STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385272	A. Building B. Wing	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tigard Rehabilitation and Care	14145 SW 105th Avenue Tigard, OR 97224

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 35854 Based on interview and record review it was determined the facility failed to support a resident's preference of health care provider for 1 of 1 sampled resident (#37) reviewed for dignity. This placed residents at risk for lack of self-determination. Findings include: Resident 37 admitted to the facility in 2018 with diagnoses including diabetes. On 8/5/19 at 2:01 PM Resident 37 stated she/he requested to not work with Staff 15 (CNA) due to past conflicts. Resident 37 stated the facility continued to assign Staff 15 to the resident and the resident refused care from Staff 15. Resident 37 stated she/he asked other staff for assistance when Staff 15 was assigned to care for her/him. A review of the 8/5/19 and 8/6/19 staff assignment sheets indicated Staff 15 was assigned to Resident 37. On 8/7/19 at 12:43 PM Staff 2 (DNS) acknowledged she was aware Resident 37 requested to not be cared for by Staff 15, but Staff 15 continued to be assigned to Resident 37 due to an oversight.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36496 Based on observation and interview it was determined the facility failed to ensure resident fans were maintained in clean condition for 9 of 11 resident rooms reviewed for environment. This placed residents at risk for poor air quality. Findings include: During a tour of resident rooms on 8/5/19 the following rooms were found to have fans with blades and protective [NAME] covered in dust: 107, 201, 203, 204, 209, 303, 305, 311 and 313. On 8/6/19 during a walk through of rooms 107, 201, 203, 204, 209, 303, 311 and 315 Staff 1 (Administrator) acknowledged the blades and protective [NAME] of the fans were covered in dust.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on interview and record review it was determined the facility failed to notify the resident and the Long Term Care Ombudsman in writing of a resident's transfer from the facility for 1 of 1 sampled resident (#21) reviewed for hospitalization . This placed residents at risk for lack of notification. Findings include: Resident 21 admitted to the facility in 2014 with diagnoses including quadriplegia (paralysis of upper and lower extremities) and chronic obstructive pulmonary disease (COPD). Resident 21's medical record indicated the resident was her/his own responsible party and was cognitively intact. Review of 5/2019 and 6/2019 Progress Notes indicated Resident 21 was transferred to the hospital on 5/30/19 and readmitted to the facility on [DATE]. Review of Resident 21's clinical record revealed no indication the resident and the Long Term Care Ombudsman were notified in writing of the resident's transfer to the hospital. On 8/13/19 at 9:01 AM Resident 21 stated she/he was not notified in writing of the reason for her/his transfer to the hospital. On 8/13/19 at 10:02 AM Staff 9 (Social Services) confirmed there was no system in place for notifying the resident and the Long Term Care Ombudsman in writing of resident transfers from the facility to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on interview and record review it was determined the facility failed to provide the resident a written notice of the facility's bed-hold policy at the time of transfer to the hospital for 1 of 1 sampled resident (#21) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their potential financial responsibilities. Findings include: Resident 21 admitted to the facility in 2014 with diagnoses including quadriplegia (full body paralysis) and chronic obstructive pulmonary disease (COPD). A review of Resident 21's medical record revealed the resident was transferred to the hospital on 5/30/19 and was readmitted to the facility on [DATE]. The medical record further indicated the resident was her/his own responsible party and was cognitively intact. On 8/13/19 at 9:01 AM Resident 21 stated she/he was not provided a copy of the bed-hold policy when transferred to the hospital. On 8/13/19 at 10:02 AM Staff 9 (Social Services) confirmed there was no system in place for notifying residents in writing of the facility's bed-hold policy at the time of transfer to the hospital.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 35854 Based on interview and record review it was determined the facility failed to ensure the resident's use of psychotropic medication and nutritional needs were comprehensively assessed within 14 days of admission for 2 of 7 sampled residents (#s 4 and 11) reviewed for medication and nutrition. This placed residents at risk for unassessed needs. Findings include: 1. Resident 11 admitted to the facility in 2019 with diagnoses including end stage renal disease and depression. a. Resident 11's 2/7/19 Admission MDS indicated Resident 11 received a therapeutic diet. The Nutrition CAA associated with the 2/7/19 MDS indicated Resident 11 received a renal diet and was on a fluid restriction. The CAA did not indicate the resident's weight trends, nutrition or hydration status, or if the resident was compliant with the dietary or fluid restrictions. On 8/12/19 at 10:38 AM Staff 4 (RNCM) acknowledged Resident 11's 2/7/19 nutritional assessment was not comprehensive. b. Resident 11's 2/7/19 Admission MDS indicated Resident 11 received antidepressant medication. The Psychotropic Drug Use CAA associated with the 2/7/19 MDS indicated Resident 11 received antidepressant medication but had no information regarding how the resident's symptoms manifested, the resident's history of psychotropic drug use, or the effectiveness of the medication. On 8/12/19 at 10:38 AM Staff 4 (RNCM) acknowledged Resident 11's 2/7/19 psychotropic drug use assessment was not comprehensive. 34324 2. Resident 4 was admitted to the facility in 2011 with diagnoses including dementia, schizophrenia and post traumatic seizures. Review of Resident 4's 1/23/19 Admission MDS Psychotropic Medication Use CAA indicated the resident received Depakote and Seroquel. The CAA failed to include the resident's history related to the use of the medication, how the resident's symptoms manifested, whether the medication was effective and what interventions were in place. On 8/12/19 at 9:50 AM Staff 3 (RNCM) stated the Psychotropic Medication Use CAA was to include information related to adverse side effects, name of the medication and the dosage. Staff 3 stated Resident 4's CAA was completed by another staff person and confirmed the CAA was not comprehensive.

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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** 40767 Based on interview and record review it was determined the facility failed to comprehensively assess behavioral health needs for 1 of 2 sampled residents (#99) reviewed for accidents. This placed residents at risk for unmet needs. Findings include: Resident 99 admitted to the facility on [DATE] with diagnoses including schizoaffective disorder and dementia. The 5/10/19 Psychotropic CAA indicated the resident had a diagnosis of schizoaffective disorder and to proceed to the resident's care plan. The 5/16/19 Preadmission Screening Resident Review Level 2 (PASRR II) indicated Resident 99 was referred for an evaluation due to suicidal ideation. The evaluation further indicated Resident 99 had a significant mental health history including psychotic symptoms, suicidal ideation, self harm and leaving multiple nursing facilities against medical advice. The care plan, last updated 6/6/19, indicated the resident had a diagnosis of schizoaffective disorder, received an antipsychotic medication and staff were to assess if the resident's behavioral symptoms. The care plan did not include the resident's behaviors, behavioral health history, interventions, or mental and psychosocial needs related to the resident's mental health diagnoses. On 8/12/19 at 1:46 PM Staff 4 (RNCM) acknowledged the care plan lacked specific information related to Resident 99's mental and behavioral health care needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36496 Based on interview and record review it was determined the facility failed to ensure coordination of hospice care for 1 of 1 sampled resident (#199) reviewed for hospice. This placed residents at risk for a lack of coordinated care between hospice and facility staff. Findings include: Resident 199 admitted to the facility on [DATE] with diagnoses including adult failure to thrive. Resident 199 began receiving hospice services on 7/27/19. Review of Resident 199's clinical record revealed no evidence a hospice plan of care was in place. On 8/9/19 at 11:11 AM Staff 1 (Administrator) confirmed the facility did not have the hospice care plan in the resident's record until it was requested from hospice on 8/9/19.

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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** 36496 Based on interview and record review it was determined the facility failed to ensure residents with pressure ulcers were assessed, care planned or treated for 2 of 2 sampled resident (#s 199 and 302) reviewed for pressure ulcers. This placed residents at risk for pressure ulcers. Findings include: 1. Resident 199 admitted to the facility on [DATE] with diagnoses including adult failure to thrive. A 7/26/19 Skin Impairment sheet indicated Resident 199 had an open wound to her/his left hip that measured 0.8 cm x 0.5 cm. The assessment did not include any other information about the wound, including depth, wound color, odor, tunneling, stage or if the resident had pain related to the wound. Review of Resident 199's clinical record revealed she/he did not have wound treatment orders upon admission to the facility. Resident 199 was admitted to hospice on 7/27/19. A 7/27/19 Nurse's Note completed by a hospice RN indicated Resident 199 had a small open area less than 1.0 cm around and no drainage. The wound was noted to be present on admission. She indicated she treated the wound. Review of Resident 199's temporary care plan revealed no indication she/he had a pressure ulcer. Review of Resident 199's 7/2019 TAR revealed no indication the resident received pressure ulcer treatment. A 7/28/19 hospice wound assessment indicated Resident 199 had a left hip Stage 2 pressure ulcer (partial thickness skin loss). The wound was noted to be 0.5 cm x 0.3 cm. On 8/9/19 at 1:33 PM Staff 3 (RNCM) acknowledged the resident's baseline plan of care did not include any information on her/his pressure ulcer and the 7/27/19 Skin Impairment assessment was not comprehensive. 41454 2. Resident 302 was admitted to the facility on [DATE] with a diagnoses of pelvic fracture. Resident 302 was cognitively intact. On 8/6/19 at 9:47 AM Resident 302 was tearful and stated she/he was unable to move in her/his bed independently and was to be turned every two hours since admission on 8/5/19 at 7:00 PM. Resident 203 stated she/he was not provided assistance to reposition in bed for over 12 hours. On 8/8/19 at 10:00 AM Staff 3 (RNCM) confirmed Resident 302 was to be repositioned every two hours as indicated on the Temporary Care Plan. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/19 at 1:54 PM Staff 13 (LPN) stated she created a care plan for Resident 302 upon admission and verbally told the CNA staff to turn Resident 302 every two hours. On 8/9/19 at 2:36 PM Staff 24 (CNA) stated he worked with Resident 302 from 8/5/19 from 10 PM until 6 AM 8/6/19. Staff 24 did not see Resident 302's Temporary Care Plan and Staff 13 (LPN) did not inform him about Resident 302's repositioning needs. On 8/13/19 at 11:25 AM Staff 25 (CNA) stated she worked with Resident 302 during the evening shift on 8/5/19. Staff 25 stated she assisted Resident 302 to her/his bed when she/he was admitted . Staff 25 stated Resident 302 was in too much pain to be repositioned in bed. On 8/13/19 at 2:00 PM Staff 28 (LPN) stated Resident 302 required repositioning to prevent skin breakdown and other immobility complications. The 8/5/19 Nursing Admission Assessment did not include Resident 302's bed mobility status. The Point Of Care History indicated on 8/5/19 Resident 302 did not move in bed. The Temporary Care Plan completed on 8/6/19 indicated the Resident 302 was to be repositioned every two hours. The CNA pocket guide outlining resident care needs was reviewed 8/6/19 and 8/8/19. The pocket guide last updated 8/3/19 included no information about Resident 302's needs and care including repositioning. On 8/8/19 at 10:45 AM Staff 2 (DNS) stated Resident 302 was to be turned by CNAs as directed on the Temporary Care Plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36496 Based on observation, interview and record review it was determined the facility failed to ensure residents were free from falls for 1 of 1 sampled resident (#13) reviewed for falls. This placed residents at risk for injury. Findings include: Resident 13 admitted to the facility in 2019 with diagnoses including a stroke. The 2/18/19 Admission assessment indicated Resident 13 was not cognitively intact and was at risk for falls. The 6/4/19 fall Care Plan indicated Resident 13 was to be in line of sight at the nurses station when up in her/his wheelchair. A 7/7/19 Fall Report indicated Resident 13 had an unwitnessed fall in the dining room. The resident was last observed to be seated in her/his wheelchair in the dining room. The report indicated the resident was found on the floor in front of her/his wheelchair with no injuries noted. On 8/12/19 at 10:56 AM Staff 3 (RNCM) Staff 3 acknowledged Resident 13's 6/4/19 fall Care Plan indicated the resident was to be in line of sight at the nurses station when she/he was up in her/his wheelchair. Staff 3 acknowledged at the time of the Resident 13's 7/7/19 fall, she/he was not in line of sight at the nurses station.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35854 Based on observation, interview and record review it was determined the facility failed to ensure residents received treatment and services related to use of a urinary catheter for 1 of 1 sampled resident (#37) reviewed for catheters. This placed residents at risk for complications from catheter use. Findings include: Resident 37 admitted to the facility in 2018 with diagnoses including bladder dysfunction. On 8/6/19 at 9:58 AM Resident 37 was observed to have an indwelling urinary catheter in place. Resident 37 stated staff did not monitor the catheter unless the resident asked them to check it. A review of the resident's current care plan, updated 4/4/19, indicated the presence of a urinary catheter. The care plan indicated staff were to provide catheter care on each shift, change the dressing daily, monitor for sign and symptoms of infection, monitor for catheter potency and change the catheter every 21 days. No evidence was found in the resident's clinical record to indicate treatment for the resident's urinary catheter was provided as outlined on the care plan. On 8/12/19 at 9:48 AM Staff 4 (RNCM) acknowledged there was no evidence to indicate catheter care was provided to Resident 37.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 34324 Based on interview and record review it was determined the facility failed to identify, reassess and maintain acceptable parameters for nutritional status for 1 of 2 sampled residents (#8) reviewed for nutrition. As a result Resident 8 had a severe weight loss greater than 7.5% in three month period. Findings include: Resident 8 was admitted to the facility in April 2019 with diagnoses including Parkinson's and congestive heart failure. The following weights were recorded for Resident 8: -4/11/19: 178.6 pounds. -5/3/19: 181.6 pounds. -6/25/19: 161.3 pounds. -7/1/19: 165.0 pounds. A 7.6% weight loss in three months, indicating a severe weight loss. The 4/15/19 care plan indicated Resident 8 was at nutritional risk related to her/his disease process. The goal included no significant weight loss (5% in 30 days). An updated 7/26/19 intervention included to monitor and record weight. A 5/15/19 Nutritional Assessment indicated Resident 8 had a weight decrease and lost her/his appetite prior to admitting to the facility. The resident agreed to a trial of health shakes at meals. The goal was for Resident 8's weight to be stable. The assessment included the recommendations of the trial of health shakes at meals and to notify the Dietician if the resident's weight decreased or if the resident refused the health shakes. A 7/17/19 nutritional follow-up note indicated Resident 8 had a weight decrease of 7.6% since admission. The note indicated the prior recommendations were not ordered and the trial of health shakes was again requested. The note further indicated the resident had a significant weight decrease over the past three months. Recommendations included to add health shakes TID and weekly weights for four weeks related to the resident's weight loss. An order for health shakes BID with med pass was completed on 7/25/19. Review of the 7/30/19 Nutrition at Risk (NAR) meeting note indicated Resident 8 had a 8.9% weight loss in 59 days. Food requested by the resident included avocado, shrimp, mango and salmon. The identified causes indicated the resident did not like the food and requested items not available and refused to eat. The plan included to purchase selected food items, provide health shakes BID and to refer to the dietician. Review of Resident 8's medical record revealed no evidence of the following: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The resident received the recommended health shakes prior to the 7/25/19 order. -Weekly weights were implemented as recommended on 7/17/19. -The resident was placed on NAR prior to 7/30/19. On 8/5/19 at 11:52 AM Resident 8 stated she/he lost weight since admission. The resident stated she/he received health shakes for the past week and confirmed she/he did not receive health shakes prior to the previous week. On 8/8/19 at 10:06 AM Staff 26 (RD) stated she was in the facility 16 hours a month and did not participate in the NAR meetings. She stated the nutritional recommendations made were given to nursing staff and she believed they were given to the physician for a written order. Staff 26 stated she relied on nursing to follow up with recommendations due to her limited time in the facility. She stated she relied on nursing staff to follow up and complete any recommendations made. Staff 26 confirmed the recommendation for a trial of health shakes requested for Resident 8 was not ordered in May and was again requested in July. Staff 26 further stated the recommendation for weekly weights was to be started quickly after the recommendation was made on 7/17/19. She stated the weekly weight would prompt nursing staff to monitor and work on appropriate interventions to address the resident's weight loss. Staff 26 confirmed Resident 8 had a 7.6% weight loss in three months. On 8/8/19 at 11:25 AM Staff 3 (RNCM) stated the dietician's recommendations were given to her and to the Dietary Manager (Staff 6). Staff 3 stated the recommendations were reviewed and dietary orders were requested from the physician. Staff 3 stated it did not take more than a week to obtain an order from the physician as he was in the facility weekly. Staff 3 confirmed she did not see the RD recommendation for the health shakes until it was requested again in July. She stated the May request for the health shakes was not implemented. Staff 3 further confirmed nursing staff did not obtain an order for the weekly weight recommendation requested in July by the RD. She stated Staff 6 monitored resident weights and was in charge of the NAR meetings. Staff 3 confirmed she was not aware of Resident 8's 7.6% weight loss until the implementation of the health shakes on 7/25/19 and the resident was placed on NAR. On 8/8/19 at 12:40 PM Staff 6 stated he set up the NAR meetings and selected the residents who needed to be monitored. He stated residents who were on NAR had a 3% weight loss from their previous weight. He stated he reviewed the weights which indicated to him what residents had weight loss. Staff 6 stated the RD did not participate in the NAR meetings. Staff 6 confirmed he made a mistake and did not catch [Resident 8's] weight loss and she/he should have been on NAR sooner. He stated he did not recall an RD recommendation for health shakes in May or July and had just decided to add the health shakes. On 8/15/19 at 1:01 PM Staff 1 (Administrator) acknowledged the RD was going to review Resident 8's recommendation for health shakes TID and the implementation of the shakes only BID.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41454 Based on observation, interview and record review it was determined the facility failed to ensure a resident's ordered pain medication was available on admission to the facility and effectively manage a resident's severe pain for 1 of 1 sampled resident (#302) reviewed for pain. This resulted in Resident 302 having severe unrelieved pain which affected her/his ability to sleep and participate in daily care including repositioning. Findings include: Resident 302 was admitted to the facility on [DATE] with a diagnosis of pelvic fracture. Resident 302 was cognitively intact. The 8/5/19 physician orders for admission to the facility indicated Resident 302 was to receive oxycodone 15 mg immediate release tablet four times a day for seven days, and oxycodone 5mg one to three tablets three times a day as needed for pain. The 8/5/19 nursing Pain Assessment indicated Resident 302 was currently having hip pain and the pain was excruciating, which interfered with her/his ability to carry on with daily routines such as socialization or sleep. The Temporary Care Plan completed on 8/6/19 indicated Resident 302 was in pain with a goal of resident will verbalize pain at an acceptable level which does not interfere with quality of life. On 8/6/19 at 9:47 AM Resident 302 was observed to be tearful, distraught and grunting. Resident 302 stated she/he told the facility staff she/he was in severe pain and was told her/his medication was ordered. Resident 302 stated she/he was unable to get comfortable and rest all night due to the pain. The medication flow sheet indicated Resident 302 did not receive any medications at the facility on 8/5/19. It further indicated Resident 302 received oxycodone 15mg one tablet at 8:00 AM on 8/6/19 which was her/his first pain medication received since admission on 8/5/19 at 7:00 PM. On 8/8/19 at 10:00 AM Staff 3 (RNCM) stated she came in to work early on 8/6/19 and checked on Resident 302. Staff 3 stated Resident 302 was experiencing pain, grimacing and posturing, so she went to the CMA and told her Resident 302 needed her/his pain medication now. Staff 3 stated Resident 302 should have received something for pain during the night without waiting. She stated an emergency locked box of common medications, including oxycodone was available for new admissions. On 8/8/19 at 2:45 PM Staff 13 (LPN) stated Resident 302 complained of pain and was distraught and distressed. Staff 13 stated she called the pharmacy for a code to get Resident 302's narcotic pain medication from the facility emergency lock box but Staff did not hear back. Staff 13 stated the process was to call the pharmacy back in 30 minutes for a code if they did not respond and ultimately call the doctor if unable to access the pain medication. Staff 13 stated she did not call the pharmacy back and did not notify anyone else and did not get a code to access medication for Resident 203. On 8/13/19 at 11:25 AM Staff 25 (CNA) stated Resident 302 was in too much pain to be repositioned in bed on the evening of 8/5/19. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 8/8/19 at 10:57 AM Staff 2 (DNS) acknowledged Resident 302 did not get any pain relief medication from admission on 8/5/19 at 7:00 PM until 8:00 AM on 8/6/19. Staff 2 also stated medications were available in the emergency box and Resident 302 should have received her/his PRN pain medication.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on interview and record review it was determined the facility failed to assess mental health needs and implement recommended health care treatment and services for 1 of 2 sampled residents (# 99) reviewed for accidents. This placed residents at risk for not maintaining their highest practicable mental and psychosocial well-being. Findings include: Resident 99 admitted to the facility on [DATE] with diagnoses including schizoaffective disorder with psychotic features and dementia. Review of Resident 99's medical record revealed the resident was her/his own responsible party and was cognitively intact. The 5/10/19 Psychotropic CAA indicated Resident 99 had a diagnosis of schizoaffective disorder. The CAA did not include the resident's targeted behaviors, diagnosis of dementia, mental health history or mental health interventions. The 5/16/19 Preadmission Screening Resident Review Level 2 (PASRR II) indicated Resident 99 was referred for an evaluation due to suicidal ideation. The evaluation further indicated Resident 99 had a significant mental health history including psychotic symptoms, suicidal ideation, self harm and had a history of leaving multiple nursing facilities against medical advice. The evaluator recommended for facility staff to implement interventions for delusions and paranoia and further recommended an evaluation for possible enhanced care placement. A 5/21/19 progress note indicated during a telephone call with the PASRR II examiner it was recommended Resident 99 be placed in a geriatric psychiatric facility due to the resident's mental health and medical needs. The care plan, last updated 6/6/19, indicated the resident had a diagnosis of schizoaffective disorder, was on an antipsychotic medication and staff were to assess the resident's behavioral symptoms. The care plan did not include the resident's behaviors, behavioral health history, interventions, or mental and psychosocial needs related to the resident's mental health diagnosis. A 6/10/19 Progress Note indicated Resident 99 left the facility against medical advice on 6/8/19 after the resident pulled the fire alarm and called a taxi to take her/him home. On 8/8/19 at 10:50 AM Staff 10 (Social Services) stated Resident 99 had left previous nursing facilities against medical advice and had a significant mental health history. Staff 10 further stated the resident made comments in 5/2019 about having no will to live if the resident had to stay in the nursing facility. On 8/9/19 at 9:57 PM Witness 2 (Case Worker) stated she felt Resident 99 was not getting her/his mental health needs met at the facility and the resident was being warehoused. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/9/19 at 1:15 PM Staff 12 (CNA) stated Resident 99 was socially isolated, did not come out of her/his room and made comments about not wanting to be at the facility and wanting to go home. Staff 12 was not aware the resident had previously left nursing facilities against medical advice. On 8/9/19 at 1:31 PM Staff 11 (RN) stated Resident 99 had made previous comments about not wanting to be at the facility and the resident did not come out of her/his room. Staff 11 stated she was not aware the resident had a history of leaving previous nursing facilities against medical advice. On 8/12/19 at 1:46 PM Staff 4 (RNCM) acknowledged the care plan lacked specific information related to Resident 99's mental and behavioral health care needs. Staff 4 stated she was unaware the resident had left previous nursing facilities against medical advice and was unaware the resident made statements about not wanting to be at the facility. Staff 4 further acknowledged PASRR II recommendations were not implemented.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33179 Based on observation and interview it was determined the facility failed to properly reconcile controlled medications for 2 of 2 medication carts (200 and 300 Hall) reviewed for medication storage. This placed residents at risk for drug diversion. Findings include: On 8/6/19 at 9:58 AM the 200 Hall Medication Cart was observed for medication storage. The narcotic reconciliation book lacked the required staff signatures to verify the narcotic count for nine of 22 narcotic count opportunities in August 2019. On 8/6/19 at 10:13 AM the 300 Hall Medication Cart was observed for medication storage. The narcotic reconciliation book lacked the required staff signatures to verify the narcotic count for five of 20 narcotic count opportunities in August 2019. On 8/6/19 at 10:33 AM Staff 2 (DNS) verified the identified missing signatures for the 200 and 300 Hall Medication Carts.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34702 Based on interview and record review, it was determined the facility failed to respond in a timely manner to pharmacist recommendations for 1 of 5 sampled residents (#27) reviewed for medication. This placed residents at risk for unmet medication needs. Findings include: Resident 27 was admitted to the facility in 2019 with diagnoses including pressure ulcers and long term use of anticoagulant drug therapy. The 5/29/19 pharmacy recommendation indicated the following: -Resident 27 did not have an assessment of renal function within the past six months. -The recommendation was to order a serum creatinine on the next lab day. -The pharmacy recommendation was not signed by the Nurse Practitioner until 6/25/19. On 8/13/19 at 10:35 AM Staff 2 (DNS) stated the pharmacy recommendation dated 5/29/19 was not addressed by the Nurse Practitioner until 6/25/19 and acknowledged the pharmacy recommendation was not addressed timely.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35854 Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary narcotic medication for 1 of 6 sampled residents (#100) reviewed for medication. This placed residents at risk for adverse side effects of narcotic medication. Findings include: Resident 100 admitted to the facility on [DATE] with diagnoses including dementia and acute pain. On 8/6/19 at 12:49 PM Witness 4 (Family Member) stated facility staff provided morphine to Resident 100 when the resident did not need the morphine. The 3/2019 MAR indicated staff were to administer morphine to the resident as needed for pain or air hunger (gasping for breath). The MAR indicated Resident 100 received a single dose of morphine on both 3/30/19 and 3/31/19. The 3/2019 PRN Medication Notes indicated Resident 100 received morphine on 3/30/19 due to an elevated pulse. No information was found to indicate why the resident received morphine on 3/31/19. No evidence was found in the resident's clinical record to indicate the resident experienced pain or air hunger on 3/30/19 or 3/31/19. On 8/13/19 at 10:57 AM Staff 3 (RNCM) acknowledged an elevated pulse was not an appropriate rationale for providing morphine to Resident 100. Staff 3 acknowledged there was no evidence to indicate an appropriate rationale for providing morphine to Resident 100 on 3/30/19 and 3/31/19.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35854 Based on interview and record review it was determined the facility failed to ensure residents were monitored for adverse side effects of psychotropic medication for 1 of 6 sampled residents (#11) reviewed for medication. This placed residents at risk for adverse side effects of psychotropic medication. Findings include: Resident 11 admitted to the facility in 2019 with diagnoses including end stage renal disease and depression. Resident 11's 2/7/19 Admission MDS indicated Resident 11 received antidepressant medication. A review of the resident's care plan revealed no information regarding the resident's psychotropic drug use. Behavioral/Psychoactive Meeting Minutes dated 7/9/19 indicated staff were to monitor the resident's sleep related to the use of psychotropic medication. No evidence was found in the resident's clinical record to indicate staff monitored the resident's sleep. On 8/13/19 at 10:53 AM Staff 4 (RNCM) stated staff did not monitor the resident's sleep.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on interview and record review it was determined the facility failed to ensure the Dietary Manager possessed the required certification to carry out the functions of the food and nutrition service for 1 of 1 kitchen reviewed for food services. This placed residents at risk for unassessed dietary needs. Findings include: A [DATE] correspondence from the Certifying Board for Dietary Managers revealed Staff 6's (Dietary Manager) certification expired on [DATE]. On [DATE] at 1:37 PM and [DATE] at 1:57 PM Staff 1(Administrator) stated Staff 6 had worked for the facility as a Dietary Manager since ,d+[DATE]. Staff 1 confirmed Staff 6 was not currently certified and the certification had expired ,d+[DATE].

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 35854 Based on observation, interview and record review it was determined the facility failed to ensure food was provided per resident preference for 2 of 5 sampled residents (#s 8 and 37) reviewed for food. This placed residents at risk for lessened quality of life. Findings include: The 7/19/19 Resident Council Meeting Minutes indicated, Kitchen not putting all items requested on the tray. Get wrong food. 1. Resident 37 admitted to the facility in 2018 with diagnoses including diabetes. On 8/6/19 at 9:56 AM Resident 37 stated her/his food preferences were not honored by the facility. On 8/8/19 at 8:51 AM Resident 37's breakfast tray was observed to include bread with cheese. No meat was observed on the tray. On 8/8/19 at 8:55 AM Staff 22 (Cook) reviewed the resident's breakfast meal order and indicated the resident requested the bacon and cheese biscuit. Staff 22 stated Resident 37 was unable to have bacon due to a sodium restriction. On 8/8/19 at 9:05 AM the breakfast meal instructions sheet was reviewed with Staff 6 (Dietary Manager). Staff 6 stated the breakfast meal instructions for residents with a sodium restriction indicated to provide the bacon and cheese biscuit. Staff 6 stated the bacon was not provided to Resident 37 because the meal was changed to bread with bacon and cheese, but the bacon in the altered meal was not able to be provided to residents with a sodium restriction. When asked how the dietary staff determined the bacon was not to be provided to Resident 37 even though the original meal instructions indicated to provide the bacon, Staff 6 stated, We just know. When asked if residents typically received a substitute item when a requested item was not available, Staff 6 stated, If they ask. On 8/8/19 at 9:35 AM Staff 6 acknowledged residents received menus which included diet restricted food items. When asked why residents received menus including items they were unable to receive, Staff 6 stated, This is the system I inherited. Staff 6 stated he was hired as dietary manager about one year prior and had pondered changing the ordering system. 34324 2. Resident 8 was admitted to the facility in 2019 with diagnoses including scoliosis and disorders of bone density and structure. A 4/15/19 History and Physical indicated Resident 8 had underlying facial palsy and had difficulty chewing related to right side facial droop. Review of the 4/15/19 nutritional care plan indicated Resident 8 was able to make her/his own decisions related to nutrition. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 5/15/19 RD Nutritional Assessment indicated the resident's meal ticket was not followed and the nutritional plan indicated to honor Resident 8's preferences as able. On 8/5/19 Resident 8 stated she/he filled out the daily menu for the following day and frequently did not get food items she/he indicated on the menu. The resident stated for example she/he requested toasted white bread for breakfast but received wheat bread. The following observations were made of Resident 8's meals: - 8/6/19 at 8:35 AM the resident's meal ticket indicated white bread and a banana. The resident received wheat toast and no banana. At 12:50 PM an observation of the kitchen revealed loaves of white bread and a box of bananas in the dry storage room. - 8/8/19 at 9:09 AM the resident's meal ticket indicated grapes and a bacon and cheese biscuit. The resident received a side of bacon, no biscuit and no grapes. - 8/9/19 at 8:43 AM the resident's meal ticket indicated orange juice, tomato juice and diced apples. The resident received orange juice, apple juice and a whole apple. Resident 8 stated she/he asked for tomato juice many times and never received it. The resident further stated she/he was not able to eat a whole apple due to her/his facial droop. On 8/8/19 at 9:23 AM Staff 6 (Dietary Manager) stated he was not able to recall what breakfast Resident 8 received that morning. He stated the grapes went bad and he had to find out why the resident did not receive an alternative fruit. Staff 6 further stated the resident should have received a bread item and a mistake was made by the kitchen. He stated Resident 8 called him when she/he did not get food she/he ordered on the menu. Staff 6 confirmed there was no formal process in place to ensure residents receive the food items ordered on the meal ticket.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36496 Based on observation and interview it was determined the facility failed to ensure produce was maintained fresh for 1 of 1 kitchen observed. This placed residents at risk for foodborne illness. Findings include: On 8/5/19 during a tour of the kitchen with Staff 6 (Dietary Manager) a large box of undated potatoes was observed. There were four potatoes that had sprouted in multiple areas. Staff 6 indicated he would date the box of potatoes and remove any potatoes that had sprouted. On 8/12/19 at 11:47 PM the same box of potatoes was observed to be undated, with multiple potatoes that were soft to the touch and wrinkled. On 8/12/19 at 11:48 PM Staff 6 confirmed the box of potatoes was undated and contained multiple spoiled potatoes.

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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. 41454 Based on observation and interview it was determined the facility failed to ensure staff utilized proper protective equipment (PPE) while performing laundry services and catheter care. This placed residents at risk for cross-contamination and infection. Findings include: 1. On 8/9/19 at 1:20 PM appropriate personal protective equipment, eye and face shield, was not present for staff use during a laundry room walk through. On 8/9/19 at 1:25 PM Staff 23 (Laundry room staff) stated she did not use eye and face protection while handling dirty laundry. She further stated she was unsure if there was any available for her use. On 8/9/19 at 1:25 PM Staff 5 (Laundry/Housekeeping Manager) stated no eye and face PPE was available in the laundry room for employee use while handling dirty linens. 36496 2. On 8/5/19 at 1:40 PM a catheter bag was observed laying on the floor near Resident 27's bed. The resident was currently on contact precautions for MRSA (bacteria) of the wound. On 8/5/19 at 1:41 PM Staff 29 (CNA) was observed to pick up Resident 27's catheter bag and place it back in her/his catheter cover. She was then observed to use her bare hands to touch the tubing of the catheter and placed part of it under Resident 27's blanket. Staff 29 acknowledged she did not wash her hands and did not use gloves when touching the resident or resident's equipment.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41454 Based on interview and record review it was determined the facility failed to ensure residents received appropriate informed consent and administration of influenza and pneumococcal vaccines for 2 of 5 sampled residents (#s 11 and 13) reviewed for immunizations. This placed residents at risk for being uninformed regarding vaccinations and at risk for being unvaccinated against communicable diseases. Findings include: 1. Resident 11 was admitted to the facility in 2/2019 with diagnoses including end stage renal disease. Review of Resident 11's medical record revealed no documentation the resident previously received the pneumococcal immunization. There was no documentation to indicate the vaccine was offered, administered or refused since admission to the facility. On 8/12/19 at 9:45 AM Staff 2 (DNS) verified the pneumococcal immunization was not offered or administered to Resident 11. 2. Resident 13 was admitted to the facility in 2/2019 with diagnoses including stroke. Review of the medical record revealed no documentation Resident 13 previously received the pneumococcal or influenza immunizations. There was no documentation to indicate the vaccines were offered, administered or refused since admission to the facility. On 8/12/19 at 9:50 AM Staff 2 (DNS) verified neither the influenza or pneumococcal immunization was offered or given to Resident 13.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 36496 Based on observation and interview it was determined the facility failed to ensure the facility was free from pests for 1 of 1 kitchen. This placed residents at risk for a lack of sanitary conditions. Findings include: On 8/6/19 at 12:50 PM Resident 8 stated there were fruit flies around her/his food tray. A dead ant was observed to be wrapped in a napkin on her/his tray. On 8/12/19 at 11:40 AM Staff 29 (Dietary Aid) an ant was observed crawling on the facility hand-washing sink in the kitchen. Staff 29 confirmed there was an ant crawling on the hand-washing sink. On 8/12/19 at 11:45 AM Staff 30 (Dietary Aid) stated the kitchen had ants that would come and go. On 8/12/19 at 11:50 AM ants were observed on the floor and table of the facility activity room. On the afternoon of 8/13/19 Staff 1 (Administrator) acknowledged the presence of ants.