STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365828	A. Building B. Wing	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Convalescent Home	18810 Harvard Ave Cleveland, OH 44122

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07380 Based on observation, interview and record review, the facility failed to ensure Resident # 14 was treated with respect and dignity. This affected one of three residents reviewed for respect and dignity in a sample of 35 residents. The facility census was 103. Findings include: Review of Resident #14's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebrovascular disease, type II diabetes, dysphagia following non-traumatic intracerebral hemorrhage, and gastro-esophageal reflux disease without esophagitis. Review of Resident #14's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Individual for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The resident was totally dependent on two persons for bed mobility, transfers, and was totally dependent on one person for dressing, toilet use and personal hygiene. Interview with Resident #14 on 06/11/19 at 11:05 A.M. revealed she was not treated with respect and dignity and stated the staff have attitudes. Resident #14 stated staff would answer the light and tell her not to put the light on because she put it on too much. The third shift staff entered her room without permission at night and used their cell phones in her room. Staff came into her room in the middle of the night without knocking. She stated I wake up in the middle of the night, and I am startled because they are in my room on their cell phones. When providing care, they talk about who was dating who. Resident #14 stated staff constantly complain while in her room about their work and other residents, and she stated I don't want to hear that. The third shift staff (mostly agency) turn off the call light and tell me not to put it on again. Resident #14 stated she had reported this to the nurse and nothing was done about it. Staff will not allow her time to finish what she was saying, roll their eyes and walk away from her. She stated it was frustrating because I have problems speaking and they don't want to wait until I am done, and they walk away from me. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/14/19 at 11:20 A.M. Resident #14 was having a conversation with the surveyor in the hallway in the front lobby, the resident stopped the conversation and attempted to ask an unidentified State tested Nursing Assistant (STNA) to bring her two-small bags of chips. Resident #14, who had slow difficulty speech, was in mid-sentence, when the staff member rolled her eyes upward at the resident and left the resident mid-sentence. Resident #14 looked at the surveyor and stated slowly she's one of the better staff. Review of the facility's Grievance Committee Concern logs from 01/01/19 to 06/12/19 revealed concerns related to staff attitude on 01/24/19, 01/28/19, 02/13/19, 02/19/19 and 04/03/19. Further interview with Resident #14 on 06/12/19 at 11:50 A.M. revealed staff would come into her room, and staff won't allow her to tell them how to make her comfortable. Resident #14 stated she wanted staff to pay attention to her. She stated she needed staff to have patience with her. She stated if she could she would change the staff's approach and have them pay attention to what the resident needed and not have to listen to them on their cell phones, discuss who was dating who or who or talk about the problem residents when they were in her room. Interview with Corporate Registered Nurse #402 on 06/12/19 12:00 P.M., verified all staff, whether regular staff or agency staff, were to treat the residents with respect and dignity. No staff member was to tell a resident not to turn their light on.

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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 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on interview and review of Resident Council minutes, the facility failed to act upon the views and concerns of the residents. This had the potential to affect all 103 residents residing in the facility. Findings include: A confidential Resident Council group meeting was conducted on 06/11/19 at 1:37 P.M. with 12 residents present (Residents #16, #18, #22, #23, #37, #53, #62, #74, #85, #91, #101 and #153). They reported they attended the Resident Council meetings regularly. The residents said they complained about not enough staff every month at the meetings, but nothing every changed. The residents reported not having enough staff to meet their needs. They identified not getting their dressings changed, not receiving showers, one staff using the mechanical lift that requires two staff and staff not responding to call lights timely. Interview with the following residents reported they felt there was not enough staff to meet their needs: On 06/10/19 at 9:57 A.M., Resident #49 stated the facility needed more aides on second shift and weekends. She stated she did not always get her showers. On 06/10/19 at 11:02 A.M., Resident #100 stated he waited a long time to get back in bed on the second shift. He stated the second shift was always short staffed, including weekends. On 06/10/19 at 11:11 A.M., Resident #40 stated he waited a long time for call lights to be answered. He stated he waited 30 minutes or more to get into the bed at night. On 06/10/19 at 4:21 P.M., Resident #48 stated the facility needed [NAME] aides on the second shift. He stated he waited 30 minutes to get in bed. On 06/10/19 at 4:58 P.M., Resident #24 stated there was not enough staff on the afternoon shift to meet her needs. On 06/10/19 at 5:02 P.M., Resident #42's daughter stated there was not enough staff, and they were keeping people in the dining room. She had concerns with the facility not having enough aides, and she felt training was needed for staff to understand residents with behaviors. On 06/10/19 at 5:36 P.M., Resident #21 stated there was not enough staff on the second shift. On 06/11/19 at 10:12 A.M., Resident #63 felt her at times her call light was on for hours before it was answered. She stated the third shift was the worst. (continued on next page)

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	On 06/11/19 at 11:11 A.M., Resident #14 stated the facility did not have enough staff. She said the facility used agency staff who just walk the halls and would not answer call lights. She reported staff would sit for two hours at the desk and then give attitude if they had to answer a call light. She stated they were always short staffed. Call lights were not answered for up to an hour, and when answered she was told not to ring it again. She reported this happened on third shift. On 06/11/19 at 11:32 A.M., Resident #59 stated it took up to 30 minutes to get help to go to bathroom. Review of the Resident Council minutes beginning on 12/18/18 revealed residents voiced concerns related to not enough State tested Nurse Aides (STNA's) on the night shift and weekends. On 01/22/19, residents voiced concerns related to not enough staff on one north and south. 02/27/19 indicated a new Director of Nursing (DON) and Dietary Manager and the facility was in search of a Maintenance Director. 03/26/19 indicated STNA's were not knocking and introducing themselves and were saying they would come back but would forget. On 04/24/19, there were questions and concerns regarding agency nurses and STNAs. There were no resolutions provided for their concerns. Review of the Resident/Family Concern Log since January 2019 revealed staffing concerns were voiced on 02/01/19, 02/06/19, 02/27/19, 02/24/19, 04/24/19, 05/15/19, 05/29/19 and 06/08/19. Concerns related to staff attitude were voiced on 01/24/19, 01/28/19, 02/13/19, 02/19/19 and 04/03/19. The facility did not provide resolutions to the concerns. Multiple requests were made to the Administrator on 06/14/19 for responses to the above concerns with no information provided.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07380 Based on interview and record review, the facility failed to ensure the concerns of Resident #42 and #152 were thoroughly investigated and acted upon. This affected two of three residents reviewed for abuse. The facility census was 103. Findings include: Review of Resident #152's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including unspecified abdominal pain, asthma, bipolar disorder, epilepsy, type I diabetes and chronic obstructive pulmonary disease. Review of Resident #152's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required extensive assistance of one person for bed mobility, transfer, toilet use and personal hygiene. Review of Resident #152's plan of care dated 05/09/19 revealed the resident was noncompliant with care and treatment as ordered by physician. The resident refused medications, including insulin. She was educated on risk, and signs and symptoms of hypo/hyperglycemia (low/high blood sugar). The goal was for Resident #152 to be compliant with physician orders through the next review. Interventions included: attempt to refocus behavior when the resident exhibited inappropriate behaviors; if appropriate, stop care when the resident was upset and try again later; administer medications as ordered, and monitor for side effects and effectiveness; approach the resident calmly without rushing, and speak in a calm voice; educate the resident of the potential negative consequences of not following physician's orders. Review of a Facility Reported Incident (FRI) dated 05/13/19, revealed Resident #152 made an allegation of physical abuse toward STNA #454, who allegedly kicked her instead of moving her leg in a side to side motion. The allegation was unsubstantiated by the facility. Review of STNA #454's written statement dated 05/15/19 revealed This resident has been a problem with me ever since I have been here. One day she's ok with me taking care of her, the next day she wants someone else to care for her. She disrupts my work assignment whenever she feels like it. The nurse is very aware of this situation. I have asked if someone else to have her, but it depends on her and the nurse that day. STNA #454 also stated I did not touch her leg on the days I worked with her. The last time I worked with her everything went fine, she did not complain to nurse or me about anything that day. I do not know what she is talking about. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 06/13/19 at 2:50 P.M. revealed statements were obtained from the nurse and staff on the unit. The residents on the unit were asked if they had been abused, and no resident stated they were abused. The Administrator did not take statements from other staff who may have completed relief for lunch breaks etc. She stated STNA #454 had indicated in the statement she had asked to have someone else take care of the resident, and it depended on the nurse on duty that day if a change of assignment occurred. She stated the facility recognized the difficulty of the resident's behavior and was not positive a change of assignment would have changed the outcome of the allegation. The facility unsubstantiated the allegation of abuse. Review of the abuse, neglect, exploitation and misappropriation of resident property policy, dated 2016, indicated annual training would include appropriate interventions to deal with aggressive and/or catastrophic reactions of a resident, dementia management and abuse prevention. Catastrophic reactions were defined to mean extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care. 07954 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, dementia without behavioral disturbance and hallux foot. Review of the physician's orders revealed the orders lacked any fall interventions. Review of the quarterly comprehensive assessment (MDS 3.0) dated 04/05/19 revealed he was severely cognitively impaired, had continuous inattention, displayed physical behaviors and rejection of care on one to three days of the seven-day assessment reference period. He required extensive assistance of one person for dressing and personal hygiene. He required extensive assistance of two staff for transfers and toileting. He required the total assistance of one staff for bathing and was always incontinent of bowel and bladder. He sustained two falls with no major injury. Review of the nursing note dated 03/14/19 at 5:52 A.M. indicated a STNA called the nurse to Resident #42's room at 5:15 A.M. reporting the resident had become resistive to care, flipped out of bed and flipped the entire bed over while he was turning him to change him. The nurse noted she observed the resident lying on the floor, face down, positioned partially on his left side, on top of the half side rail, and the bed was standing up on it's left side. The nurse noted he had no apparent injury. The nurse noted Resident #42 was tense and resistive. Neurological evaluations were initiated. Review of incident investigation number 1972 indicated on 03/14/19 the resident was tense and resistive, sad and appeared frightened at the time of occurrence. The predisposing physiological factors indicated weakness/fainted. The side rails were in the raised position, and no witness was found. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the post-fall evaluation dated 03/14/19 indicated he fell from the bed to the floor. One Licensed Practical Nurse (LPN) and two STNA's were on duty. The immediate intervention check list was blank. The bed was switched out. There was no indication why the bed had to be switched out. No new interventions were initiated. There was no statement or interview with STNA #432 regarding the incident to determine abuse did not occur. Review of the fall witness statement dated 03/14/19 indicated LPN #420 did not witness the fall. She entered the room and found him on the floor face down partially positioned on the left side on top of a half side rail, and the bed was standing up on its left side. The STNA was present. All safety measures were in place. She last observed him lying in bed. He was incontinent of urine at the time of the fall. The resident was unable to recall or explain what happened. She noted the side rails were to be removed from the bed and two STNA's were to provide care and come back to the resident if he was resistive to care. There were no statements from the two nursing assistants. These interventions were not updated in the plan of care. Interview with the Assistant Director of Nursing, LPN #408, on 06/14/19 at 11:43 A.M. indicated Resident #42 was [AGE] years old and strong. LPN #408 reported the Director of Nursing would have been responsible for investigating the incident. She was not sure if the facility had a Director of Nursing at that time. She said if their was no Director of Nursing, it would then be the responsibility of the Assistant Director of Nursing. She denied participation in the investigation. LPN #408 verified no statements were obtained from STNA's #432 an #433, who were on duty, to determine their involvement and to obtain their knowledge. LPN #408 said if a resident became combative during care, the STNA should walk away and return later. LPN #408 stated STNA #432 was terminated due to attendance issues. The lack of a thorough investigation lacked assurance that abuse did not occur. Review of the abuse, neglect, exploitation and misappropriation of resident property policy, dated 2016, indicated annual training would include appropriate interventions to deal with aggressive and/or catastrophic reactions of a resident, dementia management and abuse prevention. Catastrophic reactions were defined to mean extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22438 Based on observation, interview and record review, the facility failed to ensure individualized care plans were developed for hospice services and activities for Resident #99 and depression or suicidal ideations for Resident #87. This affected two of thirty five residents reviewed for care planning, with a facility census of 103. Findings include: 1. Review of the record revealed Resident #99 was admitted to the facility on [DATE] with diagnoses including dementia, history of stroke, falls and muscle weakness. The resident was accepted to hospice services on 05/21/19 and a significant change Minimum Data Set (MDS) 3.0 assessment was completed on 05/28/19. Review of the record did not reveal care plans related to hospice services. Review of the resident's record also did not contain a care plan to indicate her activity needs or plans. An interview with Assistant Director of Nursing, Licensed Practical Nurse (LPN) # 408, and the facility Activity Director (AD) #436 on 06/12/19 at 10:48 A.M. verified the record did not contain the plans of care for hospice or activities. 07380 2. Record Review #87 medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including adult failure to thrive, severe protein-calorie malnutrition, and late onset Alzheimer's disease. Review of Resident #87's quarterly MDS 3.0 assessment dated [DATE] revealed the resident was independent with set-up for all activities of daily living skills. Further review of Resident #87's medical record revealed the resident did not have a plan of care for depression or suicidal ideations with no plan or intent. Review of a Gero-Psych note dated 03/27/19 revealed the resident's primary diagnoses were adjustment disorder with mixed anxiety and depressed mood. The evaluation dated 03/27/19 documented the the resident was an [AGE] year-old and has a diagnosis of adjustment disorder with anxiety and mild dementia. He presented as polite and engaging. The most recent cognitive exam score of 72% was consistent with mildly impaired functioning. The resident was seen for a routine counseling session. He was troubled by homesickness and reported increased effort to go to activity department events. Resident #87's evaluation dated 03/12/19 revealed the resident presented as melancholy, with sad facial expression and low energy. He was distressed by fleeting thoughts of suicide without intent, plan or means. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #87 on 06/13/19 at 10:30 A.M. and 06/14/19 at 8:00 A.M. revealed the resident was in a low bed, room darken and in bed with his clothes on. Interview with Resident #87 stated he wasn't sure if he was going to get out of bed or not today and ended the conversation. Interview with Registered Nurse (RN) #402 on 06/18/19 at 2:30 P.M. verified the resident did not have a plan of care and address the potential for suicidal ideations and depression.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on observation, interview, record review, policy review, facility assessment and in-service review, the facility failed to review and revise care plans to ensure they were person-centered and included the current assessed interventions. This affected four Residents (#5, #31, #42 and #99) of 35 records reviewed. The facility census was 103. Findings include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities, parkinsonism, diabetes, anemia, epilepsy, hyperlipidemia, anxiety disorder, insomnia, hypo-osmolality and hyponatremia, dysphagia, mood disorder with manic features and schizophrenia. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was severely cognitively impaired. He did not display symptoms of psychosis but displayed physical, verbal, other behavioral symptoms, rejection of care and wandering on one to three days of the seven-day of the assessment reference period. He required extensive assistance of one person for transfers, dressing, toileting, personal hygiene and total dependence of one person for bathing. He had no impairment of the upper and lower extremities. Review of the behavioral plan of care revised 06/10/19 indicated he does not conform to or understand boundaries of socially accepted behaviors. He was identified as sexually inappropriate and verbally abusive toward staff. He had been verbally aggressive toward staff when asking for staff food and redirection. He was noted to lock his wheelchair brakes while being pushed in his wheelchair. The interventions included; avoid male caregivers; discuss and provide options for him to express his sexuality appropriately; discuss with the resident straight forward but kind manner that his behavior was unacceptable; evaluate if the behavior was sexual behavior or a result of cognitive impairment; may use crisis prevention intervention (CPI) technique as needed, fifteen-minute checks and refer to psychological services. Review of the State tested Nurse Aide (STNA) task documentation since 05/01/19 related to rejection of care indicated he refused care on 05/28/19 and 06/05/19. He displayed verbal and physical behaviors consistently. Review of the behavioral intervention monitoring documentation for May 2019 indicated he was monitored for exit seeking and agitation. He had no episodes of exit seeking and had 16 days with episodes of agitation on the day shift and two episodes of agitation on the night shift. In April 2019, no episodes of exit seeking were noted. He had three episodes of agitation on the day shift and two episodes of agitation on the night shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the geriatric psychological note dated 01/11/19 indicated he had schizophrenia, was polite and engaging and had mumbled speech. The note indicated due to his cognitive deficits, he struggled with intense emotions like anger. The note indicated they worked on behavior management. Provided empathy, unconditional positive regard and patience. The plan was to continue sessions. Review of the geriatric psychological note dated 03/29/19 indicated he was exhibiting increased behaviors and agitation. He struggled with intense emotions like anger. The note indicated they worked on behavior management and modeled appropriate assertive communication behaviors. Review of the geriatric psychological note dated 06/10/19 indicated his moods and behaviors were much improved. He was less agitated and anxious. The plan was to increase his antidepressant medication to maintain proper stabilization over anxiety and general moods. There was no documented evidence behavior management strategies were communicated to the interdisciplinary team and incorporated into his care plan for staff to provide consistent and effective behavior management and supervision. Resident #5 was observed on 06/10/19 at 12:49 P.M. wheeling around the dining room without purpose and running into tables with his head down. The dining room had 19 other residents present waiting for the lunch meal. He was yelling out consistently and other residents were yelling back at him to shut up. No staff were present. The other residents were frustrated and continued to yell at him. He rammed tables so hard they moved, and when he ran into other residents chairs they verbally lashed out at him and some tried pushing him away. When Resident #5 would get stuck against a table or chair he became more agitated and aggressive and used physical force against tables and/or chairs with residents present. On 06/11/19 at 3:15 P.M. Resident #5 was sitting in his wheelchair resting his head on a dining room table. There were multiple residents in the dining room participating in an activity. He occasionally looked up, banged on the table with such force it was moved. His behavior continued to escalate. Other residents reacted by either yelling at him to stop or to shut up. On 06/11/19 at 3:20 P.M., Activity Assistant #421 moved him to another table and locked his wheelchair. This increased his agitation, and he began to rock the wheelchair wildly to move before he released the brakes and continued his behaviors. At 3:25 P.M., his behaviors were so interruptive Activity Assistant #421 tried to wheel him out of the dining room. He screamed and resisted. A State tested Nurse Aide (STNA) arrived and bribed him with a pop, and he then left the dining room. On 06/12/19 at 8:11 A.M., Resident #5 was screaming and ramming into wheelchairs and standard chairs violently. Other residents yelled at him to stop and to shut up. This did not deter him. There were 21 residents and no staff in the dining room. Resident #66 could not redirect him so she left to get the nurse. The nurse arrived and asked him what he wanted. He said he wanted his medication. She told him it was not his time for his medication. He calmed for a bit and then began to escalate. He was swearing and yelling. At 8:15 A.M., he was observed to violently ram into chairs. He worked his way over to Resident #60's chair and ran into it over and over. Other residents were yelling at him to stop. Again, no staff were in the room. He rammed her so hard she stood up. She was observed to be unsteady. Resident #66 went and moved Resident #5's wheelchair out of the way and physically escorted Resident #60 to her table. Resident continued wheeling into others and screaming until he got his breakfast meal at 8:32 A.M. At 8:43 A.M., he was yelling that he was stuck. Other residents yelled at him to shut up or stop. No staff were in the dining room. On 06/12/19 at 11:18 A.M., he was heard screaming in the dining room from the nurses station and other residents were yelling at him to stop. No staff responded. The surveyor entered the dining room to observe Account Manager #426 move Resident #5 out of the way. Resident #17 said Resident #5 was ramming into the floor machine which was confirmed by Account Manager #426. (continued on next page)

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	365828	A. Building B. Wing	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Convalescent Home	18810 Harvard Ave Cleveland, OH 44122

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews with STNA #418 and Licensed Practical Nurse (LPN) #419 on 06/10/19 between 9:47 A.M. and 10:15 A.M. indicated two aides on the unit were not enough to provide the care, supervision and behavior management on the secured unit. They said they were provided dementia training but no behavior training. Interview with STNA #422 on 06/13/19 at 8:53 A.M. had never received behavior training in CPI. Interview with STNA #424 on 06/14/19 at 9:51 A.M. never heard of CPI training and had not received training in the management of behaviors. Interview with the Administrator on 06/17/18 at 10:30 A.M. verified CPI training had not been provided to staff. Interview with the Administrator on 6/13/19 at 10:00 A.M. verified no CPI training was conducted in the facility. She indicated staff competencies were provided annually. On 06/14/19 at 2:50 P.M., the Administrator provided a test the STNA's were expected to take after the secure unit caregiver training competencies. The test was related to general dementia questions. Nothing specific to behaviors or behavior interventions. Nursing assistant skills review checklist were completed annually and the licensed nurse skills review checklist included resident protection but no evidence behavioral management strategies were provided. Interview with LPN #452 on 06/17/19 at 12:45 P.M. verified the care plan was not revised. 2. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including adult neglect or abandonment, dysphagia, general anxiety disorder and Down's syndrome. Review of the current comprehensive MDS 3.0 assessment dated [DATE] indicated she was severely cognitively impaired. She rejected care on one to three days of the seven-day assessment reference period. She required the extensive assistance of one staff for transfer, dressing, toilet and personal hygiene. Review of the activity of daily living restorative assessment and progress dated 04/03/19 indicated she required one person physical assist with hygiene bathing and dressing. She needed set-up help only with eating. Review of the dietary note dated 04/26/19 indicated Resident #31 was discussed at the interdisciplinary risk meeting due to a significant weight loss of 11% in the last six months. The dietary note dated 05/10/19 indicated she was discussed at the interdisciplinary risk meeting indicated her meal intake decreased. The intervention was to feed Resident #31 at meals. Review of the nutrition plan of care indicated the interventions dated 04/18/19 were to have a nutritional supplement twice daily and initiate weekly weights; 06/05/18 scoop dish at all meals, assist with feeding as needed, offer meal substitutes for dislikes and document her intake with each meal. The intervention to have her fed by staff was not added to the care plan. Review of the plan of care related to activities of daily living related to Down's syndrome with cognitive impairment and impaired balance. The interventions included assist in choosing appropriate clothing as needed, assist with oral care, limited assistance with dressing, toileting, extensive assistance for bathing. Set-up assistance for eating. Review of the activity of daily living look back report revealed she was marked as not refusing care. The care plan was not revised to include the recommendation that she must be fed. Resident #31 was observed on 06/10/19 at 12:42 P.M., 06/12/19 at 8:23 A.M. and 06/13/19 at 8:23 A.M. to feed herself. No staff were observed to feed her. Resident #31 was observed on 06/10/19 to have excessive spillage of red liquid on her clothing protector, shirt and pants. There was excess spills of food and fluid on the floor. The treaded bottoms of her sneakers were caked with food. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Registered Dietitian #450 on 06/12/19 at 04:35 P.M. indicated she continued to recommend Resident #31 be fed at all meals. She was not aware staff were not feeding her. Interview with the Assistant Director of Nursing, LPN #408, on 06/14/19 at 12:08 P.M. said she was not aware Resident #31 needed to be fed at meals. Interview with LPN #452 on 06/17/19 at 12:45 P.M. verified the care plan was not revised. 3. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, dysphagia, hallux valgus foot acquired and dementia without behavioral disturbance. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed he was severely cognitively impaired. He displayed continuous inattention. He displayed physical behaviors and rejection of care on one to three days of the seven-day assessment reference period. He required the extensive assistance of one person for dressing and personal hygiene. He required the extensive assistance of two staff for transfers and toileting. He required the total assistance of one staff for bathing. Review of the fall risk evaluations indicated he had been a high risk for falls since 02/03/18. Evaluations for actual falls occurred on 03/26/18, 06/25/18, 08/26/18, 02/17/19, 03/14/19 and 03/16/19. Review of the falls plan of care revised 03/15/19 indicated the interventions included: assist with transfers and ambulation as needed; 08/26/18, a non-skid pad to the top of the wheelchair cushion; 04/18/18 to have appropriate non-skid footwear on at all times; 04/02/18 educate staff to turn on the call light and call for help without leaving the resident unattended; 03/26/18 to have non-skid pad to chair while seated in the dining room; 04/18/18 low bed with grab bars; 02/17/19 low bed to help prevent falls. The plan of care was not reviewed and revised to implement person-centered interventions to prevent further falls. Interview with LPN #452 on 06/17/19 at 12:45 P.M. verified the care plan was not revised. Review of the secured unit criteria (undated) indicated the purpose of the unit was to provide specialized care for cognitively impaired residents. The secured unit was available to residents who met one or more of the following criteria: require specialized activities, an environmental design that allows space for a resident to ambulate ad lib and additional security for a resident at risk for elopement. Review of the prevention and identification section of the abuse, neglect, exploitation and misappropriation of resident property policy dated 2016, indicated to deploy staff in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual resident's care needs. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors, residents with communication disorders and those that require heavy nursing care and/or were totally dependent on staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility assessment dated [DATE] indicated the average number of residents with behavioral symptoms and cognitive performance was 13 residents. The staffing plan identified the facility required four to five nurses, seven to nine nurse aides. Staffing was an area identified for Quality Assurance and Performance Improvement (QAPI) and the action to be taken/already taken this year was to maintain competent staff at a level needed to care for our residents by monthly in-services, recognition awards, evaluations with goal setting. The training and competencies indicated monthly in-services, yearly competency testing for all nurses and nursing assistance. 22438 4. Review of the record revealed Resident #99 was admitted to the facility on [DATE] with diagnoses including dementia, history of stroke and falls, and muscle weakness. The resident was accepted to hospice services on 05/21/19. Review of the record on 06/12/19 revealed the resident's responsible party and the physician had signed a do not resuscitate (DNR) form that was found in the front of her chart. The form was signed but undated. Review of the resident's care plans and the computerized record both indicated the resident was a full code. An interview with the Assistant Director of Nursing, LPN # 408, on 06/12/19 at 10:48 A.M. verified the computerized record and care plan both indicated the resident was a full code, although the form was in the record to indicate her preference to not be resuscitated. LPN #408 stated the facility had been waiting for a family member to sign the form, and it must have been put in the chart. She verified the care plan and computer should have been updated with the correct information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on observation, interview and record review, the facility failed to provide personal care services to dependent residents. This affected four Residents (#5, #31, #42 and #94) of five residents review for activities of daily living. Findings include: 1. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including adult neglect or abandonment, dysphagia, general anxiety disorder and Down's syndrome. Review of the current comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated she was severely cognitively impaired. She rejected care on one to three days of the seven-day assessment reference period. She required the extensive assistance of one staff for transfer, dressing, toilet and personal hygiene. Review of the activity of daily living restorative assessment and progress dated 04/03/19 indicated she required one person physical assist with hygiene, bathing and dressing. She needed set-up help only with eating. Review of the dietary note dated 04/26/19 indicated Resident #31 was discussed at the interdisciplinary risk meeting due to a significant weight loss of 11% in the last six months. The dietary note dated 05/10/19 indicated she was discussed at the interdisciplinary risk meeting and indicated her meal intake had decreased. The intervention was to feed Resident #31 at meals. Review of the nutrition plan of care indicated the interventions dated 04/18/19 were to have a nutritional supplement twice daily and initiate weekly weights; 06/05/18 scoop dish at all meals, assist with feeding as needed, offer meal substitutes for dislikes and document her intake with each meal. The intervention to have her fed by staff was not added to the care plan. Review of the plan of care related to activities of daily living related to Down's syndrome with cognitive impairment and impaired balance. The interventions included assist in choosing appropriate clothing as needed, assist with oral care, limited assistance with dressing, toileting, extensive assistance for bathing. Set up assistance for eating. Review of the activity of daily living look back report revealed she was marked as not refusing care. The care plan was not revised to include the recommendation that she must be fed. Resident #31 was observed on 06/10/19 at 12:42 P.M., 06/12/19 at 8:23 A.M. and 06/13/19 at 8:23 A.M. to feed herself. No staff were observed feeding her. Resident #31 was observed on 06/10/19 to have excessive spillage of red liquid on her clothing protector, shirt and pants. There was excess spills of food and fluid on the floor. The treaded bottoms of her sneakers were caked with food. Interview with Licensed Practical Nurse (LPN) #420 on 06/10/19 at 5:23 P.M. confirmed Resident #31 had been left in the same spot since lunch and had excess spillage on the table, floor and red liquid remaining on her clothing protector and clothing and food stuck on the bottoms of her shoes. She took her to be changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Registered Dietitian #450 on 06/12/19 at 4:35 P.M. indicated she continued to recommend Resident #31 be fed at all meals. She was not aware staff were not feeding her. Interview with the Assistant Director of Nursing, Licensed Practical Nurse (LPN) #408, on 06/14/19 at 12:08 P.M. said she was not aware Resident #31 needed to be fed at meals. 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, dysphagia, hallux valgus foot acquired and dementia without behavioral disturbance. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed he was severely cognitively impaired. He displayed continuous inattention. He displayed physical behaviors and rejection of care on one to three days of the seven-day assessment reference period. He required the extensive assistance of one person for dressing and personal hygiene and extensive assistance of two staff for transfers and toileting. He required the total assistance of one staff for bathing. Review of the activities of daily living plan of care revised on 10/27/18 indicated he required extensive to total assistance of staff for bathing, and staff would assist as needed with daily hygiene and showering as per the policy weekly. Resident #42 was observed on 06/10/19 at 12:42 P.M. and 06/11/19 at 9:19 A.M. and 3:16 P.M. to have excessive facial hair and significantly long fingernails of which some were broken and jagged. Interview with Resident #42's daughter on 06/10/19 at 5:13 P.M. revealed she was concerned he had long jagged fingernails and toenails and said she knew they had to hurt. She said he was often unshaved. She said he used to take pride in how he looked and dressed, but the staff do not assist him to look his best. Interview with LPN #428 on 06/11/19 at 4:01 P.M. verified his nails were long and jagged, and he was in need of a shave. She said he was one of the most combative residents. She removed him from the dining room and cut and filed his fingernails. 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities, parkinsonism, diabetes, anemia, epilepsy, hyperlipidemia, anxiety disorder, insomnia, dysphagia, mood disorder with manic features and schizophrenia. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed he was severely cognitively impaired. He did not display symptoms of psychosis but displayed physical, verbal, other behavioral symptoms, rejection of care and wandering on one to three days of the seven-day assessment reference period. He required extensive assistance of one person for transfers, dressing, toileting, personal hygiene and total dependence of one person for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the activity of daily living plan of care initiated on 02/28/19 indicated assistance was needed related to cognitive impairment, immobility and behavioral episodes. Fluctuations were expected to occur. The interventions included: providing extensive assistance of one staff for toileting; choosing appropriate clothing; keeping the call light in reach; observe for changes in activities of daily living ability and adjust assistance as needed; provide assistive devices to increase activity of daily living self-care as needed; provide incontinence care every two hours as needed; staff will assist as needed with daily hygiene and will assist with showing the resident per the facility policy. Resident #5 was observed on 06/10/19 at 12:42 P.M., 06/11/19 at 8:24 A.M. and 3:15 P.M. and on 06/12/19 at 8:15 A.M. to look disheveled. His hair was long and uncombed. He had an excessive growth of hair on his face. Review of the resident care policy, revised June 2018, indicated residents would be given nursing care and supervision based upon individual needs. Typical personal hygiene would include care of the skin to include routine and as needed bathing and food care, shampoo and grooming of the hair per the resident's preference, oral hygiene, shaving and beard trimming per the resident's preference and cleaning and cutting of fingernails and toenails. Residents would be dressed in clean garments daily and appropriate attire for the season within their preferences. Residents would be bathed or assisted to shower or bathe routinely and as needed per their preference with foot care given per order/need. Residents would be encouraged/assisted to complete oral/denture care routinely and as needed. Staff would assist with the resident's nutritional needs by encouraging/assisting them to the dining room for meals and/or providing a tray to their room. Review of the quality of life dignity policy, revised August 2009, indicated residents would be treated with dignity and respect at all times. Staff shall promote dignity and assist residents as needed by Staff will treat cognitively impaired residents with dignity and sensitivity for example addressing the underlying motives or root causes for behavior and not challenging or contradicting the resident's beliefs or statements. Promptly respond to resident's requests for toileting assistance. Demeaning practices and standards of care that compromise dignity were prohibited. 07380 4. Review of Resident #94's medical record revealed the resident was admitted to the facility with diagnoses of atrial fibrillation, Alzheimer's Disease, cerebellar stroke syndrome hemiplegia and hemiparesis, chronic kidney disease stage two and dementia with behavioral disturbance. Review of Resident #94's quarterly MDS 3.0 assessment dated [DATE] revealed the resident required total dependency of one person for bed mobility, dressing, eating, toilet use and personal hygiene and total dependence of two persons for transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #94's plan of care dated 03/31/19 revealed the resident was at risk for alteration in nutrition and/or hydration related to atrial fibrillation, pneumonia, hyperparathyroidism, vascular dementia, hypercalcemia, history of stroke, history of chewing difficulty, refusing supplements, need for mechanically altered therapeutic diet. The goals included: nutrition and hydration needs would be adequate to promote comfort and dignity; chew/swallow safely, free of chocking/aspiration. Interventions included: allow family/friends to bring favorite food/fluid within diet; monitor and record consumption; monitor for signs and symptoms of aspiration; monitor for signs and symptoms of dehydration; monitor labs per medical doctor order; monitor skin condition and request dietary interventions when necessary; monitor weight once month and as needed; offer substitutes for dislikes; provide diet counseling as needed; provide diet per physician's order; provide favorite food/fluids within diet; and speech evaluation and treatment as needed. Observation of Resident #94 on 06/11//19 at 9:50 A.M. and 10:30 A.M. revealed the resident's lips were dry, and her water was out of reach. The observation was verified with Registered Nurse, Assistant Director of Nursing #404. On 06/12/19 at 3:10 P.M. Resident # 94's water pitcher was out of reach at the foot of the resident's bed. The resident's lips were dry. The observation was verified with Registered Nurse, Assistant Director of Nursing #404 on 06/12/19 at 3:10 P.M. On 06/13/19 at 12:10 P.M., 1:20 P.M. and 3:39 P.M. the resident did not have a water pitcher in her room. The observation was verified with the Activity Director #436 on 06/13/19 at 12:10 P.M. and 1:20 P.M. Interview with Registered Nurse, Assistant Director of Nursing #404 on 06/12/19 at 10:30 A.M. verified Resident #94 was totally dependent of staff to be fed and offered fluids. Staff were to leave a pitcher of water, and the water was to be offered when staff were in the room checking on the resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22438 Based on observation, interview and record review, the facility failed to ensure an individualized activity program was provided for Resident #99. This affected one of two residents reviewed for activities with a facility census of 103. Findings include: Review of the record revealed Resident #99 was admitted to the facility on [DATE] with diagnoses including dementia, history of stroke and falls, and muscle weakness. Review of her admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was cognitively impaired, had difficulty expressing her feeling and was extensive to dependent of staff on her activities of daily living. The resident was accepted to hospice services on 05/21/19 and a significant change MDS 3.0 assessment dated [DATE] revealed no real changes in the above categories. Review of the preferences for routine and activities for both the 03/07/19 and 05/28/19 assessments revealed the resident participated in the activity assessments. Both assessments revealed the resident felt it was very important for her to listen to music, keep up with the news, do things around people, do her favorite activities, get outside when the weather was nice and participate in religious services. It was somewhat important for her to be around animals such as pets. Review of the resident's record did not reveal other notes from activities staff, including progress notes or a more detailed activity assessment to indicate what her favorite activities were. The record also did not contain a care plan to indicate her activity needs or plans. Observation of the resident on 06/10/19 at 10:00 A.M. revealed her in bed. She was dressed in a hospital gown. She opened her eyes to the surveyor, but did not answer questions or nod her head. She appeared comfortable. Continued observations on 06/10/19 at 2:30 P.M., 4:30 P.M. and 5:50 P.M., 06/11/19 at 8:45 A. M., 12:20 P.M., 3:35 P.M. and 4:50 P.M., 06/12/19 at 8:40 A.M., 10 45 AM, and 4:10 PM and 6/13/19 9:05 AM, 12:15 PM and 4:45 PM, all revealed the resident in her room in bed. She was comfortable and did not respond to surveyor questions. She was observed with staff in her room at times, assisting with bathing or with meals, and was noted on 06/10/19 at 4:30 P.M. to be visited by the hospice Chaplin. State tested nursing assistant (STNA) #424, who starting to give her a bath on 06/13/19 at 9:05 A.M., revealed the resident was asked daily if she wanted to get up, but she refused. The resident was observed as she was asked by STNA #424 if she wanted to get up in the chair after getting the bath and the resident shook her head no and closed her eyes. An interview with Activity Director (AD) #436 on 06/12/19 at 10:42 A.M. verified the record did not contain an assessment or care plan. She stated she usually talked to the resident on admission and just entered the information into her section of the MDS assessment. She verified the assessment did not provide specific likes or dislikes of the resident regarding activities and did not provide an individualized guide for an activity care plan. She stated the resident had been more active, but since declining and being on hospice, she rarely wanted to get up out of bed or leave her room. She stated she visited the resident daily but verified the record did not contain a care plan to outline the plan for individualized activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed activity grids for the last three months with AD #436 on 06/14/19 at 11:30 A.M. Review of the grids revealed the resident was marked for television and music. AD #436 indicated that she would turn on either the television or radio for the resident at times. The resident was also marked for Coffee Social. AD #436 indicated the activity occurred daily on the unit, but Resident #99 was approached in her room to ask if she wanted a snack. She was also marked for socialization. AD #436 indicated that staff socialized with the resident during care, but the designation was not for a specific time period and verified the record did not contain evidence of the socialization as a specific activity. The resident was also marked for Sing Along. AD #436 indicated the Sing Along happened on the unit and the designation for the resident was if staff went into her room and sang for her specifically. This was marked as occurring six times since 03/20/19. The resident was also marked for sensory stimulation. AD #436 could not provide evidence of what type of activity this would be but stated sometimes it was hand massage or polishing the resident's nails. She verified there was no evidence of the amount of time or specific activity spend with the resident to ensure it coincided with her interests or any type of evaluation of how the resident reacted to the activity. She was marked for sensory stimulation fifteen times in May 2019, but had not been marked for that prior to that time. AD #436 verified the record did not contain evidence of an assessment that would indicate the resident's specific interests, plan for activities, or her reaction to the activity program.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22438 Based on observation, interview and record review, the facility failed to ensure Resident #27 received anti-seizure medications as ordered, resulting in a seizure and hospitalization . This affected one of 35 residents reviewed for care. The facility census was 103. Findings include: Review of the record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including hemiplegia, dysphagia, chronic kidney disease and convulsions. Review of his quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact, required the assistance of staff for activities of daily living and did not have behaviors. Review of the record revealed the resident was ordered Vimpat, a medication that prevents seizures, on 03/22/19, to be given every 12 hours at a dose of 300 milligrams. Review of the resident's care plan dated 03/22/19 and updated through 06/14/19 for seizures revealed he was at risk for injury due to seizure activity. The interventions included medications would be administered as ordered. His care plan dated 12/07/18 and updated through 07/17/19 revealed the resident could be non-complaint with medications and treatments. Interventions included education of the resident, providing choices and notification of the physician or nurse practitioner if the resident refused medications. None of the interventions for the care plans were dated after 03/22/19. Review of a nursing note dated 05/24/19 at 5:06 P.M. revealed the nurse was called to the resident's room around 4:35 P.M. and found him having a 'full seizure. He was placed on his left side and during the episode was noted to have bitten his tongue. He was transferred to the hospital and returned to the facility on [DATE]. The admission note indicated there were no new orders and the hospital discharge paperwork indicated he had been in the hospital for sustained seizure activity for about seven minutes. He was restarted on his anti-seizure medication after nursing at the nursing facility reported that he had skipped some of the doses of medication. Review of a physician note dated 05/28/19 revealed the resident had been hospitalized for seizures due to non-compliance. Review of the medication administration record for May 2019 revealed the resident's Vimpat was circled, indicating the medication was not given for some reason, thirteen times for the morning dose between 05/01/19 through 05/24/19. There were four blanks, with no indication in the record of whether the medication had been given. In total, the resident received only 28 doses of the medication before 05/24/19 out of 48 ordered doses. The resident received a dose of medication on 05/23/19, the dose for the evening dose was blank and the morning dose for 05/24/19 was circled. The resident had only received the ordered two doses of the medication five times in May 2019, on 05/01/19, 05/04/19, 05/13/19, 05/15/19, and 05/18/19. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress notes revealed on 05/06/19 at 7:13 P.M., a message was left with the doctor's office regarding the resident refusing his medications, but there was no evidence of a return call or new orders. Another nursing note on 05/11/19 at 9:59 A.M., indicted a fax was sent to the doctor regarding the resident refusing medications, but there was no further indication of the physician's response. The resident was observed throughout the annual survey multiple times. He was non-verbal and would not open his eyes to speak with the surveyor. An interview with Licensed Practical Nurse (LPN) # 406 on 06/12/19 at 2:00 P.M. confirmed the resident did not usually speak with people he did not know but was verbal with staff most of the time. She verified he did refuse medications at times. An interview with Corporate Nurse, Registered Nurse (RN) #502 on 06/18/19 at 1:30 P.M. confirmed the resident had not received ordered doses of the anti-seizure medication and had a witnessed seizure on 05/24/19 after missing two doses of the medication. She verified the record revealed two times the physician was contacted regarding the resident's refusals, but no evidence of response by the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22438 Based on observation, interview and record review, the facility failed to ensure pressure ulcer dressing changes were completed as ordered for Resident #6. This affected one of two residents observed for dressing changes, with a facility census of 103. Findings include: Review of the record of Resident #6 revealed he was admitted to the facility on [DATE] with diagnoses including quadriplegia, neurogenic bladder and pressure areas to his sacrum and back. Review of his care plan dated 03/22/17 and updated through 06/20/19, revealed he was at times not compliant with treatments, refusing his dressing changes and other care. Interventions included to encourage him to have care completed and if he refused, staff should reapproach at another time. Review of the record revealed he had four pressure areas at the time of the annual survey, which started on 06/10/19. The wounds were on his right ischium, sacrum, right lower back and right upper back. An assessment of the areas on 06/06/19 by wound service revealed the right upper back wound was a stage 3 (full-thickness skin loss without bone exposed or palpable) wound measuring 4.5 centimeters (cm) by 3.0 cm by 0.1 cm, the right lower back was also stage 3 measuring 6.0 cm by 2.5 cm by 0.1 cm, the right ischium was a stage 4 (full-thickness skin loss with exposed or palpable bone) wound measuring 4.2 cm by 2.0 cm by 0.1 cm, and the sacral wound was a stage 4 wound which measured 10.0 cm by 12.0 cm by 0.2 cm. All four areas had the same treatment to be completed daily, with orders dated 05/01/19 to cleanse the areas with normal saline, apply silver alginate (antimicrobial absorbing agent) and cover with a foam dressing every day. On 05/23/19, the order was changed to cleanse with normal saline, pat dry, apply calcium alginate (absorbing agent) and cover with a foam dressing. Review of the treatment grids for May 2019 revealed the resident's treatments were completed as ordered through 05/15/19, but from 05/16/19 through 05/23/19, five of eight treatments were not marked as completed. After the treatment order was changed on 05/23/19, the treatment record indicated the resident refused the treatment twice, but two other treatments were not marked as completed, with the treatment not indicated as changed from 05/24/19 through 05/29/19 due to the refusals or missed treatments. Nursing progress notes for only two of the missed treatments, 05/20/19 and 05/27/19, indicated the resident refused, however, this was not marked on the treatment record. Review of the June 2019 treatment grids revealed from 06/01/19 through 06/10/19, the treatments were only marked as completed four of the ten days, with blanks for all the other treatments. Additionally, in June 2019, an order dated 02/18/19 for a treatment for the sacral wound, which indicated Santyl, a debriding agent, should be applied, was also marked as completed for the four days, although this order would have been replaced by the order on 05/01/19. An interview with the Corporate Nurse, Registered Nurse (RN) # 402, on 06/12/19 at 4:30 P.M. confirmed the treatments had not been completed as ordered and the treatments were not accurate on the treatment record.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07380 Based on observation, resident and staff interview, medical record review and review of the facility suicide policy, the facility failed to consistently implement comprehensive and individualized interventions and provide adequate supervision for one resident (Resident #41) with known suicidal ideation, to prevent self-harm. This resulted in Immediate Jeopardy on 06/12/19 when Resident #41, who had a history of suicide attempts, intentionally put oxygen tubing around her neck in an effort to injure herself and later placed the call bell cord around her neck and posed the likelihood of serious, life-threatening harm. In addition the facility failed to implement fall interventions for one resident (Resident #42) who was assessed at high risk for falls and sustained multiple falls. This affected two of six residents reviewed for accidents, hazards and supervision. The facility census was 103. The Administrator and Regional Administrator were notified on 06/13/19 at 2:21 P.M. that Immediate Jeopardy began on 06/12/19 at 7:00 A.M. when staff members did not implement every fifteen-minute checks of Resident #41 as previously ordered. The Immediate Jeopardy was removed on 06/14/19, when the facility implemented the following corrective action. On 06/13/19 at 8:15 A.M. Resident #41 was placed on one-to-one monitoring to ensure she was safe and unable to attempt actions that could result in harm. She was seen by psychiatric service and was started on a new anti-psychotic medication, Zyprexa 5 milligrams (mg) twice daily. The order for the one-to- one monitoring was written as an order to be in place until discontinued by a physician. The care plan was updated to indicate the one-to-one supervision starting 06/13/19. The policy on Suicide Threats was updated on 06/13/19 by 7:30 P.M. and renamed Suicidal ideation and self-harm attempts. The policy was revised to ensure the facility administrator would be responsible for notification of the regional team of any threats of suicide made by a resident, and a staff member was to remain with the resident until otherwise directed by the administrator or director of nursing (DON). The resident room would be assessed for safety and monitored for risk. The supervisor or DON would assess the resident in more detail and notify the physician for further direction. The facility would proceed as indicated with a psychiatric consultation or transfer for emergency psychiatric evaluation. The record would contain documentation of assessments, interventions, one-to-one monitoring and notes and responses of notification until the physician deemed the resident was no longer in danger of harming self or others. The record would also contain supporting documentation of any interdisciplinary team discussion and care plan updates. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/13/19 at 8:00 P.M. Licensed Social Workers (LSW) #403 and #416 began assessing all residents for thoughts of self-harm or self-harm behaviors. Residents who were able were interviewed, and residents who were not interviewable were reviewed by the interdisciplinary team for behaviors and discussed by the interdisciplinary team to determine if they were at risk. All 68 residents were assessed by 10:45 P.M. No additional residents were assessed as having thoughts of self-harm or suicidal ideation. Seven residents were assessed as feeling sad, and care plans were reviewed and updated as needed to ensure appropriate interventions for behaviors were in place. The new supervision policy for residents with suicidal ideation or self-harm attempts indicated residents who expressed suicidal ideation, threats of suicide or threats of self-harm would be provided with one-to-one supervision until the physician determined the resident was no longer at risk to self. On 06/13/19 starting at 8:00 P.M., the Director of Regional Operations (DRO) in-serviced the Administrator and all managers on the warning signs of suicide and interventions to take if a resident was threatening suicide or self-harm. The Administrator, DRO, Assistant Director of Nursing (ADON) / Licensed Practical Nurse (LPN) #408, and Assessment Nurse (LPN #452) in-serviced all nurses starting on 06/13/19 at 8:30 P. M. and continuing until 06/14/19 at 12:00 P.M. This included two registered nurses (RN), and 26 LPNs. The [NAME] President of Operations, ADON, Medical Records Supervisor (MR)/ State tested Nurse Aide (STNA) #445 and Scheduler/ STNA #453 in-serviced 31 STNAs starting on 06/13/19 at 8:30 P.M. All managers for housekeeping and laundry, dietary and therapy in-serviced their staff members starting on 06/13/19 at 8:00 P. M. Clinical staff members were educated on the new and revised policies, recognizing suicidal and self-harm behaviors and interventions for staff to implement if the behaviors were witnessed by staff, to include prompt reporting of the behaviors to the charge nurse. Non-clinical staff were educated on warning signs of suicide and actions to take, to include notification of the charge nurse of any witnessed behaviors or statements. As of 06/14/19 at 12:00 P.M., all facility staff had been in-serviced, either in person or by phone. Beginning on 06/14/19 RNs and LPNs were in-serviced by the Administrator, LSWs #403 and #416 and LPN #452 regarding shift to shift report and communication to staff. This was completed by 06/14/19 at 12:00 P.M. On 06/14/19 from 3:15 PM to 3:46 P.M. interviews were conducted of 16 staff members including LPN #405, #444 and #446, STNA #434, #437, #438, #440, #441 and #442, Housekeeper #427, Scheduler #435, Activity Director #436, Physical Therapist #439, Medical Records Director #445 and Maintenance Director #443. All employees verified they had been in-serviced and had knowledge of new suicide policy procedures, warning signs of suicidal ideation, what to do if a resident expressed suicidal ideation, one-to-one procedures and notification procedures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/14/19, audits were instituted to verify all staff understood the policy regarding one-to-one monitoring, self-harm and suicidal ideation. The Administrator called at shift change on 06/15/19 and 06/16/19 to verify current staff had previously received the in-servicing. Residents on one-to-one monitoring would be observed by a manager each shift to verify the monitoring was in place starting on 06/14/19, with coverage in case of a call off, and to ensure documentation of the one-to-one was current. Observations and audits would be conducted three to five times a week by the DON or designee, verifying the one-to-one care was implemented per the policy for 90 days, with findings reviewed once a week for four weeks then monthly. Clinical managers would read 24-hour report and report any behaviors to the Administrator each shift starting 06/14/19. The Administrator, Nurse Manager or Social Services staff member would complete an audit of all residents to ensure they were not having feelings of self-harm or exhibiting behaviors twice a day between 7:00 A.M and 1:00 P.M. and again between 1:00 P.M. and 8:00 P.M. to ensure behaviors were assessed and interventions were put in place as appropriate. This was completed on 06/15/19 and 06/16/19 and would be completed three to five times a week starting 06/17/19 for one month then monthly. Ambassador rounds would be conducted to assess resident concerns three to five times a week by management staff routinely/ongoing. Results of the audits would be reviewed by the monthly Quality Assurance (QA) committee monthly with recommendations for changes to be made as needed. Audit documentation was reviewed as completed through 06/16/19. Although the Immediate Jeopardy was removed on 06/14/19, the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing on-going monitoring of the corrective actions. Findings include: 1. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including morbid obesity, major depression, suicidal ideation and schizoaffective disorder. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #41 required extensive assistance of two staff to total dependence on staff with all activities of daily living. Resident #41 was cognitively intact but felt down and tired frequently with trouble concentrating. The assessment indicated the resident had seven to eleven days of the 14-day assessment reference period of feeling she would be better off dead or of hurting herself in some way. Review of the care plan for depressive behaviors dated 12/04/18 and revised on 03/31/19 indicated the resident exhibited depressive behaviors evidenced by episodes of suicidal ideation and would place objects (pants, socks, bra strap and oxygen tubing) around her neck and state she was attempting self-harm. Interventions were to administer medications as ordered, including as needed medications and monitor for side effects, attempt non-pharmacological interventions such as one-to-one supervision, change in position or scenery, offer food and fluids, redirect with activity of choice, toileting and diversional activities. The resident was to be encouraged to verbalize feeling and fears and have a psychological consult as needed. All interventions were dated 12/04/18 with no evidence of any new interventions added to the plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a care plan for the risk of self-directed violence dated 12/17/18 and revised on 03/31/19 indicated the resident was at risk for self-directed violence related to suicidal ideation and would state that a male voice would tell her to kill herself, which would cause her to become upset. The care plan indicated Resident #41 had attempted to keep the knife from her food tray. The resident would request to go to the emergency room when she was upset and would attempt to wrap oxygen tubing, pants, socks, and bra straps around her neck. The plan also indicated she would say she wants to kill herself to gain the one-to-one attention from staff. Interventions included to administer medications as ordered, interview resident to evaluate potential for self-directed violence, asking if the resident had a present plan. Document all assessments, interactions and interventions, remove any sharp items, belts and plastic bags from the resident room, and contact the Administrator, DON and Social Services of the resident's intent. All interventions were dated 12/17/18 with no evidence any interventions were added to the plan. Review of a nursing note dated 12/13/18 at 7:21 P.M. revealed Resident #41 was found holding a knife from her tray in her hand, stating a male voice was telling her to hurt herself. In addition, Resident #41 placed calls to the suicide hot line. Resident #41 was then was put on fifteen-minute checks. Review of a note by Consulting Psychologist #501 dated 12/14/18 revealed the resident had suicidal ideation and intent and was encouraged in the use of texting crisis services. Review of a nurse's note dated 12/15/18 at 2:36 P.M. indicted after several more statements regarding the voices, Resident #41 agreed to be sent to the hospital. The resident was sent to the hospital on 12/15/18 at 8:30 P.M. and returned on 12/16/18 at 1:45 A.M. The medical record did not indicate an assessment of her thoughts regarding hurting herself or any new orders concerning her thoughts of self-harm. Review of a physician note dated 12/17/18 indicated Resident #41 stated she was having suicidal ideation and had a plan. The note indicated the resident was placed on fifteen-minute checks, placed near the nurse's station and instructed to call the suicide hot line. Review of a nursing note dated 01/29/19 at 10:45 P.M. revealed the resident was having suicidal thoughts after hearing of a friend's death. Resident #41 was placed on fifteen-minute checks. A nursing note dated 01/29/19 at 11:06 P.M. revealed after one of the checks, the nurse was notified the resident had torn open a soda can and tried to slit her wrists with the sharp edge. Resident #41 had an abrasion measuring 1.5 centimeters (cm) by 0.1 cm and was sent out to hospital on 01/30/19 at 12:41 A.M. The resident returned on 01/30/19 at 5:00 A.M. and was again put on fifteen-minutes checks. Review of a psychiatric note dated 01/30/19 revealed Resident #41 had been voicing suicidal ideations and had attempted to cut herself and presented as anxious and restless. An application for an emergency psychiatric admission was completed, and a nursing note dated 01/30/19 at 2:41 P.M. revealed Resident #41 was sent to the emergency room for a psychiatric evaluation. A nursing note dated 02/04/19 at 7:42 P.M. revealed the resident returned to the facility on [DATE] at 5:15 P.M. The note indicated Resident #41 had a diagnosis of suicidal ideation with no current thoughts of self-harm. There was no evidence in the medical record of new interventions put in place to prevent suicidal behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a social work note dated 02/05/19 at 1:00 P.M. revealed Resident #41 was feeling much better, denied thoughts of self-harm and was encouraged to contact nursing or social services if feelings of sadness or self-harm arose. Review of psychiatric notes dated 02/22/19, 02/27/19 and 03/20/19 indicated the resident had fleeting thoughts of suicide without intent, plan or means and the psychologist worked with her on coping and safety strategies. Review of a nurse's note dated 04/15/19 at 6:29 P.M. revealed the resident continued to say she did not feel needed. The note also indicated an agency nurse walked in the resident's room and found cord wrapped loosely around neck. The note indicated the resident was placed on fifteen-minute checks. The record did not indicate when these checks were discontinued, although there was no further mention of the checks after that documentation. Review of a psychologist note dated 04/16/19 revealed Resident #41 had suicidal and homicidal ideations and coping mechanism were discussed. The note indicated the resident did not have the means to implement the homicidal plan and would not identify potential victims. The note also indicated fifteen-minute checks were to continue and a behavior management plan was discussed with the nurse. Review of a psychologist progress note dated 04/22/19 revealed the resident's wheelchair had been broken and she was hoping it would be fixed soon so she could be out of bed more and spend less time thinking of things that made her depressed and suicidal. Another psychiatric note dated 04/25/19 revealed she was again having fleeting thoughts of suicide and auditory hallucinations. The progress note indicated the nurse will monitor. Review of a nurse's note dated 04/26/19 at 7:06 P.M. indicated Resident #41 verbalized suicidal ideation and was put on fifteen-minute checks. Although the next note on 04/27/19 at 3:19 A.M. indicated the checks were in place, there was no further mention of the fifteen-minute checks or when the fifteen-minute checks were discontinued. Review of a nurse's note dated 04/30/19 at 8:21 P.M. (late entry) revealed the resident said she took an overdose of medication. The nurse practitioner was contacted with an order given for fifteen-minute checks and for two nurses to be in the room when giving medication. Resident #41 called Emergency Medical Services (EMS) on her personal phone and was sent to the emergency roiagnom on [DATE] at 8:25 P.M. The resident returned on 05/01/19 at 3:30 P.M. with an order to stay on fifteen-minute checks for twelve hours. A physician order dated 05/01/19 also indicated the nurses may crush meds until further notice, for the safety of resident. Review of the psychiatric service note dated 05/02/19 revealed Resident#41 was melancholy with a sad facial expression and low energy. The note indicated the resident was distressed by fleeting suicidal ideation with no intent, plan or means, and the psychologist indicated they worked on coping and safety strategies. The resident also complained of visual hallucinations and was provided with reassurance. The psychiatric note indicated Resident #41 was demonstrating some progress, so sessions would continue in a week. Resident #41 was sent to the hospital on 05/04/19 for exacerbation of chronic obstructive pulmonary disease and respiratory failure and returned on 05/28/19. Resident #41 was short of breath on 05/31/19 and again sent to the hospital, returning on 06/09/19. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the LSW note dated 06/10/19 at 7:04 P.M. revealed LSW #403 was informed the resident was suicidal. After speaking with the resident, who told her she was hearing a male voice commanding her to hurt herself, and Resident #41 planned to carry out this plan with her oxygen tubing, LSW #403 told the Unit Manager, RN #404, about the plan. Review of a note by Unit Manager, RN #404, dated 06/10/19 at 7:27 P.M., revealed Resident #41 would be placed on fifteen-minute checks and the oncoming nurse would follow-up with psychiatric services as needed for additional orders if necessary. Review of a nurse's note by LPN #415 dated 06/10/19 at 10:04 P.M. indicated Resident #41 talked about wanting to hurt herself but after talking, the resident felt better and slept. Review of Resident #41's fifteen-minute check observation sheet revealed initials in place from 7:00 P.M. through 11:45 P.M. on 06/10/19, all day on 06/11/19 and through 7:00 A.M. on 06/12/19. There was no evidence the checks continued after that. Review of Certified Nurse Practitioner (CNP) #500's note dated 06/11/19 revealed the resident did admit to voices telling her to hurt herself. The note indicated Resident #41 was on every fifteen-minute checks. On 06/12/19 at 11:50 A.M. During an interview with Resident #41 the resident stated staff had not answered her call light earlier in the morning. The resident stated she put the light on at 7:15 A.M. to let staff know she had been incontinent, and no one came until 8:00 A.M. Resident #41 said she did not think the call light worked and put it on again at 11:55 A.M. to check the function of the call light and to ask for more water. The call light was observed lit above the door signaling the call light was functioning. While waiting for someone to answer the call light, the resident told the surveyor she sometimes heard the voice of a male that told her to hurt herself. The resident said she did not want to do so but was afraid because she sometimes was weak. The resident said staff asked her if she wanted to go to the hospital, but she said no because staff at the hospital just made her wait and then would send her back to the facility. She said the staff at the hospital felt she should be on one-to-one, but they don't have enough staff to sit with her all the time. Resident #41 said she was hearing the voice at that time and didn't feel comfortable. The surveyor looked for staff in the hall, but none were observed initially, so the surveyor waited with the resident in the room, since the call light had been activated. While waiting for staff to respond to the call light, the resident used her phone to call her phone company. She was overheard talking loudly and was angry that her phone was not working correctly. LPN #405 came into the room at 12:20 P.M. and asked what Resident #41 needed. The resident was still on phone but told the nurse that she needed more water and she needed to be changed. The nurse turned off the call light and left room to get water. An interview with LPN #405 and LPN #406 when she returned with the water on 06/12/19 at 12:25 P.M. revealed the nurses were not aware of any special precautions regarding the care of Resident #41. STNA #411 approached and was also asked if she was aware of any special precautions regarding Resident #41. She indicated she was not assigned to the resident but was also was not aware of any special precautions for the resident. All three employees denied they had any knowledge of orders to check the resident every fifteen minutes. LPN #405 and #406 were made aware Resident #41 had stated she was hearing a male voice and had said she did not feel safe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #41 was heard ending her phone conversation, so the surveyor entered the room with LPN #406 at approximately 12:30 P.M. The resident had completely removed her oxygen tubing and had loosely tied the tubing around her neck. The circled end of the tubing with the nasal cannula prongs and the tightening connector (slide [NAME]) was lying to the left side of her chest, with the actual hose tubing for the oxygen around the back her neck and looped over itself. LPN #405 untied the tubing, put the oxygen back on the resident and as she did so, the resident put her arms out to hug the nurse. The nurse hugged her back and the resident appeared tearful. STNA #412 was interviewed on 06/12/19 at 12:35 P.M. and revealed she had not been assigned to the resident lately, although she did care for her at times. She was unaware of any special precautions. STNA #410 was assigned to care for Resident #41 and was interviewed on 06/12/19 at 12:40 P.M. She said she was giving another resident a shower at the time of the resident putting the oxygen tubing around her neck. STNA #410 stated she was unaware of the need to do fifteen-minute checks on Resident #41. STNA #410 said she had not received a form to record the fifteen-minute checks at the start of her shift. STNA #410 verified she had checked Resident #41 on 06/12/19 but had not completed fifteen-minute checks. An interview with RN #404 on 06/12/19 at 12:45 P.M. revealed she had gone in the resident's room around 8:00 A.M. On 06/12/19. RN #404 said the resident asked about being cleaned up for the day, and she stated she would be able to help with that after the breakfast trays were passed. RN #404 stated she went back in the room around 9:30 A.M. to check on the resident. She stated the resident was emotional at times. RN #404 said she knew the resident should be on fifteen-minute checks but had not checked for a form to make sure the checks were done. Resident #41 was observed in her room with a staff member sitting in her room on all observations on 06/12/19 after 12:45 P.M. until she was observed leaving the facility for the hospital at 3:53 P.M. with seven ambulance attendants assisting. Review of the medical record did not contain documentation of the incident when Resident #41 was found in her room at 12:30 P.M. on 06/12/19 with the oxygen tubing around her neck or that physician notification was made. review of the nurse's notes on 06/12/19 at 4:00 P.M. by LPN #405 indicated the resident's power of attorney was notified of the resident's transfer to the hospital. A note timed 4:04 P.M. indicated Resident #41 was sent to the hospital per physician order due to current behavior. An interview with the Administrator and Regional Nurse, RN # 402, on 06/12/19 at 4:50 P.M. verified on 06/12/19 at 11:50 A.M. Resident #41 was not on every fifteen-minute checks as ordered, and her call light was not responded to promptly when the surveyor observed the call light activated from 11:55 A.M. until 12:20 P.M. The Administrator and Regional Nurse, RN # 402, also verified the observation of the resident with oxygen tubing around her neck at 12:30 P.M. on 06/12/19. Review of a nurse's note dated 06/12/19 at 10:40 P.M. revealed Resident #41 returned to the facility with no new orders. The note indicated the resident was alert and oriented but did not contain any information regarding if the resident had thoughts of hurting herself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nurse's note dated 06/13/19 at 12:07 A.M. indicted LPN #400, went into the resident's room to answer the call light. The resident had pulled the call light cord from the wall and wrapped it around her neck. When asked why, the resident stated she did not know. When LPN #400 asked what she could do to help the resident, the resident asked for some snacks. Snacks were given, and the resident was placed on fifteen-minute checks. The note also indicated the Administrator, Assistant Director of Nursing/ LPN #408 and CNP #500 were made aware. Interview with LPN #400 on 06/13/19 at 8:30 A.M. by phone revealed she went in the room with Resident#41 when she returned from the hospital around 10:40 P.M. LPN #400 stated the resident did not mention any thoughts of self-harm and the LPN did not ask her if she had any. LPN #400 stated she stayed in the room briefly, returned with snacks, then said she thought the nursing assistant may have gone in the room. LPN #400 said she went in the room at about 11:30 P.M. when the call light was ringing and saw the call light cord around the resident's neck. LPN #400 stated she started the resident on every fifteen-minute checks and called the Administrator, Assistant Director of Nursing/ LPN #408 and CNP #500, and left them text messages. She stated Assistant Director of Nursing/ LPN #408 called her back after just a couple of minutes and told her to make sure she had charted, and to keep the resident on the fifteen-minute checks. She said the Administrator and CNP #500 did not call back. An observation and interview with Resident #41 on 06/13/19 at 8:13 A.M. revealed the resident was in her in bed. There was no staff in her room with her at the time the surveyor entered her room. The resident told the surveyor, I knew it was a waste of time to go to the hospital. I came back and tried to hurt myself again. The resident said the Administrator had been in her room and had moved her fan, so she could be seen from the doorway, and she stated she was happy that she might get a shower on that day. An interview with the Administrator on 06/13/19 at 8:15 A.M. revealed she did not see the phone call or text until early on 06/13/19 and called the facility regarding the incident with Resident #41. She then came into the facility to further review the incident. An interview with Assistant Director of Nursing/ LPN #408 on 06/13/19 at 9:45 A.M. revealed she got the text and saw the phone call at 4:00 AM. on 06/13/19 but did not call the facility or talk with LPN #400. An interview with Regional Nurse/ RN # 402 at 06/13/19 at 10:00 A.M. verified the resident was sent to the hospital on 06/12/19 at approximately 4:00 P.M. but returned at approximately 10:40 P.M. RN #402 verified there was no evidence of an assessment of Resident #41's emotional status or potential for inflecting harm to herself. RN #402 verified Resident #41 was found at 11:30 P.M. with a call light cord wrapped around her neck. RN #402 indicated Resident #41 was put on every fifteen-minute checks through the night, until 06/13/19 at 9:00 A.M. when she was placed on one-to-one monitoring. An interview with CNP #500 on 06/14/19 at 11:00 A.M. revealed he had worked with the resident since her admission. CNP #500 stated he usually managed her medical concerns but knew of her suicidal ideation. He stated he saw the resident on 06/11/19 and knew she was on fifteen-minute checks but stated he did not know that she had an actual plan to hurt herself by using her oxygen tubing. He stated he had not been involved in discussion of interventions regarding her psychiatric care, stating he knew she followed with psychiatric services. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Consulting Psychologist #501 on 06/17/19 at 12:20 P.M. revealed she saw the resident several times a month. She stated the resident had self-injurious behaviors. She indicated she would assist the resident with coping mechanisms such as relaxation techniques, challenging her cognitive distortions and reality testing. Consulting Psychologist #501 stated Resident #41 was also encouraged at times to use the suicide hot line, as she was familiar with staff there and could talk with them at any hour using her phone, which gave her some control. Consulting Psychologist #501 stated she would be willing to be involved in team meetings to discuss interventions that would be helpful to try to prevent some of the harmful behaviors exhibited by Resident #41. 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, dementia without behavioral disturbance and hallux foot acquired. Review of the physician orders lack any fall interventions. Review of the quarterly comprehensive assessment (MDS 3.0) dated 04/05/19 revealed he was severely cognitively impaired, had continuous inattention, displayed physical behaviors and rejection of care on one to three days of the seven-day assessment reference period. He required the extensive assistance of one person for dressing and personal hygiene and extensive assistance of two staff for transfers and toileting. He required the total assistance of one staff for bathing and was always incontinent of bowel and bladder. He sustained two falls with no major injury. Review of the fall risk evaluations indicated he had been a high risk for falls since 02/03/18. Evaluations for actual falls occurred on 03/26/18, 06/25/18, 08/26/18, 02/17/19, 03/14/19 and 03/16/19. Review of the fall plan of care revised 03/15/19 indicated the interventions were to assist with transfers and ambulation as needed. On 08/26/18, a non-skid pad was applied to the top of the wheelchair cushion; 04/18/18 to have appropriate non-skid footwear on at all times; 04/02/18 educate staff to turn on the call light and call for help without leaving the resident unattended; 03/26/18 to have non-skid pad to chair while seated in the dining room; 04/18/18 low bed with grab bars; and 02/17/19 to have low bed to help prevent falls. The resident had three falls since February 2019 and failed to implement new and effective interventions. Review of the nurses note, incident report and post fall evaluation indicated on 02/17/19 at 3:37 A.M. Resident #42 was found on the floor on his left side after trying to toilet himself. No new interventions were implemented. Review of the nurses note, incident report and post fall evaluation indicated on 03/14/19 at 5:52 A.M. State tested Nurse Aide (STNA) #433 called Licensed Practical Nurse (LPN) #420 to Resident #42's room. LPN #420 documented that she observed Resident #42 lying on the floor, face down, positioned partially on his left side, on top of the half side rail and the bed was standing up on its left side. The nurse noted he had no apparent injury. The nurse noted Resident #42 was tense and resistive. Neurological evaluations were initiated. No new interventions were implemented. Review of the nurses note, incident report and post fall evaluation dated 03/16/19 at 6:58 A.M. indicated two staff were at the nurse's station along with the resident. Resident #42 attempted to get out of the chair and sat back down on command from the staff. The resident then stood up and fell to the floor hitting his head on the right side of his face. The resident sustained a 2.0 centimeter (cm) by 0.3 cm laceration to the right eyebrow, swelling and a minimal amount of blood. The resident was assisted back to his chair. The resident was sent to the hospital for an evaluation. No new fall interventions were implemented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #42 was observed on 06/12/19 at 08:45 A.M. in bed eating breakfast. The bed was in the high position, and no staff were present. On 06/13/19 at 08:25 A.M., he was in the dining room sitting in a standard chair. After breakfast at 9:00 A.M. two staff were observed transferring him from the standard chair to his wheelchair. There was no non-skid mat on the standard chair. Resident #42 was obse [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on observation, interview, resident council minutes and policy review, the facility failed to provide sufficient staff on the secured unit to provide care and manage behaviors. This affected all 33 Residents (#1, #2, #5, #8, #10, #11, #12, #17, #25, #29, #30, #31, #32, #34, #38, #39, #42, #45, #46, #47, #50, #56, #60, #61, #65, #66, #72, #73, #82, #88, #89, #92 and #253) who resided on the secured unit and 9 Residents (#40, #100, #49, #24, #21, #63, #14, and #54) who did not reside on the secured unit. The facility census was 103. Findings include: The following observation occurred on the secured unit on 06/10/19 beginning at 4:21 P.M.: Resident #31 was observed in the dining room in the same spot as she had eaten her lunch. She was wearing a clothing protector, shirt and pants heavily soiled with food and red liquid, the same as she wore during the lunch meal. Periodically she would stand and pull the front of her pants down, put her hands inside her incontinence brief and then sit back down. No staff were in the dining room. There were 17 other residents in the dining room. Resident #31 continued the behavior off and on. On 06/10/19 at 5:00 P.M., Licensed Practical Nurse (LPN) #420 verified her condition and took her out of the dining room to have care provided. The following observation occurred on the secured unit on 06/11/19 beginning at 3:15 P.M.: Resident #5 was seated in his wheelchair yelling with his head resting on a dining room table. He occasionally looked up banged on the table with enough force that the table moved. He continued this behavior while other residents were participating in a bowling activity. At 3:20 P.M. Activity Assistant #421 who had been asking him to stop, approached him, moved his wheelchair to another table and locked the breaks on the wheelchair. Resident #5's behaviors continued including frustration with his wheelchair being locked. He was able to unlock his wheelchair, swear, yell and ram his wheelchair into chairs and tables. At 3:20 P.M., Activity Assistant #421 tried to bring him out of the dining room and he resisted. He kept locking his wheelchair saying he did not want to go. Other residents began to yell at him to get out. A State tested Nurse Aide (STNA) arrived and bribed him with a pop. He agreed to leave the dining room. The following observations occurred on the secured unit on 06/12/19 beginning at 8:00 A.M.: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:11 A.M., the food cart arrived in the dining room. There were no staff in the dining room to begin passing the meal trays. Resident #5 was yelling and violently ramming his wheelchairs into wheelchairs and standard chairs. Other residents yelled at him to stop, but the behavior continued. Resident #66 left the dining room to get the nurse. The nurse calmed him and left the dining room. Resident #5 began to swear and yell. There were 21 residents in the dining room. At 8:15 A.M., Resident #5 repeatedly rammed his wheelchair into Resident #60's chair. Resident #60 stood up and was unsteady. Other residents continued to yell at Resident #5 to stop or shut up. Resident #66 then moved Resident #5 out of the way as he resisted she assisted Resident #60 to her table. At 8:16 A.M., Resident #73 reached into the food cart and moved things around, pulled an item out and then put it back. She reached in again but did not remove any items. No staff were in the dining room. Resident #5's behaviors continued causing the other residents to react by yelling at him. On 06/12/19 at 8:21 A.M., staff arrived to the dining room to begin passing meal trays. At 8:43 A.M., Resident #73 was observed assisting Resident #31 during breakfast. She wiped her face several times and would move her beverages closer to her. At the end of the meal Resident #73 wiped her face, removed her clothing protector and wiped up the table. On 06/12/19 at 10:53 A.M., Resident's #38 and #12 got into a verbal argument. Other residents yelled at them to stop. At 10:54 A.M., Registered Nurse (RN) #425 entered the dining room and had to ask residents who they were. Resident's #17 and #66 identified some of them for her. She passed medication to one resident and left the room. At 11:01 A.M., RN #425 entered the dining room again. Interview with RN #425 at that time said it was her second day on the unit. She said she was going to have to quit this job because it was not safe. She said not all of the residents can tell you their name, not all have an identification bands and some did not have pictures in the electronic record. She said she had to play Price is Right with them. She would call out their name and say come on down. On 06/12/19 at 11:18 A.M., Resident #17 was heard yelling at Resident #5. No staff responded. The surveyor entered the dining room and observed Account Manager #426 moving Resident #5 out of the way as he yelled and resisted. Interview with Account Manager #426 said Resident #5 rammed into him as he was using the floor machine. There were no other staff in the dining room with 19 residents. Interview with the following residents reported they felt there was not enough staff to meet their needs: On 06/10/19 at 9:57 A.M., Resident #49 said they needed more aides on second shift and weekends. She said she was not always getting her showers. On 06/10/19 at 11:02 A.M., Resident #100 stated he waited a long time to get back in bed on the second shift. He said the second shift was always short staffed including weekends. On 06/10/19 at 11:11 A.M., Resident #40 said he waited a long time for call lights to be answered. He waited 30 minutes or more waiting to get into the bed at night. On 06/10/19 at 4:21 P.M., Resident #48 said they need [NAME] aides second shift. He waited 30 minutes to get in bed. On 06/10/19 at 4:58 P.M., Resident #24 said there was not enough staff in the afternoon to meet her needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/10/19 at 5:02 P.M., Resident #42's daughter said there was not enough staff, and they were keeping people in the dining room. She had concerns with not enough aides and felt training was needed to understand residents with behaviors On 06/10/19 at 5:36 P.M., Resident #21 said there was not enough staff on second shift. On 06/11/19 at 10:12 A.M., Resident #63 felt her light was on sometimes for hours before it was answered. She said the third shift was the worst. On 06/11/19 at 11:11 A.M., Resident #14 said the facility did not have enough staff. She said they used agency staff who just walked the halls and would not answer call lights. She reported staff would sit for two hours at the desk and then give attitude if they had to answer a call light. They were always short staffed. Call lights were not answered for up to an hour, and when the light was answered, she was told not to ring it again. She reported this happened on third shift. On 06/11/19 at 11:32 A.M., Resident #59 said it took up to 30 minutes to get help to go to bathroom. Interviews with the following secured unit staff stated there was not enough staff to provide the care and manage the behaviors on the secured unit: Interview with STNA #418 on 06/10/19 at 9:47 A.M. said when there were only two staff it was hard to provide the care and manage behaviors because many of the residents needed two staff for assistance. STNA #418 indicated some nurses would help but it depended on the nurse. Interview with LPN #429 on 06/10/19 at 10:15 A.M. said it was definitely hard with only two STNA's scheduled to work the unit. She said the second shift often utilized agency staff, and they were not as capable as the regular aides. She said she often pitched in to help. Interview with LPN #420 on 06/11/19 at 9:45 A.M. indicated second shift staffing was a problem indicating they had to use agency aides. Interview with STNA #422 on 06/13/19 at 8:53 A.M. said two aides could not get everything done. She said they had complained but nothing changed. She indicated they often did not take their breaks or their lunches because the residents needed help and supervision. She said many of the residents require two STNA's, one to provide distraction and the other to provide care. She said she was threatened to be written up because she had not gotten all of her documentation completed. She said there was so much documentation that would take away from resident care. She said she had no training in how to deal with behaviors. Interview with LPN #423 on 06/13/19 at 9:04 A.M. hesitated to talk with the surveyor for fear she would get into trouble. She verified there was not enough aides to provide care, provide supervision and manage behaviors on the unit. She said this was not a simple dementia unit but a behavior unit. Interview with STNA #424 on 06/14/19 at 9:51 A.M. stated behaviors and assistance varied from day to day and that was what administration did not understand. She thought she had behavior training in the past but was not sure. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nursing, LPN #408, indicated there were usually three STNA's on the first shift and two on the second and third shifts. She verified there were only two on the first shift on 06/11/19, 06/12/19 and 06/13/19. She said there were three STNA's on 06/10/19 but one went home ill. Interview with the Administrator on 06/13/19 at 10:00 A.M. verified crisis prevention intervention (CPI) had not been provided to the staff. She indicated dementia training including some behavioral training was provided to all staff. Review of the Resident/Family Concern Log since January 2019 revealed staffing concerns were voiced on 02/01/19, 02/06/19, 02/27/19, 02/24/19, 04/24/19, 05/15/19, 05/29/19 and 06/08/19. Concerns related to staff attitude were voiced on 01/24/19, 01/28/19, 02/13/19, 02/19/19 and 04/03/19. The facility did not provide resolutions to the concerns. Review of the Resident Council minutes since 12/18/18 revealed residents voiced concerns related to not enough STNA's on the nights and weekends. On 01/22/19, residents voiced concerns related to not enough staff on one north and south. On 02/27/19, indicated the facility had a new Director of Nursing and Dietary Manager and were in search of a Maintenance Director. On 03/26/19, residents indicated STNA's were not knocking and introducing themselves and were saying they would come back and would forget. On 04/24/19, there were questions and concerns regarding an agency nurse and STNA. Review of the secured unit criteria (undated) indicated the purpose of the unit was to provide specialized care for cognitively impaired residents. The secured unit was available to residents who meet one or more of the following criteria: require specialized activities, an environmental design that allows space for a resident to ambulate ad lib and additional security for a resident at risk for elopement. Review of the prevention and identification section of the abuse, neglect, exploitation and misappropriation of resident property policy dated 2016 indicated to deploy staff in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual resident's care needs. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors, residents with communication disorders and those that require heavy nursing care and/or were totally dependent on staff. Review of the medication administration record for the second floor with the Administrator on 06/17/19 at 9:00 A.M. revealed nine Residents (#1, #5 ,#8, #29, #31, #32, #46, #56 and #99) did not have a picture form of identification. Interview with the Administrator on 06/17/19 at 9:00 A.M. verified the facility used paper medication administration records rather than electronic medication administration records. The Administrator indicated photographs of residents were obtained by the activities department. She said the residents have the right to refuse to be photographed. The Administrator was informed the facility policy indicated the resident/sponsor must authorize to photograph the resident. The Administrator indicated the policy would need to be reviewed and revised. Interview with Activity Director #436 on 06/17/19 at 9:10 A.M. confirmed she took photographs of the residents if they allowed and uploaded their photographs into the electronic record. She said for residents who refused their photograph a generic photograph was uploaded to their electronic record. She confirmed Resident #99 refused her photograph be taken and in place of her photograph was a tie dye design.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on observation, interview, review of the record, facility assessment, secured unit criteria and in-service review, the facility failed to have sufficient and competent staff to provide care and behavioral interventions to manage Resident #5's negative behaviors. This affected one of 33 residents on the secured unit with the potential to affect all 33 Residents (#1, #2, #5, #8, #10, #11, #12, #17, #25, #29, #30, #31, #32, #34, #38, #39, #42, #45, #46, #47, #50, #56, #60, #61, #65, #66, #72, #73, #82, #88, #89, #92 and #253). Findings include: Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities, Parkinsonism, diabetes, anemia, epilepsy, hyperlipidemia, anxiety disorder, insomnia, hypo-osmolality and hyponatremia, dysphagia, mood disorder with manic features and schizophrenia. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] he was severely cognitively impaired. He did not display symptoms of psychosis but displayed physical, verbal, other behavioral symptoms , rejection of care and wandering on one to three days of the seven-day assessment reference period. He required extensive assistance of one person for transfers, dressing, toileting, personal hygiene and total dependence on one for bathing. He had no impairment of the upper and lower extremities. Review of the behavioral plan of care revised 06/10/19 indicated that he does not conform to or understand boundaries of socially accepted behaviors. He was identified as sexually inappropriate and verbally abusive toward staff. He has been verbally aggressive toward staff when asking for staff food and redirection. He noted to lock his brakes while being pushed in his wheelchair. The interventions included avoid male caregivers, discuss and provide options for him to express his/her sexuality appropriately, discuss with the resident in a straight forward but kind manner that his behavior was unacceptable, evaluate if the behavior was sexual behavior or a result of cognitive impairment, may use crisis prevention intervention (CPI) technique as needed, 15-minute checks and refer to psychological services. Review of the State tested Nurse Aide (STNA) task documentation since 05/01/19 related to rejection of care indicated he refused care on 05/28/19 and 06/05/19. He displayed verbal and physical behaviors consistently. Review of the behavioral intervention monitoring documentation for May 2019 indicated he was monitored for exit seeking and agitation. He had no episodes of exit seeking and 16 days with episodes of agitation on the day shift and two episodes of agitation on the night shift. In April 2019, no episodes of exit seeking, three episodes of agitation on the day shift and two episodes of agitation on the night shift were noted. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the geriatric psychological note dated 01/11/19 indicated he had schizophrenia, was polite and engaging and had mumbled speech. The note indicated due to his cognitive deficits, he struggled with intense emotions like anger. The note indicated they worked on behavior management, provided empathy, unconditional positive regard and patience. The plan was to continue sessions. Review of the geriatric psychological note dated 03/29/19 indicated he was exhibiting increased behaviors and agitated. He struggled with intense emotions like anger. The note indicated they worked on behavior management and modeled appropriate assertive communication behaviors. Review of the geriatric psychological note dated 06/10/19 indicated his moods and behaviors were much improved. He was less agitated and anxious. The plan was to increase his antidepressant medication to maintain proper stabilization over anxiety and general moods. There was no documented evidence behavior management strategies were shared with the staff to provide consistent and effective supervision to manage his behaviors and create a more peaceful environment for all residents on the secured unit. Resident #5 was observed on 06/10/19 at 12:49 P.M. wheeling around the dining room without purpose and running into tables with his head down. The dining room had 19 other residents present waiting for the lunch meal. He was yelling out consistently and other residents were yelling back at him to shut up. No staff were present. The other residents were frustrated and continued to yell at him. He rammed tables so hard they moved, and when he ran into other residents chairs they verbally lashed out at him and some tried pushing him away. When Resident #5 would get stuck against a table or chair he became more agitated and aggressive and used physical force against tables and/or chairs with residents present. On 06/11/19 at 03:15 P.M., Resident #5 was sitting in his wheelchair resting his head on a dining room table. There were multiple residents in the dining room participating in an activity. He occasionally looked up, banged on the table with such force it was moved. His behavior continued to escalate. Other residents reacted by either yelling at him to stop or to shut up. On 06/11/19 at 3:20 P.M., Activity Assistant #421 moved him to another table and locked his wheelchair brakes. This increased his agitation, and he began to rock the wheelchair wildly to move before he released the brakes and continued his behaviors. At 3:25 P.M., his behaviors were so interruptive Activity Assistant #421 tried to wheel him out of the dining room. He screamed and resisted. A STNA arrived and bribed him with a pop, and he then left the dining room. On 06/12/19 at 8:11 A.M., Resident #5 was screaming and ramming into wheelchairs and standard chairs violently. Other residents yelled at him to stop and to shut up. This did not deter him. There were 21 residents in the dining room and no staff. Resident #66 could not redirect him so she left to get the nurse. The nurse arrived and asked him what he wanted. He said he wanted his medication. She told him it was not his time for his medication. He calmed for a bit and then began to escalate. He was swearing and yelling. At 8:15 A.M., he was observed to violently ram into chairs. He worked his way over to Resident #60's chair and ran into it over and over. Other residents were yelling at him to stop. Again, no staff were in the room. He rammed her so hard she stood up. She was observed to be unsteady. Resident #66 went and moved Resident #5's wheelchair out of the way and physically escorted Resident #60 to her table. Resident #5 continued wheeling into others and screaming until he got his breakfast meal at 8:32 A.M. At 8:43 A.M. he was yelling that he was stuck. Other residents yelled at him to shut up or stop. No staff were in the dining room. On 06/12/19 at 11:18 A.M., he was heard screaming in the dining room from the nurses station, and other residents were yelling at him to stop. No staff responded. The surveyor entered the dining room to observe Account Manager #426 move Resident #5 out of the way. Resident #17 said Resident #5 was ramming into the floor machine which was confirmed by Account Manager #426. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews with STNA #418 and Licensed Practical Nurse (LPN) #419 on 06/10/19 between 9:47 A.M. and 10:15 A.M. indicated two aides on the unit were not enough to provide the care, supervision and behavior management on the secured unit. They said they were provided dementia training but no behavior training. Interview with STNA #422 on 06/13/19 at 8:53 A.M. revealed she had never received behavior training in CPI. Interview with STNA #424 on 06/14/19 at 9:51 A.M. never heard of CPI training and had not received training in the management of behaviors. Interview with the Administrator on 6/13/19 at 10:00 A.M. verified no CPI training was conducted in the facility. She indicated staff competencies were provided annually. On 06/14/19 at 2:50 P.M., the Administrator provided a test the STNA's were expected to take after the secure unit caregiver training competencies. The test was related to general dementia questions, nothing specific to behaviors or behavior interventions. Nursing assistant skills review checklists were completed annually and the licensed nurse skills review checklist included resident protection but no evidence behavioral management strategies were provided. Review of the secured unit criteria (undated) indicated the purpose of the unit was to provide specialized care for cognitively impaired residents. The secured unit was available to residents who meet one or more of the following criteria: require specialized activities, an environmental design that allows space for a resident to ambulate ad lib and additional security for a resident at risk for elopement. Review of the prevention and identification section of the abuse, neglect, exploitation and misappropriation of resident property policy dated 2016, indicated to deploy staff in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual resident's care needs. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors, residents with communication disorders and those that require heavy nursing care and/or were totally dependent on staff. Review of the facility assessment dated [DATE], indicated the average number of residents with behavioral symptoms and cognitive performance was 13 residents. The staffing plan identified the facility required four to five nurses, seven to nine nurse aides. Staffing was an area identified for quality assurance and performance implementation (QAPI) and the action to be taken/already taken this year was to maintain competent staff at a level needed to care for our residents by monthly in-services, recognition awards, evaluations with goal setting. The training and competencies indicated monthly in-services, yearly competency testing for all nurses and nursing assistance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39969 Based on observations, interview, record and policy review, the facility failed to ensure sanitary conditions in the kitchen and in the nursing unit refrigerators. This had the potential to affect all residents. The facility census was 103. Findings include: Tour of the kitchen on 06/10/19 between 8:50 A.M. and 9:17 A.M. with Dietary Manager (DM) #400 revealed a buildup of ice underneath the fan and a small amount of ice on the wall underneath the fan in the walk-in freezer. The walk-in freezer located across from the reach in coolers was noted to be out of order revealed on the top shelf of the rack against the wall to the right, was a large amount of a pink colored, frozen spill and ice buildup. The side of the convection oven next to the stove had various food splatter and grease build-up. There were approximately 20 large cookie sheet pans that were stacked on the bottom shelf of a preparation table against the far-left wall where the clean dishware was stored. The top five large cookie sheet pans were greasy to touch and left a film of grease on surveyor's hands. Interview on 06/10/19 between 8:50 A.M. and 9:17 A.M. with DM #400 verified the above findings. Observation on 06/10/19 between 9:24 A.M. to 9:26 A.M., the south nursing unit refrigerator revealed a large brownish stain on the bottom shelf, and the bottom part of the refrigerator had various reddish splatters. The second-floor refrigerator had various food splatters and sticky spills throughout the inside of the refrigerator and freezer and along the inside and side of refrigerator door. Interview on 06/10/19 between 9:24 A.M. to 9:26 A.M. with DM #400 verified observations. Review of the list of residents and their diets revealed no one had a diet order for nothing by mouth. Review of the policy titled Environment dated May 2014, revealed the food service director will ensure that proper procedures for cleaning all food service equipment and surfaces and all food contact areas are cleaned and sanitized after each use.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 39969 Base on observations, staff interview and policy review, the facility failed to maintain sanitary conditions around the outside dumpsters. This had the potential to affect all residents. The facility census was 103. Finding include: Observation on 06/10/19 at 9:30 A.M. of the two outside dumpsters revealed a moderate amount of debris on the ground in front of and on the side of the dumpsters. Observed were used plastic gloves, food wrappers, and other debris. Both lids of the dumpsters were open. Behind the dumpsters was a clear garbage bag filled with a moderate amount of trash situated between the two dumpsters. At this time an interview with Dietary Manager (DM) #400 verified the observations and stated maintenance was responsible for dumpsters. Review of the facility's policy titled Environment dated May 2014, revealed the food service director will insure that all trash is properly disposed in the external receptacles (dumpsters) and that the area is free from debris.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on review of the facility assessment, census and condition report, resident matrix submitted by the facility and the list of residents identified with behaviors revealed the average number of residents with behavior/cognition was inaccurate. This had the potential to affect all 103 residents. Findings include: Review of the facility assessment dated [DATE] indicated the average number of residents with behavioral symptoms and cognitive performance was 13 residents. The staffing plan identified the facility required four to five nurses and seven to nine nurse aides. Staffing was an area identified for quality assurance and performance improvement (QAPI), and the action to be taken/already taken this year was to maintain competent staff at a level needed to care for the residents by monthly in-services, recognition awards, evaluations with goal setting. The training and competencies indicated monthly in-services, yearly competency testing for all nurses and nursing assistants. Review of the resident matrix dated 06/10/19 identified 59 residents with a diagnoses of Alzheimer's/dementia. Review of the resident list report dated 06/13/19 revealed 46 residents were identified as have behaviors. The facility's second floor had a 37 bed secured unit for residents with dementia and behaviors with 33 residents currently residing. Review of the census and condition report dated 06/10/19 identified 46 resident with psychiatric signs and symptoms, 21 residents with behaviors and 31 residents receiving anti-psychotic medication. Interview with the Administrator on 06/17/19 at 1:10 P.M. verified the facility assessment was inaccurate.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on interview, record and policy review, the facility failed to ensure the medical records were complete, accurate and reflected the residents experiences in the facility. This affected three Residents (#5, #82 and #103) of 35 records reviewed. Findings include: 1. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE] with diagnoses including schizophrenia, symbolic dysfunction, dysphagia, moderate protein-calorie malnutrition, major recurrent depressive disorder, dementia with behavioral disturbance, osteoporosis and adult failure to thrive. Review of the oral assessment dated [DATE] indicated she had no natural teeth or fragments (edentulous). She had full dentures. Her oral status did not affect her ability to eat. She had dentures and wore them as she chose to. Review of the significant change comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated she was edentulous. Review of the 360 care dental note indicated she received service on [DATE] including a periodic exam, prophy, tooth charting and oral cancer screen. The findings included heavy calculus, light plaque, unable to safely hand scale, oral hygiene status poor. Oral hygiene instructions reviewed. Review of the dental plan of care revised [DATE] indicated she had no upper teeth with some natural bottom teeth and missing back teeth. Resident #82 was observed on [DATE] at 2:00 P.M. with bottom front teeth that were thick with white and gray plaque. Interview with Resident #82 on [DATE] at 2:00 P.M. said the staff do not brush her teeth. She said the water was contaminated so she would not allow them to brush her teeth. Interview with Licensed Practical Nurse (LPN) #452 on [DATE] at 12:45 P.M. verified the resident had some bottom teeth. She confirmed the assessment and comprehensive assessment were not accurate. 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities, parkinsonism, diabetes, anemia, epilepsy, hyperlipidemia, anxiety disorder, insomnia, hypoosmolality and hyponatremia, dysphagia, mood disorder with manic features and schizophrenia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed he was severely cognitively impaired. He did not display symptoms of psychosis but displayed physical, verbal, other behavioral symptoms, rejection of care and wandering on one to three days of the seven-day assessment reference period. He required the extensive assistance of one person for transfers, dressing, toileting, personal hygiene and total dependence on one person for bathing. Review of the progress note dated [DATE] at 6:27 A.M. indicated no contact was made with resident involved in recent altercation. There was no other notation in the clinic record regarding the incident. Review of the incident/event summary investigation dated [DATE] at 8:55 P.M. indicated Resident #5 was near the elevator preparing to go out for a smoke break when there was yelling because he was accused of stealing a residents remote. The other resident swung and hit Resident #5 on the side of the head. No injuries were identified. The other resident was sent to the hospital for a psychiatric evaluation. Review of the dietary note dated [DATE] indicated the resident was on a 1300 cubic centimeter (cc) fluid restriction. Review of the State tested Nurse Aide (STNA) task documentation for the last 30 days revealed fluid data was not documented on 10 of the last 30 days (,d+[DATE]-18, ,d+[DATE], 29-,d+[DATE] and ,d+[DATE]-, d+[DATE]) documented once on 16 of the 30 days, twice on three of the last 30 days. Interview with Registered Dietitian #450 on [DATE] at 4:35 P.M. said he had a necessary fluid restriction due to hyponatremia metabolic status, and staff should be monitoring his intake. 3. Review of the medical record revealed Resident #103 was admitted to the facility on [DATE] with diagnoses including acquired absence of the left leg below the knee, diabetes with complications and foot ulcer, unstageable right heel ulcer, peripheral vascular disease, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, major recurrent depressive disorder, ischemic cardiomyopathy, hyperlipidemia, morbid severe obesity, solitary pulmonary nodule, disorders of the kidney and ureter, iron deficiency anemia, gastro-esophageal reflux disease, idiopathic peripheral autonomic neuropathy, cocaine abuse and anemia in chronic kidney disease. He expired on [DATE]. He was [AGE] years old. Review of the progress notes lacked the events that lead to his death. Interview with the Administrator on [DATE] at 1:43 P.M. verified there was no progress notes to reflect Resident #103's death. The Administrator provided one written statement by the nurse on the death of Resident #103. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated documentation guidelines revealed guidelines were provided to provide suggestions related to the documentation of specific medical diagnoses/conditions. The purpose was to have information readily accessible, show the assessments completed and the care and treatment provided and addressed it the plan of care. The section documenting an unusual event or occurrence indicated to be factual. Don't use emotional or dramatic words or descriptions. Document only what was actually known or observed. Do not place blame. The incident or occurrence report is not a place for heresy. Do not attribute reasons or cause and effect. Document what was known or what the resident says. The investigation and witness statements should be documented in the appropriate places per policy. It does not belong in the medical record. Report promptly. Complete a risk report as soon as possible and always by end of shift. Fill in the information accurately and completely.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 07954 Based on review of the payroll based journal (PBJ) and interview, the facility failed to meet the submission requirements. This affected all 103 residents. Findings include: Review of the PBJ final file validation report submitted on 05/17/19 revealed no census information, information on direct care staff turn over or tenure, on the hours of care provided by each category of staff per resident per day, and no agency staff were listed in the report reviewed for January through March 2019. According to the Centers for Medicare and Medicaid Services (CMS) website the first quarter submission was due 05/15/19, and the facility submitted the payroll based journal on 05/17/19. Interview with Corporate Nurse, Registered Nurse #402, on 06/17/19 at 11:55 A.M. said the facility did not submit the use of agency staff. Further interview with the Administrator on 06/17/19 at 12:30 P.M. said the facility began using agency staff in March 2019 and verified no census or turn over/tenure were submitted to CMS.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22438 Based on observation, interview and record review, the facility failed to ensure infection control guidelines were followed during a dressing change for Resident #6 and during medication pass for Resident #73. This affected one of two residents observed for dressing changes and one of five residents observed for medication pass with a facility census of 103. Findings include: 1. Review of the record of Resident #6 revealed he was admitted to the facility on [DATE] with diagnoses including quadriplegia, neurogenic bladder and a pressure areas to his sacrum and back. Review of the record revealed he had four pressure areas at the time of the annual survey, which started on 06/10/19. The wounds were on his right ischium, sacrum, right lower back and right upper back. An assessment of the areas on 06/06/19 by the wound service revealed the right upper back wound was a stage 3 (full thickness skin loss without bone exposed or palpable) wound measuring 4.5 centimeters (cm) by 3.0 cm by 0.1 cm, the right lower back was also stage 3 measuring 6.0 cm by 2.5 cm by 0.1 cm, the right ischium was a stage 4 (full thickness skin loss with exposed or palpable bone) wound measuring 4.2 cm by 2.0 cm by 0.1 cm and the sacral wound was a stage 4 wound which measured 10.0 cm by 12.0 cm by 0.2 cm. All four areas had the same treatment to completed daily, with orders dated 05/01/19 to cleanse the areas with normal saline, apply silver alginate (antimicrobial absorbing agent) and cover with foam dressing every day. On 05/23/19 the order was changed to cleanse with normal saline, pat dry, apply calcium alginate (absorbing agent) and cover with a foam dressing. Observation of the dressing change with Licensed Practical Nurse (LPN) #406 on 06/12/19 at 4:05 P.M. revealed the resident had a shower prior to the dressing change, and the dressing had been removed prior to the surveyor entering the room. The resident was lying on the bed, with the Hoyer lift pad beneath him, partially on his side. Two state tested nursing assistants held the resident while LPN #406 completed the dressing change. LPN #406 had measured the wounds prior to the surveyor entering the room and was washing her hands. She applied clean gloves and proceeded to open plastic vials of normal saline and packets of four by four gauze to cleanse the wound areas. The nursing assistants held Resident #6 on his side as she cleansed the wound areas, including one on his upper right back, which was far under the resident as he lay on his right side. As LPN #406 cleansed the wounds, she touched the resident's intact skin with her gloved hands to move him further to allow her to cleanse the wounds and when the upper right back wound had been cleansed, the resident was allowed to lay back onto that wound, resting on the pad for the Hoyer lift, which was under him. LPN #406 finished cleansing the wounds, and started opening packages of alginate to apply to the wounds, ripping pieces of the material to fit the wound with her gloved fingers. She layed the pieces of alginate on the wounds, one by one and covered them with foam pads. She had not changed her gloves from cleansing the four wounds, which she did, one after the other, and the resident was allowed to roll back partially onto the Hoyer pad while LPN #406 was not working with him directly, with the open wounds touching the Hoyer pad. After all four wounds were dressed, LPN #406 removed her gloves and washed her hands. (continued on next page)

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	365828	A. Building B. Wing	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Convalescent Home	18810 Harvard Ave Cleveland, OH 44122

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN #406 on 06/12/19 at 4:15 P.M. verified she had not changed her gloves after cleansing the wounds, touching the resident's intact skin, and the procedure had occurred while he layed on the Hoyer lift pad, with the wounds coming into contact with the pad at times during the dressing change. She also verified she had prepared the clean dressings, including tearing the alginate material with gloved hands still on her hands after cleansing the wounds, and touching his intact skin, and she had completed all four dressing changes with the same gloves, which in the case of infection, could have spread the infection from one area to all the other wounds as well. Review of the facility policy on Dressing Change, Dry/Clean, dated November 2015, did not specify that gloves should be changed after cleansing the wound, but an interview with the Corporate Nurse, Registered Nurse (RN) #402, on 06/12/19 at 4:30 P.M. confirmed the nurse should have changed her gloves after cleaning the wound prior to touching and applying the clean dressing, especially after touching the resident's skin to help position him and prior to touching the alginate material that was applied directly to the wound area. 2. Observation of the medication pass with RN #425 on 06/12/19 at 8:30 A.M. revealed her as she prepared medications for Resident #73. She dropped a tablet of a blood pressure medication (Metoprolol) on the medication cart, put on a glove and put the tablet in the cup to administer to the resident. After she completed her medication pass at 8:48 A.M., RN #425 verified she had dropped the tablet and picked it up to administer to the resident. She stated she had cleaned the medication cart surface earlier that morning (not witnessed by the surveyor) and felt the surface was clean. She verified she had not been in the presence of the cart at all times and could not ensure the surface was clean. She verified she should have discarded the tablet and obtained a new one to administer to the resident. An interview with Corporate Nurse, RN #402, on 06/12/19 at 4:30 P.M. confirmed the nurse should have discarded the tablet after it touched the medication cart.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07380 Based on observation and interview, the facility failed to timely provide a bed of proper size for Resident #23. This affected one resident reviewed for proper bed size in a sample of 35 residents. The facility census was 103. Findings include: Review of Resident #23 medical record revealed the resident was admitted on [DATE] to the facility with diagnoses including osteomyelitis, Multiple Sclerosis, paraplegia, chronic ischemic heart disease, peripheral vascular disease and chronic obstructive pulmonary disease. Review of Resident #23's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required an extensive assist of two for bed mobility, transfer, and toilet use. Resident #23 required an extensive assist of one for dressing and personal hygiene Observation of Resident #23's bed with the resident in bed and the head of the bed elevated on 06/10/19 at 11:00 A.M., 06/11/19 at 9:20 A.M. and 06/13/19 at 7:30 A.M. revealed the resident's feet were pushed up against the footboard. On 06/14/19 at 10:30 A.M. observation of Resident #23's dressing changed revealed the nurse had to remove the resident's feet from the bottom of the footboard before the resident could be turned for the dressing change. Interview with Resident #23 on 06/10/19 at 11:00 A.M., 1:30 P.M. and 06/12/19 at 3:10 P.M. revealed the resident complained the bed was too short, and when the head of the bed was elevated his feet were pushed up against the footboard causing his feet to hurt. Interview with Registered Nurse (RN) #453 on 06/12/19 at 3:04 P.M. revealed Resident #23 had been complaining his bed was too small, and his feet pressed up against the footboard of the bed. RN #453 stated this had been an ongoing issue, and corporate was aware of the resident's request. RN #453 stated as of 06/12/19, the resident was still in the same bed. Further interview with the Regional Administrator #401 on 06/13/19 at 2:50 P.M. revealed he and the new Administrator #407 measured the bed with the resident in the bed with the resident lying flat in bed. Regional Administrator #401 stated the bed measured 84 inches, and the resident had adequate room in his bed without his feet touching the foot rest when flat. Regional Administrator #401 verified he did not measure the bed or observe the resident's position with the resident in bed with the head of bed elevated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on observation, interview and job description review, the facility failed to maintain a clean and safe environment for residents, staff and visitors. This affected 40 Residents (#1, #2, #5, #8, #10, #11, #12, #15, #16, #17, #19, #25, #29, #30, #31, #32, #34, #36, #38, #39, #41, #42, #43, #45, #46, #47, #50, #56, #60, #61, #65, #66, #72, #73, #82, #86, #88, #89, #92 and #253) of the 103 residents residing in the facility. Findings include: The second floor common dining room was the central hub for all meals and activities. There were 14 tables and 27 standard chairs. All of the 27 chairs had food stuffs, residues and liquids on the seats, sides of the seats, arm rests and the top of the back rests in varying degrees from light to heavily soiled. Sixteen of the 27 were heavily soiled. The tables also had various food and fluid residues that were not cleaned before the next meal. The floor beneath where Resident #31 sat was heavily stained with food and liquids. The tread in the bottoms of her sneakers were thick with food debris. Both window air conditioning units, that were plugged in to the walls, covers were on the floor. The exposed filter was thick with white to gray dust. The bottom of one of the standard chairs in the dining room was missing a chair leg peg causing Resident #60 to rock when seated. Resident #66 was observed to place a shopping bag or a towel on a chair before she sat on it. One of the chair's wooden left arm rest was detached from the chair. This was observed on 06/10/19 at 11:35 A.M., 06/11/19 at 3:21 P.M., 06/12/19 at 8:07 A.M. and 10:22 A.M. The fan behind the nurse's station on 06/13/19 at 9:25 A.M. remained extremely thick with dust and debris, and the vented area on the bottom was completely obstructed. This observation was verified with Licensed Practical Nurse (LPN) #423 at 9:26 A.M. Interview with LPN #420 on 06/10/19 at 5:23 P.M. verified the condition of the chairs, floors and air conditioning units. She said Resident #66 was sitting on bags or towels because she did not want to get wet from someone else's urine. Interview with Housekeeping #427 on 06/12/19 at 10:22 A.M. said she was responsible to clean the chair seats, backs, arms and legs and sweep the floors. She said a floor technician was responsible for cleaning the floors. She verified a floor technician had not been on the unit all week. Interview with Account Manager #426 on 06/12/19 at 11:20 A.M. verified the condition of the chairs, floors and air conditioning units. Review of the job description for housekeeping effective 05/11/17 indicated assigned work areas were to be maintained. 39969 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Tour of the facility on 06/12/19 from 3:31 P.M. to approximately 4:00 P.M. with Maintenance Director (MD) #500 revealed in Residents #16 and #43's room the ceiling light and light above the sink were not functioning when switched on. Also, the lights above Residents #16 and 43's beds did not have a string to turn the light on or off. These lights were not on. The toilet in Resident #19's bathroom had shifted and was loose, not bolted to the floor. Observation of Residents #15 and #36 dresser drawers in their rooms were broken and off the tracks. There was a medium sized hole in the wall near Resident #36's bed and a telephone jack with exposed wires laying on the floor. Observation of a half dollar sized hole in the lower left side corner panel of the exit door near room [ROOM NUMBER]. Interview on 06/12/19 from 3:31 P.M. to approximately 4:00 P.M. with MD #500 confirmed the above findings. Observation on 06/13/19 at 9:17 A.M. with MD #500 of Resident #86's room revealed the cable cord outlet cover hanging off the wall. At this time Resident #86 stated her grab bars were fixed. MD #500 confirmed the above observations. Review of the maintenance log book revealed on 05/23/19 a nurse entered a maintenance request indicating Resident #43 needed the lights fixed. On 05/17/19, a nurse aide entered a request for Resident #19, stating the toilet was very loose, and mice were found dead in his room. Review of the Resident Council minutes dated from 12/18/18 to 05/28/19 revealed from 12/18/18 to 02/27/19 Resident #86 had a concern regarding grab bars in the bathroom. They were noted to be fixed on the Resident Council meeting minutes dated 03/26/19. 3. Interview on 06/11/19 at 8:48 A.M. with Resident #41 revealed the facility did not have a bariatric shower chair, and stated she hadn't had a shower in a month. Interview on 06/13/19 at 10:12 A.M. with LPN #501 revealed Resident #41 had not received a shower due to needing a bariatric shower chair. LPN #501 stated a bariatric shower chair was ordered and arrived on 06/11/19 but did not fit in the shower room.