effective system in place to ensure that annual performance reviews were being completed for the Geriatric Nursing Assistants (GNA). This was found to be evident for 3 out of 3 GNAs (GNA #4, #20 and #13) reviewed for presence of an annual performance review and has the potential to affect all residents. The findings include: On 8/11/17 review of the GNA #4's employee file revealed that the GNA had been terminated from employment in June 2017. Further review of the employee file revealed the GNA had been hired in April of 2014 but there was no evidence of an annual performance review within the year prior to the termination. On 8/14/17 review of GNA #20's employee file revealed a hire date in April 2016. No evidence of an annual performance review was found in the file. On 8/14/17 review of GNA #13's employee file revealed a hire date in October 2015. No evidence of an annual performance review was found in the file. On 8/14/17 the Administrator confirmed that no annual evaluations had been completed for these employees. Of note, the failure to complete annual performance reviews for GNAs had been cited during the 2016 annual survey as well. This information was reviewed with the Administrator prior to exit.

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F 0498 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs. 16218 Based on review of employee files and interview it was determined that the facility failed to have an effective system in place to ensure that the geriatric nursing assistants (GNAs) were able to demonstrate competency in skills and techniques necessary to care for resident's needs. This was found to be evident for two out of three GNAs (GNA #21 and #22) selected for review of skills competency documentation in stage two of the survey. This failure has the potential to affect all residents at the facility. The findings include: On 8/14/17 interview with the Nurse Educator reported that newly hired GNAs have 3 days of orientation on the floor with competency sheets which are checked off and that these sheets should be in the employee files. Review of the Nurse Tech Skills Checklist revealed areas to document return demonstration by the orientee and/or meets performance objective on a variety of knowledge and skills. These competencies include, but are not limited to: Acting as resident advocate; Infection Control; Safety including body mechanics and transfers; Emergency procedures; Vital Signs, personal care, use of specialized equipment; and abuse reporting, prevention and immediate interventions. Surveyors requested the Nurse Tech Skills Checklist for GNAs 21, 22 and 24. Review of GNA #21's employee file revealed a hire date of 6/8/17 and review of the staffing sheets revealed the GNA was scheduled to work on 8/10, 11, 13 & 14, 2017. The facility was unable to provide a Nurse Tech Skills Checklist for GNA #21. Review of GNA #22's employee file revealed a hire date of 3/30/17 and review of the staffing sheets revealed the GNA was scheduled to work on 8/11 & 14, 2017. The facility was unable to provide a Nurse Tech Skills Checklist for GNA #22. On 8/14/17 surveyor reviewed the concern with the Director of Nursing and the Administrator regarding the failure to have a system in place to ensure GNA skills competency. Of note, the failure to ensure skills competencies for GNAs had been cited during the 2016 annual survey as well. This information was reviewed with the Administrator prior to exit.

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F 0502 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give or get quality laboratory services/tests in a timely manner to meet the needs of residents. 31985 Based on medical record review and interview with staff it was determined that the facility staff failed to ensure that a Complete Blood Count (CBC) and Basic Metabolic Profile (BMP) laboratory test ordered by the physician was obtained. This was evident for 1 out of 15 residents (Resident #50) reviewed during the revisit survey. The findings include: On 11/2/17 Resident #50's physician orders and laboratory records was reviewed. This review revealed a physician order dated 10/27/17 to check CBC and BMP on Monday 10/30/17. A CBC is blood test used to evaluate your overall health and detect a wide range of disorders and a BMP is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys are working. During an interview with Staff #6 the surveyor asked to see the results of the CBC and BMP, after reviewing the resident's chart Staff #6 acknowledged that the resident did not have the blood test on 10/30/17 as ordered by the physician. She further stated that she is going to call the physician assistant to make him aware that the blood test was not done. Further review of the medical records reveal an order dated 11/2/17 for stat (immediately) CBC and BMP. All findings discussed with the Director of Nursing and administrator during the survey process and exit.

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F 0514 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep accurate, complete and organized clinical records on each resident that meet professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on medical record review and interview with staff it was determined that the facility failed to ensure that staff maintained accurate medical records as evidenced by: 1. staff documenting that a medication had been administered despite no evidence that the medication was available, 2. failure to document and monitor a resident for any noted increase in anxiety on the behavior monitoring sheet in order to notify the psychiatric practitioner of the need for services, 3. failure to a. complete skin assessments weekly as ordered and b. when injuries noted, document accordingly, 4. failure to have documentation of a resident being admitted to a hospital, and 5. failure to accurately document the administration of a resident's medication. This was found to be evident for 5 of the 31 residents (Resident #15, #77, #102, #50 and #1) reviewed during stage two of the survey. The findings include: 1. On 8/10/17 review of Resident #15's medical record revealed an order, originally written 4/14/17, for Ativan 0.5 mg to be given every day at 4 PM for anxiety. Review of the June 2017 MAR revealed documentation that the Ativan was administered as ordered on June 16 and 17, however no documentation was found to account for these doses on the Controlled Medication Utilization Record. On 8/10/17 at 12:15 PM this information was reviewed with the Director of Nursing (DON). On 8/11/17 at 9:29 AM the DON reported that there was no evidence that the nurse obtained the medication on 6/16. She went on to report that on the MAR for 6/17, it was not a full signature so then it is considered an omission, but confirmed that even if not signed off as given there was no evidence that the nurse did anything about the fact that the medication was not available. 30428 2. Review of the medical record for Resident #77 on 8/11/17 at 8:48 AM revealed diagnosis including generalized anxiety disorder, and major depressive disorder. Further review revealed physician orders for clonazepam 1 mg (sedative for anxiety) before bed for anxiety starting on 6/9/17, clonazepam .5 mg twice a day for agitation ordered 6/9/17, Zoloft 100 mg (antidepressant) once a day for depression starting 9/12/15 and ambien (sedative) for insomnia started on 5/31/17. Review of the resident's medical records for psychology visits revealed a visit on 6/20/17 that noted the resident to be 'stable,' with 'change in his/her environment with increased anxiety, will follow up.' Review of the resident's medical record revealed psychology didn't follow-up on the resident until 7/24/17. Interview with the facility Director of Nursing (DON) on 8/15/17 at 9:48 AM revealed that according to her interview with the facility psych services representative, when they document 'follow-up' it is usually in 2-3 weeks unless there is a change or services are needed sooner. (continued on next page)

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F 0514 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the residents behavior monitoring record with the DON revealed that the June record was blank and had no identifying behaviors on it to monitor. The July record had the behavior of A. crying and B. checking doors, but the data sections were crossed out. The August flow record was also blank with no behaviors listed to be monitored. The concern that the psychology associate had noted an increase in anxiety in the June assessment and the facility staff failed to document monitoring was reviewed and confirmed with the DON. The DON stated that the facility staff document on the behavior monitoring record based on exceptions, however, there were no identified behaviors placed on the June behavior symptom monitoring flow record and the July record had lines going through the interventions. Review of the nursing notes for June 22 and 23 documented that the resident was noted pulling and throwing foot pads off of wheelchair and had agitation with speech difficulty. It was also noted that staff do not do daily notes that would document on the residents behavior and status in the interdisciplinary progress notes that could be a reference to the residents' behavior. Review of the 7/24/17 psych associate visit revealed recommendations to: monitor anxiety, agitation and mood; Facility changes can increase anxiety and confusion. The concerns were reviewed with the facility DON, Administrator and Chief Nurse during exit on 8/15/17. 3. Review of the medical record for Resident #102 on 8/14/17 at 12:04 PM revealed diagnosis including dementia with history of falls. A review of the resident's treatment administration record (TAR) revealed that a skin assessment was to be completed weekly on Tuesdays, facility policy. The results of the assessment were to be documented on the weekly skin integrity review form. On the weekly skin integrity form, staff could mark if the skin was intact, had open areas, bruises, skin tears, rashes, redness and other. Additionally, staff were to mark on the pictured body where the area of injury or discoloration was located. a. Further review of the resident's previous skin assessments revealed that although the weekly skin assessments were checked off on the TAR as complete, they were not signed off consistently on the weekly skin integrity review. This was true for September 2016 through January 2017. b. Closer review revealed that on 11/7/16 an SBAR communication document was completed stating that the resident was noted with a rash on the left chest. Additionally, the nurse practitioner documented on 11/7 the presence of the rash on the left chest noted as a dermatitis that a cream was ordered for. However, the November skin integrity review failed to show any documentation or indication of the rash. On 1/28/17, according to a complaint #MD00110462, the resident was found with a scratch and bruising on his/her chest. Review of the residents TAR revealed that on 1/31/17 a skin assessment was completed, however, the weekly skin integrity review was blank. (continued on next page)

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F 0514 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record failed to reveal any documentation of the rash that was noted on 11/7/16 or bruising noted on 1/28/17 and further no documentation of monitoring of the rash and bruising for healing and improvement. The concerns were reviewed with the facility DON, Administrator and Chief nurse during exit on 8/15/17. 30440 4. Intake #MD00110498 was reviewed on 8/8/17. The complainant alleged Resident #50 was sent to the hospital on 1/27/17 and the staff was unaware of the resident's admission to the hospital. A phone interview was conducted with the complainant on 8/11/17 at 9:00 AM. The complainant stated Resident #50 was admitted to the hospital in January of this year,and the facility was unaware of this. The complainant went on to say that Resident #50 had an appointment at the wound clinic and was directly admitted to the hospital. The complainant stated that s/he came into the facility to visit Resident #50 on Sunday 1/29/17 after church, and the resident was not there. The complainant further stated that the facility staff did not know where the resident was. An interview was conducted with the Nursing Home Administrator (NHA) and Nurse #6 on 8/15/17 at 8:45 AM and they were asked if there was documentation of Resident #50 hospitalization on [DATE]. The NHA could not produce documentation. Cross Reference F-157 37979 5. Review of Resident #1's medical record revealed the following nursing note, dated 6/7/17 at 3:45 PM by Nurse # 11: resident sitting up in the wheelchair this shift. Several crying episodes. PRN (as needed) Ativan given with little effect. Ativan is a medication used to treat anxiety. Review of Resident #1's June 2017 Medication Administration Record (MAR) revealed the absence of documentation to indicate that the medication was administered to the resident on 6/7/17. The Director of Nursing (DON) was made aware of the findings on 8/10/17 at 2:30 PM and confirmed that incidences of medication administration should be documented on a resident's MAR.

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F 0520 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action. 16218 Based on review of previous years annual surveys and interview with staff it was determined that the facility failed to establish an effective quality assurance program to develop and implement appropriate plans of action to correct identified quality deficiencies as evidenced by the repeat citation of 14 of the 31 deficiencies cited during the 2016 annual survey; and the repeated citation at F431 for the fourth year in a row. This deficient practice has the potential to affect all of the residents. The findings include: On 8/15/17 at 10:33 AM the Quality Assurance Nurse (Nurse #7), when asked if they had committees that were working on identified issues, she responded that they are working on it. She went on to report that she has been doing QA for less than a year. Of note the QA Nurse is also the Assistant Director of Nursing, the Infection Control Nurse and responsible for Employee Health as well. Surveyor informed the QA nurse of the concern regarding QA based on the fact that so many deficiencies identified during this survey had also been cited last year. Review of the 2016 annual survey report revealed that deficiencies had been identified for the following regulations: F 248 F 278 F 280F 309F 323F 329F 371F 431 (fourth year in a row)F 428 F 425F 497F 498F 514F 520 Deficient practices were identified during this current survey for all 14 of the above listed regulations. Review of the Plan of Correction for the 2016 survey revealed that compliance was alleged as of 8/30/16 for all of the identified deficiencies. Included in the plan for these deficiencies, except F 520, was the following: The results of the monitoring will be reported to the monthly Quality Assurance Committee for three months for review and further recommendations to include continued monitoring as appropriate. Once the Quality Assurance Committee determines the problem no longer exists, monitoring will be conducted on a random basis. For F 520, the Quality Assurance deficiency, the plan included the following: that plans of correction must be established and maintained to address issue to mitigate repeat deficient practices. (continued on next page)

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F 0520 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/17 at 11:06 AM the Administrator reported that they had revamped the QA process since [name of company that owns the facility as of 7/1/17] had taken over.