STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. Building B. Wing	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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** 40452 Based on observations, staff interview, and clinical record review, the facility staff failed to maintain respect and dignity for two residents (Resident #87, Resident #29) in a sample size of 59 residents. The findings include: 1. For Resident #87, the facility staff failed to protect Resident #87's private space. A facility vendor was observed entering the room without knocking on the door. Resident #87, a [AGE] year old female was admitted to the facility on [DATE]. Diagnoses include but not limited to cerebral palsy, Parkinson's disease, dysphagia, schizoaffective disorder, bipolar, quadriplegia, and gastroesophageal reflux. Resident # 87's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/16/2019 was coded as a quarterly assessment. Resident # 87 was coded with a Brief Interview of Mental Status (BIMS) score of 5 out of possible 15 indicating severe cognitive impairment. Functional status for eating, dressing, and personal hygiene was coded as extensive dependence on staff. On 02/20/2019 at 11:26, Employee C was observed walking into rooms 316, 313, 309, 308, and 306 without knocking. Resident #87 was in her bed with the privacy curtain only partially drawn. When asked if he was a facility employee, Employee C stated No. He went on to say he was a plumber hired by the facility and we're doing construction here. On 02/20/19 01:38 PM, Resident #87 was observed lying in her bed, watching TV, with the head of the bed elevated approximately 60 degrees. Resident #87 was dressed in a shirt, no pants, wearing a disposable brief, and covers at the foot of the bed. When asked about her pants, she stated, They're around here somewhere; I keep the curtain drawn and motioned to the partition curtain which was partially drawn. On 02/21/19 at 08:07 AM, Resident #87 was observed lying on her right side, sleeping in bed. She was covered with a sheet up to her chest. (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 02/21/2019 at approximately 12:50 PM, Resident #87 was observed lying in bed watching TV, She had a shirt on and covered with a blanket up to her chest. On 02/22/19 at 08:28 AM, Resident #87 was observed lying in her bed while watching TV. She was wearing a shirt and covered with a sheet. On 02/25/2018 at 11:15 AM, the Administrator and DON were notified of concerns. When asked was the expectation is of vendors entering resident rooms, the Administrator stated, They should be knocking. A policy addressing dignity/vendors working in the facility was requested. On 02/25/2019 at approximately 6:30 PM, the Administrator stated they don't have a policy pertaining to this issue. The Administrator and DON offered no further information or documentation. 2. For Resident #29, the facility staff failed to protect Resident #29's private space. A facility vendor was observed entering the room without knocking on the door. Resident #29, an [AGE] year old female was admitted to the facility on [DATE]. Diagnoses include but not limited to cerebrovascular disease, Alzheimer's disease, aphasia, contracture left hand, and diabetes. Resident # 29's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/2018 was coded as an annual assessment. Resident # 29 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision-making were coded as severely impaired. Functional status for dressing and toileting were coded as requiring extensive assistance from staff. Functional status for eating and personal hygiene were coded as total dependence on staff. On 02/20/2019 at 11:26, Employee C was observed walking into rooms 316, 313, 309, 308, and 306 without knocking. Resident #29 was in her room receiving care by an aide and the privacy curtain was drawn. When asked if he was a facility employee, Employee C stated No. He went on to say he was a plumber hired by the facility and we're doing construction here. On 02/20/19 at 01:49 PM, Resident #29 was observed dressed and seated in a high back wheelchair. On 02/21/19 at 08:08 AM, Resident #29 was observed lying in bed with her covers pulled up to mid-chest level. Resident was awake and the TV was on. On 02/21/19 at 12:50 PM, Resident #29 was observed lying in bed in her room and the TV was on. On 02/22/19 at 12:40 PM, Resident #29 was observed sleeping in her bed. On 02/25/2018 at 11:15 AM, the Administrator and DON were notified of concerns. When asked was the expectation is of vendors entering resident rooms, the Administrator stated, They should be knocking. A policy addressing dignity/vendors working in the facility was requested. On 02/25/2019 at approximately 6:30 PM, the Administrator stated they don't have a policy pertaining to this issue. The Administrator and DON offered no further information or documentation.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, resident interview, staff interview and clinical record review the facility staff failed for 1 resident (Resident #115) of 59 residents in the survey sample to ensure the resident had been assessed to self administer medications. 1) For Resident # 115, the facility staff failed to remain with the resident during administration of nebulizer treatment and failed to assess the resident to determine if self administration of medication was clinically appropriate and safe. 2) For Resident #510, the facility staff failed to provide supervision and oversight of medication administration during a nebulizer treatment and failed to assess the resident to determine if self administration of medication was clinically appropriate and safe. 3. For Resident #76 the facility staff failed to provide supervision and oversight of topical medication and failed to assess the resident to determine if self administration of medication is clinically appropriate and safe. The findings included: Resident #115, a [AGE] year old, was admitted to the facility on [DATE]. Resident #115's diagnoses included but were not limited to: Respiratory Failure with hypoxia, Acute Respiratory Failure with Hypercapnia, Pneumonia, Hypertension, Atrial Fibrillation, Diabetes, Gout, Anemia and Sleep apnea. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 1/30/19. Resident # 115 was coded with a Brief Interview of Mental Status score of 14 out of 15, indicating no cognitive impairment. Resident # 115 required extensive assistance of one to two staff persons with activities of daily living except for eating. Resident # 115 required supervision and set up only for eating. On 2/20/19 at 11:42 a.m., Resident #115 was in his room sitting in a wheelchair in front of the overbed table and watching television. Resident # 115 had oxygen via nasal cannula infusing at 3 liters per minute. On 2/20/2019 at 11:48 a.m., Licensed Practical Nurse (LPN) F was observed passing medications to Resident # 115. LPN F was observed putting the medication in the nebulizer and applying the mask. LPN F then left the room and went next door to another resident (Resident # 43) stating she was going to give more medications to Resident # 43. On 2/20/2019 at 11:57 a.m., LPN F returned to Resident # 115's room and removed the nebulizer. On 2/20/2019 at 3:45 p.m., an interview was conducted with Resident # 115 who stated the nurses often leave while the nebulizer treatment is being administered. Review of the Physicians orders revealed documentation of an order for Albuterol inhale contents of 1 vial via nebulizer every four hours while awake. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed no assessment for self administration of medications. On 2/22/2019 at 12:15 p.m., LPN D was observed administering a nebulizer treatment to Resident # 131. LPN D was observed standing in the doorway of Resident # 115's room during the administration of the nebulizer. Review of directions of how to administer a nebulizer treatment revealed: - Put the mouthpiece in your mouth between your teeth and close your lips around it. - Hold the nebulizer in an upright position. This prevents spilling and promotes nebulization. - Assure deep breathing throughout the treatment. - Occasionally tapping the side of the nebulizer helps the solution drop to where it can be misted. On 2/25/2019 at 3:05 p.m., an interview was conducted with LPN D who was asked how nebulizer treatments should be administered. LPN D stated that nurse should put the medication in the nebulizer and apply the mask. LPN D stated the nurses were expected to remain with the residents while administering nebulizer treatments. During the end of day debriefing on 2/25/19, the Administrator, Director of Nursing (DON) and Corporate Nurse were informed that for Resident # 115, the nebulizer and mask were applied by the nurse and the nurse left the bedside. Resident # 115 finished the nebulizer treatment without supervision. When asked if it was okay that LPN F left Resident # 115 while the nebulizer treatment was being administered, the DON stated no. When asked if Resident #115 had been assessed to self administer medications, the DON stated no. The DON and Corporate Nurse stated the expectation was that nurses should remain with residents until the nebulizer treatments were completed and should complete an assessment for self administration of medications to determine if clinically appropriate and safe for residents to self-administer medications. No further information was provided. 41449 2. For Resident #510, the facility staff failed to provide supervision and oversight of medication administration during a nebulizer treatment and failed to assess the resident to determine if self administration of medication was clinically appropriate and safe. Resident #510, is a [AGE] year old male, was admitted to the facility on [DATE]. His diagnosis included but were not limited to: chronic pulmonary edema, Muscle weakness, Difficulty in walking, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit, hear failure, type 2 diabetes, sepsis, morbid obesity, hypertension, atherosclerotic heart disease, acute respiratory failure with hypoxia, disorder of kidney and ureter and shortness of breath. Resident #510 did not have a complete MDS (minimum data set) (an assessment tool), due to being a new admission. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/19 at 11:43 am, during an initial observation of Resident #510 he was observed sitting in his room with a nebulizer mask on with the nebulizer machine running. No staff were present in his room or in visual line of sight of the resident. A review of physician's orders dated 2/9/19 and signed on 2/11/19 showed there was no order for self administration of medications. A physician's order dated 2/18/19 for the Duoneb gives no instruction for self administration of medication. A record review conducted on 2/21/19 showed there was no documentation of an assessment of Resident #510 to determine that he was assessed for self administration of medication. During a staff interview with Employee B on 2/25/19, Employee B stated if he is self administering medications he should have an assessment but I don't see one either. A facility record review of the Self-Administration of Medications Policy Statement reads, residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The facility Administrator and Director of Nursing were informed of the findings on 2/25/19. No further information was provided. 3. For Resident #76 the facility staff failed to provide supervision and oversight of topical medication and failed to assess the resident to determine if self administration of medication is clinically appropriate and safe. Resident #76, is a [AGE] year old female, was initially admitted to the facility on [DATE] with a recent readmission on 1/14/18. Her diagnosis include Chronic obstructive pulmonary disease, phantom limb syndrome with pain, diabetes mellitus, conversion disorder with seizures or convulsions, anxiety disorder, major depressive disorder, urinary tract infection, gastro-esophageal reflux disease, pain in right leg, difficulty walking, other symptoms and signs involving the musculoskeletal system, candidiasis, cellulitis of right lower limb, pain in right hip, pain in right knee, pain in right shoulder, hypotension, overactive bladder, pure hypercholesterolemia, anemia insomnia, hypertension, peripheral vascular disease, acquired absence of left leg below knee. Resident #76's most recent MDS with an ARD (assessment reference date) of 12/20/18 was coded as a quarterly assessment. Resident #76 was coded as having a BIMS (Brief Interview for Memory Status) score of 15 indicating no cognitive impairment. She was also coded as requiring supervision with her activities of daily living except coded as requiring limited assistance of one staff member for dressing. On 2/21/19 at 04:31 PM, Resident #76 was observed to have on her overbed table two small cups with a cream in one and a powder in the other. When asked, the resident stated the powder is nystatin and I don't know the name of the cream, but the nurses bring it to me several times a day to put on my rash. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician's order sheets for 2/1/19-2/28/19, signed by the MD on 2/11/19 showed no order for self administration of medications. The orders read nystatin cream apply topically to affected area twice daily as needed for 360 days. A physician's order dated 2/5/19 read, nystatin powder under bilat (bilateral) breaks & abd (abdominal) folds TID (three times per day) x 14 days. A physician order dated 2/11/19 read, Ketoconazole cream 2% apply to bilateral groin & abd folds BID (twice a day) x 10 days. A facility record review of the Self-Administration of Medications Policy Statement read, residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The facility Administrator and Director of Nursing were informed of the findings on 2/25/19. No further information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27662 Based on observation, resident and staff interview, facility documentation and clinical record review, the facility failed to, for one resident (Resident #78), in a survey sample of 59 residents, to allow the resident to choose his own preferred activities. Resident #78 stated the facility would not let him go outside in his wheel chair. The findings included: Resident #78, was admitted to the facility on [DATE] and was readmitted on [DATE]. Diagnoses included; stroke, anxiety, history of small bowel obstruction and hypothyroidism. Resident #78's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-8-19 was coded as a significant change in status assessment. Resident #78 was coded as having no memory deficits, did not refuse care, and was able to make own daily life decisions. The Resident was also coded as needing extensive assistance of one to staff members to perform his activities of daily living, except for independent locomotion, both on and off the units. On 2/20/19 at 1:23 PM an interview was conducted with Resident #78. He stated, I am unable to go across the street. The resident stated he had an electric wheel chair and stated, It's like imprisonment. On 2/22/19 at 12:42 PM, Resident #78's was observed in his room. Resident #78 stated, Have you found out if I can go outside yet? Review of the resident's care plan revised 1-17-19 read as follows: Enjoys activities such as watching TV and movies in room, visiting friends in center and calling Bingo. He travels independently throughout the facility in his electric wheel chair and also in the community. He has signed a safety waiver. The goal was . riding out in wheelchair as he desires and weather permits. One of the interventions for this care plan was, Resident to check out red flag for wheel chair when leaving building and to return red flag when he returns. On 2/22/19 at approximately 1:00 PM, the Administrator stated, I don't know why he can't go out, I know residents have to be assessed for safety outside.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility documentation review, clinical record review, hospital record review, and in the course of a complaint investigation, the facility staff failed to implement their abuse/neglect policies for 1 Resident (Resident #210) in a survey sample of 59 residents. The facility failed to verify if disciplinary action in effect against professional license before hire for 6 of 25 employees and failed to provide training/orientation programs that include topics such as abuse prevention for 6 of 7 employees. 1. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days. 2a. The facility failed to verify if disciplinary action in effect against professional license before hire for six employees. 2b. CNA B, CNA I, CNA K, CNA M, CNA N, and CNA P were found to have abuse training and other training on dates that they didn't work or were coded as having more inservice hours than they actually worked on the day of the inservice. The finding included: 1. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days. Resident #210 was admitted to the hospital on 11-16-18, and discharged to the facility on [DATE]. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on [DATE] included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression. Review of the nursing and physician progress notes revealed that upon admission to the facility on [DATE], the admission nursing assessment documented that the Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. This document reveals a significant change in all areas for this Resident from the facility admission assessment, and the discharge documents from the hospital on 11-19-18. The Resident was on a Regular, with thin liquids, diet. The facility policy for abuse/neglect was reviewed and revealed the facility Abuse policy read, Our Residents have the right to be free from abuse, neglect Investigate and report allegations within the federally required time frames. Neglect is defined as the failure of the facility, it's employees or service providers to provide goods and services to a Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The Administrator was interviewed on 2-22-18, and information was requested regarding the allegation of neglect submitted to her on 11-22-18 by the responsible (RP) party for this Resident. The RP filed a written grievance with the Administrator on that day documenting plainly that the facility had neglected the Resident. The Administrator submitted copies of the forms and grievance document for review. The documents revealed that the Administrator stated she answered all of the RP's questions, and documented on the grievance form Reportable to state agency NO, no identified areas of neglect during this complaint. The initial report, nor the 5 day follow up report, were ever submitted to the state agency by the facility, as per regulation. Found in those documents was a statement written by the Director of Nursing as a Witness statement quoting the nurse (NP) practitioner on 12-4-18 (7 days after the Resident was discharged , and 12 days after the allegation of neglect), which was part of the facility investigation, and documented the following; RP complained of patient not eating and declining, not as active as she was on admission. DON (Director of Nursing) called NP - NP stated she was en route and wanted to see the patient before she gave order to send out. Approximately 5-10 minutes later NP in building gave order to send patient to ER (emergency room) due to family request. Patient with no signs of pain/distress. Patient not as verbal as usual. Patient was sent to ER. On 2-25-19 at 11:30 a.m., a follow-up interview was conducted with the Administrator, regarding the omission in reporting the allegation of neglect that was made on 11-22-18. She stated, Allegations of abuse/neglect are expected to be reported immediately, within 24 hours. On 2-25-19 the Administrator and the Director of Nursing were informed that they failed to report to the state agency an allegation of neglect, and the investigation was ongoing for at least 12 days after the allegation of neglect was initiated. No additional information was submitted. 41449 2a. The facility failed to verify if disciplinary action in effect against professional license before hire for six employees. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to verify if disciplinary action in effect against professional license before hire for 6 of 25 employees, (employees LPN K and CNA O, CNA P, CNA Q, LPN L, LPN N). During employee record review on 2/25/19 no license verification prior to hire could be found for (employees LPN K and CNA O, CNA P and CNA Q.) LPN L was hired 5/9/17 and her license was verified 2/17/17 which is greater than 60 days prior to hire. LPN N's hire date was 8/7/18 and her license verification was completed on 10/30/17. 2b. CNA B, CNA I, CNA K, CNA M, CNA N, and CNA P were found to have abuse training and other training on dates that they didn't work or were coded as having more inservice hours than they actually worked on the day of the inservice. Employee CNA I whose hire date is 2/20/18 was recorded on individual employee education record as attending 7 hours of orientation training on 2/21/18 which included abuse/neglect/rights and payroll records indicate CNA I worked 5.75 orientation hours on 2/21/18. CNA B whose hire date was 12/18/18 was recorded on the individual employee education record as attending 8 hours of education/orientation training on 12/18/18 which included abuse/neglect/rights and review of facility payroll records indicate CNA B had no hours for the date of 12/18/18. CNA K with a hire date of 11/30/18 was recorded on the individual employee education record as attending 12 hours of education/orientation on 11/30/18 and review of facility payroll records indicate CNA K worked 4.75 hours of orientation time on 11/30/18. CNA M was recorded on the individual employee education record as attending 12 hours of training to include abuse/neglect/rights on 10/17/18, review of payroll records indicate CNA M worked 7.75 hours that day. CNA N was recorded on the individual employee education record as attending 3 hours of training on 8/9/18 and 2 hours on 8/10/18 which included abuse/neglect/rights and review of payroll records for CNA N she didn't have any hours on 8/9/18 or 8/10/18. CNA P was recorded on the individual employee education record as attending 6 hours of training on 3/12/18 and 6 hours which included training on abuse/neglect/rights on 3/13/18. Review of employee payroll records for CNA P she had no hours on 3/12/18 and worked 4 hours on 3/13/18. On 2/25/19 15:23 interview with RN D about the training records and hours recorded, she stated these hours on here are wrong then, I can not verify when these people did it. When asked about the signature on the forms as to who signed off that the training was complete RN D stated that is my signature. Facility record review of Abuse Prevention Program policy reads: As part of the resident abuse prevention, the administration will: 2. conduct employee background checks and will not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law; have had a finding entered into the state nurse aide registry concerns abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. 4. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. The Administrator and DON were made aware of the findings on 2/25/19. No further information was provided.

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Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40452 Based on staff interview, clinical record review, and facility documentation, the facility staff failed to report to the state agency allegations of abuse or neglect for two residents (Resident #72, #210) in a sample size of 59 residents. 1. For Resident #72, the facility staff failed to report resident-to-resident altercation to the state agency. 2. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days. The findings include: 1. For Resident #72, the facility staff failed to report resident-to-resident altercation to the state agency. Resident #72, a [AGE] year old female, had an initial admitted [DATE]. Diagnoses included but not limited to cerebrovascular disease, cerebral infarction, hemiplegia, depression, anxiety, schizophrenia, and schizoaffective disorder. A diagnosis of dementia (with an onset date of 10/30/2018) was added to the facility list of diagnoses in the medical record on 02/22/2019 during the survey process. Resident #72's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/03/2019 was coded as an annual assessment. Resident #72's Brief Interview for Mental Status (BIMS) was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Functional status for eating was coded as requiring limited assistance from staff. Functional status for dressing, toileting, and personal hygiene were coded as requiring extensive assistance from staff. Wandering presence was coded as behavior not exhibited and wandering impact was not coded. Excerpts of SBAR (Situation, background, appearance, review) note dated on 01/07/2019 at 1 p.m. documented, Change in condition noted related to reported today that Resident entered another residence room and when she was asked to leave she hit the resident. Patient does not have a possible or active infection. Physical aggression noted. MD was notified on 01/07/2019 at 1:15 PM. A complaint grievance report dated 1-7-2019 was presented by Administration. Under the section describe concern in detail, it was handwritten that the daughter of another resident was told by her mother that another pt (patient) [Resident #72] came into her- stated going through roommate's belongings and when she asked her (illegible) pt (patient) [Resident #72] hit her in the back and she hit resident #72 back (in the back). Under the section Findings of the investigation it was documented, DON met with (other resident) - stated Resident #72 pointed her out in the hallway and stated pt (patient) [Resident #72] came into me - hit her and she hit her back. Pt (patient)[Resident #72] then left with no problems (stated pt (patient) [Resident #72] was messing with roommate's clothing). Resident #72 could not remember the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/22/2019 at 9:15 AM, an interview with RN A was conducted. When asked about behaviors for Resident #72, she stated Resident #72 has crying episodes, she can be verbally aggressive, and she can have loud outbursts. When asked about interventions in place when behaviors arise, RN A stated we leave her alone until she calms down and redirect. RN A stated Resident #72 also wanders; she goes from room to room every now and then entering other resident's rooms and, at times, using their bathroom. When asked if Resident #72 had ever hit another resident, RN A stated if I recall, she hit a resident recently. When asked about triggers for Resident #72, RN A stated she was not aware of triggers for Resident #72. On 02/25/19 at 11:45 AM, the Administrator was asked if the resident-to-resident altercation was reported to the state agency. She stated that if both residents have dementia and no injuries we don't have to report. On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings and they offered no further documentation or information. 31199 2. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days. Resident #210 was admitted to the hospital on 11-16-18, and discharged to the facility on [DATE]. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on [DATE] included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression. Review of the nursing and physician progress notes revealed that upon admission to the facility on [DATE], the admission nursing assessment documented that the Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay. Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. This document reveals a significant change in all areas for this Resident from the facility admission assessment, and the discharge documents from the hospital on 11-19-18. The Resident was on a Regular, with thin liquids, diet. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for abuse/neglect was reviewed and revealed the facility Abuse policy read, Our Residents have the right to be free from abuse, neglect Investigate and report allegations within the federally required time frames. Neglect is defined as the failure of the facility, it's employees or service providers to provide goods and services to a Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The Administrator was interviewed on 2-22-18, and information was requested regarding the allegation of neglect submitted to her on 11-22-18 by the responsible (RP) party for this Resident. The RP filed a written grievance with the Administrator on that day documenting plainly that the facility had neglected the Resident. The Administrator submitted copies of the forms and grievance document for review. The documents revealed that the Administrator stated she answered all of the RP's questions, and documented on the grievance form Reportable to state agency NO, no identified areas of neglect during this complaint. The initial report, nor the 5 day follow up report, were ever submitted to the state agency by the facility, as per regulation. Found in those documents was a statement written by the Director of Nursing as a Witness statement quoting the nurse (NP) practitioner on 12-4-18 (7 days after the Resident was discharged , and 12 days after the allegation of neglect), which was part of the facility investigation, and documented the following; RP complained of patient not eating and declining, not as active as she was on admission. DON (Director of Nursing) called NP - NP stated she was en route and wanted to see the patient before she gave order to send out. Approximately 5-10 minutes later NP in building gave order to send patient to ER (emergency room) due to family request. Patient with no signs of pain/distress. Patient not as verbal as usual. Patient was sent to ER. On 2-25-19 at 11:30 a.m., a follow-up interview was conducted with the Administrator, regarding the omission in reporting the allegation of neglect that was made on 11-22-18. She stated, Allegations of abuse/neglect are expected to be reported immediately, within 24 hours. On 2-25-19 the Administrator and the Director of Nursing were informed that they failed to report to the state agency an allegation of neglect, and the investigation was ongoing for at least 12 days after the allegation of neglect was initiated. No additional information was submitted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident Assessment Instrument) for one Resident (Resident #210) in a survey sample of 59 Residents. For Resident #210, the facility staff failed to accurately code her falls prior to admission in Section J-B, and weight loss in Section K-0300. The findings included: Resident #210 was admitted to the hospital after a fall at home. Hospital admission occurred on 11-16-18, and she was discharged to the nursing facility on 11-19-18. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on [DATE] included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression. Review of the nursing and physician progress notes revealed that upon admission to the facility on [DATE], the admission nursing assessment documented that the Resident was oriented to person, place, and time. The Resident was continent of bowel and bladder. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay. Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. This document reveals a significant change in all areas for this Resident from the facility admission assessment, and the discharge documents from the hospital on 11-19-18. The Resident was on a Regular, with thin liquids, diet. The Resident's weight records were reviewed from the hospital and facility, and revealed an unexpected and undesired significant weight loss. Those weights follow below. Hospital discharge on 11-19-18 (173.63 pounds) Facility admission on 11-19-18 (172.4 pounds) Discharge from facility on 11-26-18 (151.6 pounds) indicating a loss of 20 pounds in 1 week. No falls prior to admission were coded, and no significant weight loss was coded. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS was completed on 12-1-18, 5 days after the discharge of the Resident. The administrator, and DON (director of nursing),were informed of the failure of the staff to accurately code falls, and weights on 2-25-19, no further information was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on staff interview, facility documentation and clinical record review and in the course of a complaint investigation the facility failed ensure they had (Pre Admission Screening And Resident Review) PASARR screening prior to admission for 2 Residents (#69 & #212) in a survey sample of 59 Residents. 1. For Resident #212 the facility failed to ensure Resident had PASARR Screening prior to admission. 2. For Resident #69 the facility failed to ensure the Resident had PASARR Screening prior to admission. The findings include: 1. For Resident #212 the facility failed to ensure Resident had PASARR Screening prior to admission. Resident #212 an [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to(End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia. Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on [DATE] and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment. On [DATE] during the course of an investigation involving Resident #212 the entire closed record was requested. The DON met with this surveyor and stated I have the entire closed record but I do not have the PASARR apparently it was not done prior to admission, and unfortunately she has expired as you know so we cannot do one now. On [DATE] during end of day conference PASARR was discussed with the Administrator and no further information was provided. 2. For Resident #69 the facility failed to ensure the Resident had PASARR Screening prior to admission. Resident #69 an [AGE] year old Resident admitted to the facility on [DATE] with diagnoses of but not limited to (Chronic Obstructive Pulmonary Disease) COPD, delusional disorder, insomnia, vertigo, anemia, Dementia without behavioral disturbance. On [DATE] during a clinical record review, the surveyor requested several documents for Resident #69. The DON stated she was having trouble locating the PASARR but submitted the other documents that were asked for The DON stated she would continue to look for the PASARR documentation. On [DATE] at end of day briefing PASARR documents were requested for several Residents to be given to surveyors by [DATE]. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] in an interview with the DON, the DON stated she did not have PASARR Level I Screening from admission for Resident #69. The DON submitted a PASARR Level I dated [DATE]. She stated she was aware the CMS was still going to Tag us for not having the PASARR but we could do it now to avoid future tags. The PASARR was discussed during end of day conference on [DATE] and no further information was given.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, staff interview, clinical record review and facility documentation the facility failed to review and revise care plans for 2 Residents (#212 and #69) in a sample size of 59 residents. 1. For Resident # 212 the facility failed to develop and implement a care plan that addressed the behaviors of pulling at dialysis port and uncapping dialysis ports. 2. For Resident #69 the facility did not update care plan to add Resident is on thickened liquids and only family may give water / thin liquids. The finding include: 1. For Resident # 212 the facility failed to develop and implement a care plan that addressed the behaviors of pulling at dialysis port and uncapping dialysis ports. Resident #212 an [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to (End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia. Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on [DATE] and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment. On [DATE] during clinical record review and it was discovered that the care plan for Resident #212 did not specifically address the behavior of pulling at dialysis port or uncapping dialysis port. The care plan for this Resident on page 16 reads: FOCUS: Resistive / non-compliant with treatment / care pulling at dialysis port while at dialysis/LTCF removing oxygen related to cognitive impairment and anxiety. (Dated [DATE] no revision until [DATE] after resident expired) INTERVENTIONS: Allow for flexibility in ADL routine to accommodate mood preferences and customary routine Ask physician to explain the need for treatment Elicit family input for best compliance Provide education about Risks of not complying with therapeutic regimen (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide non care related conversation proactively before attempting ADL's Psych consult as needed. (Dated [DATE] no revision until [DATE] after resident expired) On page 23 of the care plan the following was entered on [DATE]: FOCUS: At risk for behavior symptoms related to Dementia with psychosis. Resident has a history of pulling at port, Scratches self. INTERVENTIONS: Administer medication per physician order Attempt psychotropic drug reduction per physician order Observe for mental status/behavioral changes when new medication is started or with change in dosage Psych referral as needed Use consistent approaches when giving care Wander guard bracelet (canceled on [DATE]) On [DATE] at 5:00 pm, an interview with the DON was conducted. The DON she stated she was not in the facility when the Resident was there. The DON was asked what the expectation was for nurses and CNA's for a Cognitively Impaired Resident with a known history of pulling at her dialysis port. She stated she wound expect frequent rounding, a bandage might cause her to pick at it more. When asked what is frequent, the DON stated every 2 hours, On [DATE] at 5:10 pm an interview was conducted with the Administrator. The Administrator stated that they do not have any other cognitively impaired residents that pulls at the dialysis port. She stated she was aware the staff made rounds every two hours at minimum. On [DATE] at 5:30 pm, an interview was conducted with RN A. When asked what the facility did about the Resident pulling at the dialysis port, RN A stated we used to wrap it in gauze. When asked if it was a deterrent to the Resident RN A stated Not really it slowed her down but didn't really stop her from doing it. When asked was this in the Residents care plan, RN A stated she didn't know. When shown the care plan, RN A stated that it was not in the care plan. On [DATE] the Administrator and DON were made aware that the care plans were not updated to include the taping or the dressing the facility placed on the dialysis port when she returned from the dialysis center. The care plans were also not updated to include any other interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided. 2. For Resident #69 the facility did not update care plan to add Resident is on thickened liquids and ONLY family may give water / thin liquids. Resident #69 an [AGE] year old Resident admitted to the facility on [DATE] with diagnoses of but not limited to (Chronic Obstructive Pulmonary Disease) COPD, delusional disorder, dysphagia, insomnia, vertigo, anemia, Dementia without behavioral disturbance. On [DATE] during initial tour, this Resident was observed drinking thickened liquids with her lunch. On [DATE], a clinical record review was being conducted. The review showed the (Physicians Order Sheet) POS for January and February 2019 stated: FAMILY ONLY TO PROVIDE WATER-THIN LIQUIDS, STAFF TO PROVIDE NECTAR THICKENED LIQUIDS AS ORDERED Resident #69's care plan states: FOCUS: Potential for nutrition/fluid imbalance d/t medication side effects with disease process of Parkinson's, HLD, Basal Cell CA of Skin, CHF, and dysphagia. INTERVENTIONS: Critical care Active QD ([DATE]) No weights as ordered ([DATE]) ST to evaluate and treat as indicated FEES TEST ordered ([DATE]) Magic Cup BID [twice a day] ([DATE]) Administer medications as ordered ([DATE]) Administer vitamin/mineral supplements as ordered ([DATE]) Fortified Foods ([DATE]) Honor Food Preferences ([DATE]) Notify physician and responsible party of significant weight changes) ([DATE]) Obtain labs as ordered and notify physician of results ([DATE]) Provide diet as ordered (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regular- Thin, No Straws ([DATE]) On [DATE], the DON was asked why the Resident's care plan stated Regular -Thin No Straws but the Physicians Orders Stated that only family may give her water-thin liquids. The DON responded that the Resident's (Responsible Party) RP had spoken to the doctor and been informed by the doctor of the risks of giving her thin liquids, they accepted that responsibility and the doctor wrote the order so that the staff knew that they could only use thickened liquids and the family could give thin liquids. The DON further stated you can see the Regular-Thin No straws was initiated [DATE] and must not have been updated to include the order for family not to give Nectar consistency thickened liquids. On [DATE] the Administrator was made aware no further information was provided.

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	495115	A. Building B. Wing	02/25/2019

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Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, resident interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of practice for medication and treatment administration for 4 Residents (Residents #49, #115, #510, and #211) in a survey sample of 59 Residents. 1. For Resident #49, the facility staff failed to ensure medications were documented as having been administered. 2. For Resident # 115, the facility staff failed to remain with the resident during administration of nebulizer treatments. 3. For Resident #510, the facility staff failed to obtain an Arterial Brachial Index (ABI), and to clarify the frequency of dosing for prednisone medication, which were ordered by a physician. 4. For Resident #211, the facility staff failed to obtain a physician's order for treatment of a skin tear. The findings included; 1. Resident #49 was initially admitted to the facility 5-8-18, and readmitted after a hospitalization on [DATE]. Diagnoses included; anxiety, diabetes, anemia, urinary retention, hypertension, congestive heart failure, asthma, heart surgery, encephalopathy, glaucoma, bacteremia, pressure ulcer, and gout. Resident #49's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12-18-18 was coded as a full significant change assessment. The Resident was coded with a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #49 was coded as needing extensive assistance of one staff member to perform activities of daily living. On 2-20-19 during initial tour of the facility an interview was conducted with the Resident. At that time she was asked if she had any concerns that she would like to discuss. Resident #49 stated that she was satisfied with her care at the facility, but, Every once in a while they (nursing staff) will have a problem with my medications. When asked if she received her medications as ordered by the physician, Resident #49 said, not every time. Review of Resident #49's clinical record and MARs (Medication Administration Records) revealed no documentation that the following medications were administered on the days and times indicated: Eliquis 2.5 milligrams (mg) 1 tablet by mouth twice per day at 9:00 a.m., and 6:00 p.m. omitted 2-7-19, and 2-10-19 at 6PM. Insulin Lantus (units) u-100 subcutaneous 40 units every night at 9:00 p.m. omitted 2-10-19. Lasix 40 mg twice per day at 9:00 a.m., and 6:00 p.m. omitted 2-6-19 at 6:00 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dialysis site access checks every shift, (11p.m., to 7 a.m. shift omitted 2-9-19, and 2-11-19), and (3 p.m. to 11 p.m. shift omitted 2-10-19). Dialysis site capped and clamped checks every shift, 11 p.m. to 7 a.m. omitted 2-11-19), and (3 p.m. to 11 p. m. shift omitted 2-10-19, 2-17-19, and 2-20-19), and (7 a.m. to 3 p.m. shift 2-8-19). Valid physician's orders were evident for the medications and assessments not documented as having been administered. On 2-22-19 at approximately 1:00 p.m., the director of nursing (DON) was asked about the medications and assessments that were not documented as having been administered. The DON said if they are not documented they are not done. The facility policy entitled General Guidelines for the Administration of Medications read; Procedure #3 The nurse observes the 5 rights in administering each medication. #10 The nurse records the administration in the medication administration record. The administrator and DON were informed of the failure of the staff to document the above mentioned medications as having been administered, during the end of day debrief on 2-22-19. 34894 2. For Resident # 115, the facility staff failed to remain with the resident during administration of nebulizer treatments. Resident # 115 nebulizer and mask were applied by the nurse and the nurse left the bedside. Resident # 115 finished the nebulizer treatment without supervision. Resident #115, a [AGE] year old, was admitted to the facility on [DATE]. Resident #115's diagnoses included but were not limited to: Respiratory Failure with hypoxia, Acute Respiratory Failure with Hypercapnia, Pneumonia, Hypertension, Atrial Fibrillation, Diabetes, Gout, Anemia and Sleep apnea. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 1/30/19. Resident # 115 was coded with a Brief Interview of Mental Status score of 14 out of 15, indicating no cognitive impairment. Resident # 115 required extensive assistance of one to two staff persons with activities of daily living except for eating. Resident # 115 required supervision and set up only for eating. On 2/20/19 at 11:42 a.m., Resident #115 was in his room sitting in a wheelchair in front of the overbed table and watching television. Resident # 115 had oxygen via nasal cannula infusing at 3 liters per minute. On 2/20/2019 at 11:48 a.m., Licensed Practical Nurse (LPN) F was observed passing medications to Resident # 115. LPN F was observed putting the medication in the nebulizer and applying the mask. LPN F then left the room and went next door to another resident (Resident # 43) stating she was going to give more medications to Resident # 43. On 2/20/2019 at 11:57 a.m., LPN F returned to Resident # 115's room and removed the nebulizer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/2019 at 3:45 p.m., an interview was conducted with Resident # 115 who stated the nurses often leave while the nebulizer treatment is being administered. Review of the Physicians orders revealed documentation of an order for Albuterol inhale contents of 1 vial via nebulizer every four hours while awake. On 2/22/2019 at 12:15 p.m., LPN D was observed administering a nebulizer treatment to Resident # 131. LPN D was observed standing in the doorway of Resident # 115's room during the administration of the nebulizer. Review of directions of how to administer a nebulizer treatment revealed: - Put the mouthpiece in your mouth between your teeth and close your lips around it. - Hold the nebulizer in an upright position. This prevents spilling and promotes nebulization. - Assure deep breathing throughout the treatment. - Occasionally tapping the side of the nebulizer helps the solution drop to where it can be misted. The facility cited [NAME] as the resource used for professional nursing standards. Guidance was given from [NAME], Fundamentals of Nursing, which reads: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation On 2/25/2019 at 3:05 p.m., an interview was conducted with LPN D who was asked how nebulizer treatments should be administered. LPN D stated that nurse should put the medication in the nebulizer and apply the mask. LPN D stated the nurses were expected to remain with the residents while administering nebulizer treatments. During the end of day debriefing on 2/25/19, the Administrator, Director of Nursing (DON) and Corporate Nurse were informed of the failure of the staff to provide supervision of medication administration during a nebulizer treatment. When asked if it was okay that LPN F left Resident # 115 while the nebulizer treatment was being administered, the DON stated no. The DON and Corporate Nurse stated the facility's expectation was consistent with the professional nursing standard that nurses should remain with residents until the nebulizer treatments were completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided. 41449 3. For Resident #510 the facility staff failed to obtain an arterial brachial index (ABI), and to clarify the frequency of dosing for prednisone medication, which were ordered by a physician. Resident #510, is a [AGE] year old male, was admitted to the facility on [DATE]. His diagnosis included but were not limited to: chronic pulmonary edema, Muscle weakness, Difficulty in walking, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit, hear failure, type 2 diabetes, sepsis, morbid obesity, hypertension, atherosclerotic heart disease, acute respiratory failure with hypoxia, disorder of kidney and ureter and shortness of breath. Resident #510 did not have a complete MDS (minimum data set) (an assessment tool) due to being a new admission. On 2/21/19 physician orders for resident #510 were reviewed and revealed an order for an ABI and arterial Doppler to bilateral lower extremities r/t (related to) wound on 2/13/19. Review of other clinical documents revealed that on 2/14/19 a mobile x-ray company performed the Doppler study and noted ABI was not possible due to lower extremity too large for the BP cuff to fit. Review of nursing notes provided no documentation that the physician was notified the order was unable to be carried out. On 2/21/19 physician orders for Resident #510 were reviewed and revealed an order on 2/18/19 that reads Prednisone 40mg x 5 day dx: SOB (shortness of breath). There was no route or frequency noted in this order. Review of additional orders and nurses notes show no contact with the physician to clarify the order as to how the resident is to receive the medication or how often per day. Review of the Medication record for Feb. 2019 showed the order was written as Prednisone 40mg po (by mouth) daily x 5 days. There was no physician order to indicate the resident is to receive the medication once daily as the medication administration record shows the resident was receiving. Review of the facility's policy entitled Medication Orders included: Recording Orders 1. Medication orders- when recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. Review of the facility's policy entitled: Physician Orders: Obtaining and Transcribing included: Medication orders should include the following information in the text of the order: name of medication, strength, dosage, route frequency, parameters pertaining to administration i.e. blood pressures; blood sugars, etc., diagnosis/reason for administration, stop dates should be included as indicated and for: antibiotics, medrol pak, tapered drugs. The facility stated they utilized [NAME] as their professional nursing standard. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guidance for nursing standards for the administration of medication is provided by [NAME], Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. Medications and treatments are given in accordance with physician's orders. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. The facility Administrator and Director of Nursing were notified of the findings on 2/25/19. No further information was provided. 40452 4. For Resident #211, the facility staff failed to obtain a physician's order to assess, treat, and monitor a skin tear on her upper left arm. Resident #211 was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses for Resident #211 included but are not limited to coronary artery disease, hypertension, gastroesophageal reflux, diabetes, stroke, hemiparesis/hemiplegia, and Alzheimer's disease. Resident #211's most recent quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/17/2018 coded Resident #211 Brief Interview of Mental Status (BIMS) as 15 out of possible 15 indicative of no cognitive impairment. Functional status was coded as requiring extensive assistance from staff for transferring, dressing, toileting, and personal hygiene. A closed record review was conducted. Nurse's notes ranging from 06/02/2018 through 07/31/2018 were reviewed. A nurse's note dated 6/5/2018 at 7:51 PM documented, Resident has new order; site was cleaned with normal saline skin approximated steristrips and kling applied. Site red/pink with scant blood 3cm x 3cm to upper left arm. Resident has new order for Geri-sleeves to wear as tolerated, to both upper extremities r/t (related to) skin tear caused by resident hitting arm on wheelchair arm rest. R/P (responsible party) aware. There were no further entries in the nurse's notes pertaining to assessment or treatment of the skin tear on Resident #211's upper left arm. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The skin assessment documentation ranging from 06/04/2018 through 07/31/2018 was reviewed. There were no entries addressing assessment or treatment of the skin tear to Resident #211's left upper arm. The SBAR (situation, background, appearance, review) documentation dated 06/05/2018 was reviewed. Under Situation, it was documented, Writer noted skin tear to left upper arm 3cm x 3cm, scant blood noted to site, clean, skin approximated, steri strips applied. resident hit her arm on armrest of wheelchair. Under Review, it was documented physician was notified on 06/05/2018 at 5:05 PM. Under Ordered Tests and Interventions, there were none. The provider notes ranging from 06/04/2018 through 07/31/2018 were reviewed. Excerpts of an entry by the nurse practitioner dated 6/7/2018 at 9:45 AM documented, I was asked to see patient for a skin tear to her left arm. no recent injury noted did not recall hitting it on anything. patients skin is thin and likely to have skin tears easily. (sic) Small skin tear covered with steri strips, minimal bleeding but over all looks fine Assessment/plan: skin tear: keep it clean and covered Excerpts of an entry dated 06/08/2018 at 9:24 AM documented, follow up on recent skin tear to her left arm, wound is healing appropriately. Patient denies any issues and no other skin tears noted. small skin tear covered with steri strips, bleeding has stopped assessment/plan: skin tear: keep it clean and covered An excerpt of an entry dated 06/20/2018 at 12:50 PM documented, small skin tear covered with steri strips, bleeding has stopped There were no further provider notes addressing the skin tear to Resident #211's upper left arm. Physician's orders ranging from 06/01/2018 through 07/31/2018. A telephone order dated 06/05/2018 at 5:10 PM documented, Resident to wear protective sleeves as tolerated to BUE (bilateral upper extremities) There were no orders addressing assessment or treatment of the skin tear on Resident #211's left upper arm on 06/05/2018 through 06/10/2018. Excerpts of a telephone order dated 06/11/2018 (no time included) documented, Continue: Monitor steri strips to (L) (left) (upper) arm qshift (every shift) until healed. Change film dsg (dressing) q 7 days (every 7 days) until healed. There are no further orders addressing the skin tear to Resident #211's upper left arm. The Treatment Administration Records ranging from 06/01/2018 through 07/31/2018 were reviewed. The treatment Monitor steri strips to left upper arm q shift until healed was signed as administered once on day shift on 06/06/2018 and every shift thereafter (three times a day) for the month of June 2018. For the month of July 2018, the treatment was signed off as administered on night shift (07/10, 07/11, 07/12, and 07/14), day shift (07/01, 07/12, 07/14, and 07/15), and evening shift (07/01, 07/05, 07/06, 07/07, 07/09-07/12, 07/14, and 07/15). In the column beyond 07/15/2018, it was documented, D/C (discontinued) 07/15/2018 healed, five weeks after the steri-strips had been applied. The facility policy for skin tears was reviewed. Under the section, Steps in the Procedure an excerpt of item #16. Documented, Cleanse the wound with ordered cleanser. An excerpt of item #18. Documented, Apply the ordered dressing and secure with tape or bordered dressing per order. The care plan was reviewed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A focus initiated on 06/05/2018 documented, Actual skin breakdown related to left upper arm skin tear. It had one intervention: Administer treatment per physician's orders. On 02/25/2019 at 11:10 AM, the DON was asked about the nursing practice expectations when a resident gets a skin tear. She stated an SBAR (situation, background, appearance, review/notify) should be completed and the nurse should obtain doctor's orders. When asked what reference guides their professional standards, the DON stated [NAME]. The physician's orders pertaining to the skin tear on Resident #211's left upper arm were requested. On 02/25/2019 at 11:50 AM, the DON stated, I don't have any orders associated with Resident #211's skin tear to the left upper arm. In summary, there were no physician's orders for assessment or treatment plan of skin tear on Resident #211's left upper arm. There was no subsequent monitoring, assessment, or documentation of wound appearance by the nursing staff. According to Lippincott Manual of Nursing Practice, 10th Edition, 2014, departures from standards in nursing care include, failure to assess the patient properly or in a timely fashion, follow physician's orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record (Nettina, 2014, p. 1169). On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings. They confirmed they do not have standing orders addressing skin tears. They offered no further information or documentation.

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F 0684 Level of Harm - 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** 41449 Based on staff interview, facility documentation review, clinical record review, hospital record review, and in the course of a complaint investigation, the facility staff failed to ensure the highest practicable well being for 4 Residents (Residents #76, #78, #260, and #210), resulting in harm for Resident #76 in a survey sample of 59 residents. 1. For Resident #76, the facility staff failed to provide care and treatment for a skin condition, resulting in increased depression and social isolation. This is harm. 2. Resident #78 had two episodes of impaction without timely treatment, resulting in nausea and vomiting and admissions to the hospital. 3. Resident #260 did not receive his antifungal for complaints of thrush timely. 4. The facility staff failed to assess and implement bowel protocol for Resident #210. The finding included: 1. For Resident #76, the facility staff failed to provide care and treatment for a skin condition, resulting in increased depression and social isolation. This is harm. Resident #76, a [AGE] year old female, was initially admitted to the facility on [DATE] with a recent readmission on 1/14/18. Her diagnosis include Chronic obstructive pulmonary disease, phantom limb syndrome with pain, diabetes mellitus, conversion disorder with seizures or convulsions, anxiety disorder, major depressive disorder, urinary tract infection, gastro-esophageal reflux disease, pain in right leg, difficulty walking, other symptoms and signs involving the musculoskeletal system, candidiasis, cellulitis of right lower limb, pain in right hip, pain in right knee, pain in right shoulder, hypotension, overactive bladder, pure hypercholesterolemia, anemia insomnia, hypertension, peripheral vascular disease, acquired absence of left leg below knee. Resident #76's most recent MDS with an ARD (assessment reference date) of 12/20/18 was coded as a quarterly assessment. Resident #76 was coded as having a BIMS (Brief Interview for Memory Status) score of 15 indicating no cognitive impairment. She was also coded as requiring supervision with her activities of daily living except coded as requiring limited assistance of one staff member for dressing. She is coded as being occasionally incontinent of bladder and frequently incontinent of bowel. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/21/19 at 4:31 PM, during interview with Resident #76, she was observed with two small cups on her over bed table. One with a cream and a powder in the other. When the resident was asked about it she stated the powder is nystatin and I don't know the name of the cream but the nurses bring it to me several times a day to put on my rash. Resident #76 stated, I have rashes due to my pull ups and I can't put any clothes on, it gets really red and bloody. They said there was nothing else they can do for me because the company doesn't make anything else due to the size. I've talked to [Employee H] but she said she can't find any other big ones. This has gone on for quite some time, Dr. has put me on antibiotics and some cream before. I'm getting depressed because I don't know what to do, do I stay in my room in my housecoat all the time? Resident #76 has not been assessed, nor found to be safe to self administer medications. On 2/22/19 at 10:03am, during an interview with Resident #76, she stated I have tried underwear with the pad but I soak right through them. I can't live in my housecoat and gown all the time. I can't go in a gown with no pants on. I feel isolation and depressed, I loved to go to activities and now I can't. [Employee H] tells me there is nothing else. A record review on 2/22/19 revealed Resident #76 is on Oxybutynin tab 5mg 1 tablet by mouth twice daily for overactive bladder. She is also on bethanechol tab 25 mg 2 tablets (50mg) by mouth twice daily for urinary frequency. Her MDS with an ARD of 12/20/18 was coded that she needs supervision, set-up help only with toileting. It was also coded that she is occasionally incontinent of bladder and frequently incontinent of bowel. Nursing Notes dated 12/20/18 state resident offered briefs and mesh liners. Resident is able to use bathroom for toileting but chooses not to. During an observation of Resident #76's groin by another surveyor on 2/22/19 at 10:07am with LPN A present, the surveyor stated; it is bleeding with red open weeping areas, and looks like moisture, it doesn't look like yeast, LPN A stated yeah, it's moisture. LPN A asked the resident what kind of soap are you using? Resident #76 states she went 2 weeks without wearing clothes and it got better. LPN A stated this has been a concern of hers, she has voiced her concern about her briefs, they have been trying to see if the company has anything else. Employee H talked to me two weeks ago or about a month ago. She has talked to the Nurse Practitioner. On 2/22/19 at 10:19am during interview with Employee H, she stated I've talked to her several times and have offered the best solution, she has the largest pullup the manufacturer offers. I have offered mesh underwear with pads but she doesn't want to do that, says she tried it in the past and it didn't work. She said they are too tight in the leg area and I told her we don't offer a different brand. When asked how long Resident #76 has been complaining, Employee H said its been going on for the last month but she spoke with me about it before about four months ago, I wish I could help her, I really do. When asked , if they had considered cloth options employee H said I would have to see, its not on my formulary, I may have to call and get them to add it. On 2/22/19 at 10:57am Employee H returned and stated I called my manufacturer and they don't offer it, my representative said they had never heard of them but she's not going to go for this. She told me it was too tight, not that it was breaking her out, she said it was rubbing her legs, today y'all are the first ones to tell me it was a rash. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of weekly skin assessment reports for Resident #76 showed her groin area was pink on 12/10/18. Weekly skin assessments dated 1/7/19, 1/21/19, and 1/28/19 noted treatment to groin area. The assessment dated [DATE] indicated there was redness with treatment. The 2/11/19 assessment indicated treatment to groin, and the 2/18/19 assessment indicated redness with treatment. A review of progress notes on 2/22/19 showed Resident #76 reported to the nurse practitioner on 12/19/18 that she had chronic groin discomfort. On 12/20/18, the resident reported to the Nurse Practitioner that her groin discomfort improved and the Nurse Practitioner wrote to continue with warm compresses and epson salt. There was no further evidence in the clinical record review that the warm compresses were being administered. On 1/3/19 nursing note read, patient does not have a possible or active infection. A note dated 1/8/19 read, patient does not have a possible or active infection. A review of Resident #76's treatment record dated 12/1/18-12/31/18 had the following orders to the groin: Nystatin Cream apply topically to affected area twice daily. However, this was not signed off as being completed on two occasions on 12/14, 12/21, 12/26, and 12/27. Epsom Salt Gra [sic] Topical soaks to bilateral groin and ABD (Abdominal) folds q (every) shift. This was started on 12/19/18. However, the treatment record showed this treatment was not provided on: 12/28, two omissions on 12/29, two omissions on 12/30, and 12/31. Clobetasol ointment 0.05% apply thin layer topically to affected area twice daily. However this was not signed off as being administered any for the month of Dec. Bacitracin Ointment 500/gm cleanse right side groin area with normal saline and apply bacitracin to affected area topically every shift. However, this was not signed off on 7a-3pm shift on 12/12, 12/13, 12/14, 12/17, 12/18, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/26, 12/27, 12/28, 12/31; and was not signed off as being administered on 3p-11p shift on 12/14, 12/23, 12/24, 12/27. 12/31; and was not signed off as being administered on 11p-7a shift on 12/12, 12/17. Review of Resident #76's treatment record dated 1/1/19-1/31/19 had the following orders to the groin: Nystatin Cream apply topically to affected area twice daily. However, this was not signed off as being completed on 1/28, 1/29, 1/30, 1/31. Epsom Salt Gra [sic] Topical soaks to bilateral groin and ABD (Abdominal) folds q (every) shift. However, the treatment record showed this treatment was not provided on: 1/1, 1/28, 1/29, 1/30, 1/31 . Bacitracin Ointment 500/gm cleanse right side groin area with normal saline and apply bacitracin to affected area topically every shift. However, this order was not administered on the following dates: 1/6, 1/9, 1/10, 1/11, 1/13, 1/14, 1/15, 1/25, two omissions on 1/28, 1/19, 1/30 and two omissions on 1/31. Review of Resident #76's treatment record dated 2/1/19-2/28/19 has the following orders to the groin: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Nystatin Cream apply topically to affected area twice daily. Epsom Salt Gra [sic] Topical soaks to bilateral groin and ABD (Abdominal) folds q (every) shift. The order was discontinued on 2/5/19. However, the treatment record indicates this treatment was not provided on: three omissions on 2/2, two omissions on 2/3, 2/4. Bacitracin Ointment 500/gm cleanse right side groin area with normal saline and apply bacitracin to affected area topically every shift. However, this order was not administered on 2/15, 2/20. Review a physician's order dated 2/5/19 read, diflucan 150mg po (by mouth) qd (every day) x 2 doses, nystatin powder under bilat (bilateral) breaks & abd (abdominal) folds TID (three times per day) x 14 days. Another physician order dated 2/11/19 read, Dry gauze to abdominal folds (BID) twice daily and prn (as needed) x 7 days; Ketoconazole cream 2% apply to bilateral groin & abd folds BID (twice a day) x 10 days. Although the Ketoconazole cream was ordered 2/11/19, it was not on the treatment record for February. During an interview with Resident #76 on 2/21/19 at 04:31 PM, it was observed on her overbed table two small cups with a cream in one and a powder in the other. When the resident was asked about it she stated the powder is nystatin and I don't know the name of the cream but the nurses bring it to me several times a day to put on my rash. She indicates that staff bring it to her for her to apply herself. A review of Resident #76's most recent MDS with an ARD of 12/20/18 which was a quarterly assessment indicated she scored 00 for mood interview indicating she has no sign or symptoms of depression. During resident interviews on 2/21/19, 2/22/19 and 2/25/19 she verbalized being depressed and became tearful, which she relates to the rash on her groin. On 02/25/19 at 11:45 AM, during follow up interview with resident in her room, Resident #76 was asked if anyone followed up with her about her incontinence supplies she says I haven't seen anyone. I don't know what they are going to do. The nurse practitioner is here and asked how I was doing, so I told her not good [RN A] kept asking about the soap I am using. Resident #76 became tearful and said I just want to wear clothes and be out there with everyone else. On 02/25/19 at 11:56 AM, an interview was conducted with Employee D, the Activity Director. When Employee D was asked about her activity participation she stated Resident #76 is very independent, likes Bingo, parties, crafts, goes on Lunch Bunch. Employee D further stated when Resident #76 attends group activities she wears regular clothes, sometimes shorts. Employee D acknowledged that her participation has decreased slightly, she told the assistant she doesn't feel well. A review of activity progress notes from 11/1/16-1/2/19 showed that she participates in at least 3 OOR (out of room) activities each week, was happy to resume activities and the socialization with others, attends activities of choice 5-7 times per week, Participates in activities of choice daily both in room and out of room, resident continues to participate in activities of choice both independently and OOR groups on a daily basis. The review of her activity attendance indicated the Resident #76 attended 22 group activities in December, attended 17 in January and has attended 9 from February 1st until 2/24/19. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The administrator and DON were made aware of the findings on 2/25/19. No further information was provided. 27662 2. Resident #78 had two episodes of impaction without timely treatment, resulting in nausea and vomiting and admissions to the hospital. Resident #78, was admitted to the facility on [DATE] and was readmitted on [DATE]. Diagnoses included; stroke, anxiety, history of small bowel obstruction and hypothyroidism. Resident #78's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-8-19 was coded as a significant change in status assessment. Resident #78 was coded as having no memory deficits, did not refuse care, and was able to make own daily life decisions. The Resident was also coded as needing extensive assistance of one to staff members to perform his activities of daily living, except for independent locomotion, both on and off the units. On 2/20/19 at 1:30 PM: An interview was conducted with Resident #78. He stated he had weight loss due to recent problems with intestines. Review of the resident's bowel movements (BM) from 9-20-18 to 9-23-18 (4 days), showed Resident #78 had no BM during this time. A laxative protocol was not initiated, usually consisting of milk of magnesia, dulcolax suppository, and then enemas. On 9-24-18, nurse's notes documented noted with nausea and vomiting three times that day. Senna 8.6 mg (milligrams) 1 tablet was ordered, which was not given. A KUB (x-ray of kidneys, ureters and bladder) revealed an early or incomplete small bowel obstruction, with small bowel maximum diameter measuring 4.5 cm (centimeters), minimal stool. Citrate of Magnesia was ordered the same day and was given. On 9-25-18 at the 6:33 AM, nurse's note recorded: Resident continues with nausea but no vomiting. Unable to hear bowel sounds times 4 quadrants. On 9-25-18 at 3:00 PM, the nurse's notes read: Monitoring continue (sic) related to bowel obstruction and nausea and vomiting resident has bowel sounds times 4 quads sluggish noted, nausea and vomiting times 2, clear liquid diet in place . alert and verbal denies abdominal pain states its tender there remains in bed. On 9-25-18 at 4:44 PM, the nurse's notes read: Resident continues nausea and vomiting noted, vomitus brown in color about 200 cc (cubic centimeters) without sediment. Nurse Practitioner (name) updated. New orders to send resident to emergency room , sent to ER at 5:30 PM. The resident was admitted to the hospital at 9:10 PM with a small bowel obstruction. Review of the hospital records for the admitted d 9-25-18 revealed the diagnosis was small bowel obstruction, vomiting. came to emergency room after having nausea vomiting and abdominal pain for the last 3 days, workups done in the ER shows small bowel obstruction. The history and physical notes, NG (nasal gastric tube) with low suction, patient has copious amount of bloody drainage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan dated 5-11-15 revealed: Potential for constipation related to decreased mobility and medications (antipsychotic). The goal was Will have a BM at least every 3 days. Interventions included: Enemas per physician order, record bowel movements and report abnormalities. Report signs and symptoms of constipation such as abdominal cramping, diarrhea, nausea and vomiting, no bowel movement for 3 days. On 12/25/18, review of the resident's BM from 12/25/18 to 12/28/18 (4 days), the BM record revealed no bowel movements during this time period. 12/29/18 nurse's notes documented: Writer unable to obtain urine specimen via straight (Catheter). During procedure resistance met. NP made aware, new orders to monitor output for 8 hours, if no results, send to ER. There was no documentation that the constipation was reported or treated. Documentation from 12/24-18 through 12-29-18 revealed the resident was refusing his Senna (laxative). There was no rationale provided why the resident was refusing this medication (nausea, vomiting, etc). 12/30/18 nurse's notes documented Clysis (intravenous fluids into the tissues). A KUB was ordered and showed a small bowel obstruction. The resident was readmitted to the hospital 12-31-18 for a small bowel obstruction. There was no documentation his constipation was recognized or treated until 12/30/18. Review of the hospital records for this admitted [DATE], the discharge diagnosis was acute urinary retention and small bowel obstruction. The final report read: Patient had a poor appetite last 4 days, abdominal swelling has gotten worse, is nauseated he threw up once as well. On 2/22/19 at 11:05 AM an interview with an LPN (licensed practical nurse) was conducted . She stated the resident had problems with his bowels and had been diagnosed with a bowel obstruction. She stated the bowel protocol as followed: We monitor BM's and if no BM for 3 days, we let the MD know and we can give prn laxatives. She went on to state there is a flow sheet that the unit manager checks every day to see who is flagging for no BM for three days. On 2/22/19 at 11:10 AM an interview with the unit manager a registered nurse about the BM monitoring was conducted. She stated it will flag on the dash board, and she would know who is flagging. She stated the system will flag due to no BM's for 3 days. On 2/22/19 at 11:44 AM Review of the policy for bowel protocol read as followed: Assessment and Recognition: As part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms. This should include a review of gastrointestinal problems during any recent hospitalization s, results of previous barium studies, endoscopies, etc. There was no laxative protocol for no BM for 3 days. On 2/25/19 at 3:10 PM The Administrator, DON (director of nursing) and corporate nurse were informed of the concerns. 3. Resident #260 did not receive his antifungal for complaints of thrush timely. On 2/20/19 at 2:26 PM: During the initial interview, the resident stated, I haven't gotten my swish/swallow for days. Resident stated he had thrush; he opened his mouth and the tongue has cracks on it. He stated it was making it hard for him to eat. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2-20/19 at 3:29 PM Review of the clinical record (SBAR- situation, background, assessment, review) dated 2-16-19 addressed: Change in condition noted to resident had complaints of certain areas in his mouth bothers him when he is eating anything . mouth has areas of redness and signs of irritation. No recommendations were obtained. On 2-18-19, there was a physician's order for Diflucan (treatment for thrush) and Nystatin swish and swallow four times daily. The swish and swallow was noted on the MAR (medication administration record) but had not been given. On the back of the MAR, it was noted the medication was not available for 6 doses. Later on 2-20-19 Resident #260 was observed at the nurse's station, asking for the swish and swallow. On 2-20-19 (No time on order) a physician's order for Clotrimazole (another treatment for thrush) twice daily for thrush. On 2-21-19 at approximately 9:15 AM, Resident #260 was observed receiving the Clotrimazole for treatment of his thrush. 31199 4. The facility staff failed to assess and implement bowel protocol for Resident #210. Resident #210 was admitted to the hospital on 11-16-18, and discharged to the facility on [DATE]. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on [DATE] included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression. Review of the nursing and physician progress notes revealed that upon admission to the facility on [DATE], the admission nursing assessment documented that the Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay. Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. The Resident was on a Regular, with thin liquids, diet. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Resident's weight records were reviewed from the hospital and facility, and revealed an unexpected and undesired significant weight loss. Those weights follow below. Hospital discharge on 11-19-18 (173.63 pounds) Facility admission on 11-19-18 (172.4 pounds) Discharge from facility on 11-26-18 (151.6 pounds) indicating a loss of 20 pounds in 1 week. Meal consumption records were reviewed and indicated that the Resident consumed the following; Breakfast - 50-75% every day including 11-26-18. Lunch - 50-75% 11-20-18 through 11-23-18, 25-50% on 11-24-18, nothing on 11-25-18, and 50-75% on 11-26-18. Dinner - 50-75% 11-20-18 through 11-23-18, nothing 11-24-18 through 11-26-18. Progress notes indicated that the Resident was unresponsive on 11-26-18 from 10:00 a.m., until discharge at 2:00 p.m., and could not have consumed any meals that day. The bedtime snack record also indicated no consumption for 11-21-18, 11-24-18, and 11-25-18. The Bladder and Bowel continence records indicated that the Resident became completely incontinent of bowel and bladder on 11-24-18. The record goes on to show that the Resident did not have any urine production on 11-24-18, and 11-25-18 on the 3p.m.-11p.m. shift, and on 11-25-18 on the 11p.m.-7a.m. shift. The bowel record documented that the Resident had a medium bowel movement every day shift from 1:00 p. m. to 3:00 p.m. with the exception of 11-23-18 when there was no bowel movement. No other shifts record any other bowel movements occurring at any other time or day the descriptions were exactly identical, and documented by the same individual every day during this stay. Further review of the nursing and physician progress notes revealed the following pertinent findings in chronological order; 11-19-18 - Admission - 3:30 p.m., Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. 11-20-18 - Resident continues to adjust well, no discomfort or distress noted, per nursing. 11-20-18 - The nurse practitioner was in to see the Resident that day and documented left flank and abdominal pain with movement or palpation, but improving, urinary tract infection resolving, alert and oriented to person and place, follows commands speaks little English, is Spanish speaking, and granddaughter (daughter) translates, no respiratory problems, no weight loss, and is tolerating diet without any issues. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11-20-18 - the social worker was in to see the Resident and documented that the granddaughter posted her phone number in the room so staff could call her as needed and use her as a translator. 11-21-18 - The doctor was in to see the Resident, and documented the Resident had no acute findings and would receive physical therapy for ambulation and stair climbing. 11-21-18 - Nursing notes document ambulating with assistance from staff and continent of bowel and bladder, and a new order was received to decrease pain medication from 1-2 tablets of 50 milligram tramadol every 6 hours as needed for pain, to one tablet 4 times per day on a routine schedule. 11-22-18 - Nursing notes indicate a change in condition due to 2 falls, occurring at approximately 4:00 a.m., and at 6:50 a.m. Resident with no new injuries noted, able to make her needs known, eating meals with no assistance needed. A left hip x-ray with KUB (kidneys/ureters/bladder) view was ordered and obtained. The result was normal with no problems. 11-23-18 - the nurse practitioner was in to see the Resident who has a cough and is producing mucus, and has indigestion. The nurse practitioner documented Prilosec for indigestion, and speech following. No speech therapy orders were ever received, and no speech therapy notes existed in the clinical record according to examination of the clinical record by surveyors, and a statement by the medical records staff member, there are none. 11-24-18 - The Resident has a productive cough/congestion, thick phlegm, wheezing, shortness of breath, abnormal lung sounds, and oxygen saturation perfusion is at 87% (dangerously low), oxygen is ordered via nasal cannula at 2 liters per minute for shortness of breath, Duoneb inhaled medicine via nebulizer is ordered to open airways, mucinex is ordered to relieve mucus and a chest x-ray is ordered to be performed STAT (immediately) at 1:00 p.m. The chest x-ray was completed and results obtained at 4:00 p.m. that day, which showed mild congestive heart failure. The physician ordered lasix 40 milligrams every day, on that day, however, the Resident did not receive it until the following day. The Lasix was in the building in the emergency box, and available to be given, when it was ordered. At 10:45 p.m. the doctor documented general weakness ongoing, and resident was worse. 11-25-18 - Change in condition, Resident eating less than 50% of meal in 24 hours, no diagnosis of heart failure, no respiratory issues noted, new order for daily weights, notify MD (doctor) of weight gain greater than 3 pounds per day or greater than 5 pounds per week. Mighty shake supplements were started, to be given with each meal, three times per day. The narcotic pain medication Tramadol was changed back again to one 50 milligram tablet every 6 hours as needed, from the 4 times per day routinely which was started on 11-21-18. 11-26-18 - The diet order was changed from regular to no added salt. No dietician evaluation was completed for this Resident until 11-26-18, at 1:14 p.m., just before discharge. The dietician note states not able to ascertain weight status because of refusals/omissions. However, the Resident had a weight obtained that morning at 6:47 a.m., and revealed weight loss. The note goes on to say average meal intake 50-75%. Meal consumption records indicated that the Resident consumed that at breakfast, however, at lunch the Resident consumed 25-50% on 11-24-18, and nothing on 11-25-18, and 11-26-18. At dinner nothing 11-24-18 through 11-26-18. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11-26-18 - The Social worker wrote at 10:35 a.m., that the Resident was non-responsive to questioning, and her eyes were closed. At 2:10 p.m., - nursing documented diagnosis of heart failure, compared to baseline the following was observed decreased level of consciousness, decreased mobility, needs more assistance with activities of daily living. 11-26-18 - The doctor wrote at 2:52 p.m., that the Responsible party was at bedside, poor appetite - ongoing, altered mental status, non-verbal, no command following, deficits noted, diminished lung sounds, send to ER (emergency room) for evaluation, on lasix x 3 days, however, she had only taken the 40 milligrams of lasix 2 days. The nursing home transfer form indicated the Resident was sent to the hospital at 3:00 p.m., on 11-26-18. Hospital records were reviewed for the admission on 11-26-18. The records revealed (The Resident) was a week ago walking and talking and now is bedridden and not talking/eating. Spanish speaking only, brought in due to unresponsiveness. Last meal Saturday (11-24-18) in the morning very small amount. admitted with hyperkalemia (high blood potassium) of 7, (normal is 3.5-5.0, a reading of 7 is considered severe hyperkalemia). Creatinine sodium and chloride were also high, and a Kayexalate enema was administered to bring the numbers down, twice, but with poor results as the Resident was so constipated. The Resident had an abdominal x-ray on admission which shows generalized impaction. After D50 (dextrose intravenous infusion) and insulin, (the Resident was not diabetic this was to decrease the high minerals in her blood) the Resident improved. The Resident was started on fluid resuscitation for dehydration from not consuming fluids, and began to have a good urinary output. Her abdomen was described as soft, tender, and distended, a frontal radiograph of her abdomen was obtained and stated No bowel obstruction (such as cancer etc), Large quantity of fecal material mainly in the ascending, transverse, and descending colon. The Resident's care plan was reviewed and revealed no dietary care plan until 11-27-18, after the Resident was discharged on [DATE], and no bowel care plan at all. There was an incontinence care plan which stated assist as needed with incontinence. The Resident was not incontinent on admission. The facility policy for Bowel disorders was reviewed and revealed That the staff and physician will identify risk factors related to bowel dysfunction such as recent antibiotic use, (diuretics, antidepressants) medications that may cause dysmotility (movement, narcotics), symptoms such as abdominal pain, presence of cramps or bloating, localized tenderness. The nurse shall assess/document/report signs of dehydration (such as) altered levels of consciousness, lethargy, dizziness, recent change in mental status, dry mucus membranes, decreased urine output. (failing to eat or drink). In summary, the Resident was administered opioid, diuretic, cardiac, prilosec, mucinex, and antibiotic medications on a routine basis. The Resident had become immobile, and stopped eating and drinking, and no dietary or bowel management programs had been instituted for this Resident. The Resident stopped eating and drinking on 11-24-18, lost significant weight, weakening the Resident, she became bowel impacted, and dehydrated causing the need for re-hospitalization , and treatment. On 2-25-19 the Administrator and the Director of Nursing were informed of the findings. No additional information was submitted.

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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** 27662 Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to, for one resident (Resident 143) in a survey sample of 59 residents, to ensure wound care was provided in a manner to prevent infection. The wound care nurse did not clean her hands between moving from the sacrum to the heel. The findings included: Resident #143, was admitted to the facility on [DATE] and was readmitted from the hospital on 12-6-18. Diagnoses included: dementia, weight loss, anemia, diabetes and high blood pressure. Resident #143's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-6-18 was coded as a significant change in status assessment. Resident #143 was coded as having severe memory deficits, and was unable to make own daily life decisions. The Resident was also coded as needing extensive to total assistance of one to staff members to perform activities of daily living, such as bed mobility and eating. On 2/21/19 at 10:41 AM Wound care observation was conducted by the wound care nurse. The tube feeding was off. The procedure was explained to the resident. Toilet room is now clean. Hand sanitizer used. Soiled clean area designated. Has pants on in bed, not pulled up. Has been medicated for pain. Brief saturated. Right buttock dressing off, area clean with granulation tissue. No drainage or odor. Has another small area, open, granulating. Cleansed areas with normal saline. The wound doctor is calling both areas MASD -moisture associated skin damage . Medihoney applied. After completing the sacral wound and the gloves were removed, the hands were not cleaned. The right boot was removed, hard eschar noted to entire heel . Painted with Betadine. The boot reapplied. The left boot was removed. No wounds evident. 02/21/19 01:04 PM Review of the clinical record revealed wounds were present on readmission from hospital 2-12-19. On 2/25/19 at 3:10 PM: The Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40452 Based on observations, staff interviews, clinical record review, and facility documentation, the facility staff failed to provide services to provide a left hand roll as ordered by physician to prevent reduction in range of motion for one resident (Resident #29) in a sample size of 59 residents. The findings include: Resident #29, an [AGE] year old female was admitted to the facility on [DATE]. Diagnoses include but not limited to cerebrovascular disease, Alzheimer's disease, aphasia, contracture left hand, and diabetes. Resident # 29's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/2018 was coded as an annual assessment. Resident # 29 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision-making were coded as severely impaired. Functional status for dressing and toileting were coded as requiring extensive assistance from staff. Functional status for eating and personal hygiene were coded as total dependence on staff. On 02/20/19 at 01:49 PM, Resident #29 was observed dressed and seated in a high back wheelchair. On 02/21/19 at 08:08 AM, Resident #29 was observed lying in bed with her covers pulled up to mid-chest level. Resident was awake and the TV was on. On 02/21/2019 at approximately 10:00 AM, the clinical record was reviewed. A current physician's order in the date range of 02/01/2019 through 02/28/2019 documented, Patient to wear left hand roll at all times except during ADLS (activities of daily living) as tolerated. A care plan intervention initiated on 06/01/2017 and revised on 01/11/2018 documented, Resting hand splint roll as tolerated (left hand contracture) under the focus entitled, ADL (activities of daily living) Self care deficit related to disease process (Dementia/Alzheimer) (sic), physical limitations s/p (status post) CVA (cerebral vascular accident) Refuses showers at times Another intervention initiated on 04/10/2018 (no revisions) under this same focus documented, Patient to wear wash cloth roll in left hand at all times except during ADLs as tolerated. On 02/21/19 at 12:50 PM, Resident #29 was observed lying in bed and the TV was on. A left hand roll was not visualized. On 02/22/19 at 12:40 PM, Resident #29 was observed sleeping in her bed. A left hand roll was not visualized. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/2019 at 2:15 PM, an interview with RN C, the MDS coordinator, was conducted. When asked about the restorative nursing plan for Resident #29, RN C looked for documentation regarding Resident #29 then stated she didn't see any documentation about a restorative program for Resident #29. When asked if Resident #29 had a contracture of left hand, she stated, Yes. When asked about the purpose of restorative nursing for Resident #29, she stated, To prevent further contractures. On 02/25/2019 at approximately 2:25 PM, RN A, RN C, and this surveyor entered Resident #29's room. Upon entrance into Resident #29's room, RN C looked at Resident #29 and stated that her legs are also contracted. Resident #29 did not have a left hand roll in place and her fingers were flexed consistent with contractures. Resident #29 winced as RN A gently extended left fingers. The left palm appeared clean with no open areas. When asked about padding for left hand, RN A stated they use a rolled washcloth in her left hand but she pulls it out. A washcloth was not seen in the bed and RN A stated she would go find a washcloth to place in Resident #29's left hand. On 02/25/2019 at approximately 3:30 PM, RN C presented a document entitled Restorative Nursing Program Monthly Review July 31, 2016. It contained a list of residents with individualized information regarding restorative care. For Resident #29, it was documented, Discontinue RNP (restorative nursing program) services due to non-compliance effective 07/18/16. The facility policy entitled 1.2 Restorative Range of Motion Program was reviewed. Under Process, it was documented, 1. A nursing evaluation will be done on all residents on admission, readmission, after a significant change in condition, annually, or as otherwise indicated. On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings and offered no further information or documentation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on staff interview, clinical record review, and facility documentation the facility failed to ensure Residents were free from accidents and hazards for 2 Residents (#212 and #72) in a survey sample of 59 Residents resulting in harm for Resident #212. 1. For Resident #212 the facility failed to adequately supervise and monitor closely for pulling at dialysis port resulting in Resident pulling off the caps of the port and subsequently bleeding out which resulted in death. This is harm. 2. For Resident #72, the facility staff failed to follow physician's orders for No straws associated with aspiration risk. Resident #72 was observed drinking water at bedside, unsupervised, through a straw. Also, the discharge diet recommendation from occupational therapy dated [DATE] included supervision. The findings include: 1. For Resident #212 the facility failed to adequately supervise and monitor closely for pulling at dialysis port resulting in Resident pulling off the caps of the port and subsequently bleeding out which resulted in death. This is harm. Resident #212 an [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to (End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia. Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on [DATE] and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment she was also coded under G 0110 as #3 Extensive Assistance- Resident involved in activity, staff provide wt. bearing support and Support was coded as #2 One person physical assist. On [DATE] a clinical record review was conducted. Resident #212's Care Plan showed the following: FOCUS: Resistive/noncompliant with treatment /care/pulling at dialysis port while at dialysis/LTCF, removing oxygen related to cognitive impairment and anxiety [initiated [DATE]]. (Dated [DATE] no revision until [DATE] after resident expired) INTERVENTIONS: Allow for flexibility in ADL routine to accommodate mood preferences and customary routine (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ask physician to explain the need for treatment Elicit family input for best compliance Provide education about Risks of not complying with therapeutic regimen Provide non care related conversation proactively before attempting ADL's Psych consult as needed. (Dated [DATE] no revision until [DATE] after resident expired) On page 23 of the care plan the following was entered on [DATE]: FOCUS: At risk for behavior symptoms related to Dementia with psychosis. Resident has a history of pulling at port, Scratches self. INTERVENTIONS: Administer medication per physician order Attempt psychotropic drug reduction per physician order Observe for mental status/behavioral changes when new medication is started or with change in dosage Psych referral as needed Use consistent approaches when giving care Wander guard bracelet (canceled on [DATE]) According to a progress note dated [DATE] @ 11:45 AM the Dialysis Center phoned the facility at 6:20 AM to inform them that Resident #212 was confused and pulled her bandage off. According to progress notes, a care plan meeting was held on [DATE] at 6:27 AM. The note stated the following departments were present. Social Services, Nursing Case Manager, and it stated the Patient Representative was invited but did not attend. The note goes on to say the topics discussed were Discharge Goal, Advanced Directives, Cognition/Orientation Mood and Behavior, Social Service needs, Medications and Treatments, Continence/ Elimination, Risk for skin breakdown, Communication, Pain management, Nutrition,, ADL function, Risk for Falls,/safety activities. The summary stated [Interdisciplinary Care Plan] IDCP team met to review plan of care. Care plans updated as needed. Team to remain available as needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] during clinical record review it was noted that no changes were made to the care plan on [DATE] as a result of the care plan meeting or thereafter. A progress notes dated [DATE] at 10:50 AM stated: Change in condition noted related to removing top from shunt port bleed out and remove scab from upper left leg above knee. This change in condition started on [DATE]. Since this started she has stayed the same. Other relevant information RP [Responsible Party] RP N states She has a History of doing this it's not the first time at home you walk in her bedroom and blood would be everywhere. According to note, the Nurse Practitioner was informed on [DATE] at 11:00 AM and gave orders only to clean and redress the right upper chest [port site] and dress (as needed) PRN. Also to clean area to knee and redress daily. The Behavioral Tracking Sheets for ,d+[DATE] code Resident and #7 Pulling enteral feeding tube she is coded as O (indicating number of times pulling at tube) every shift for entire month. For October and November the behavior tracking sheets do not list #7 pulling tubes as a behavior problem in spite of the incident on [DATE]. A progress notes on [DATE] at 05:30 am stated: Resident last rounded on at 4:05 AM. Dressing to dialysis port dry and intact. Resident acknowledged staff presence by opening eyes while site being checked. Progress note on [DATE] at 05:30 am stated: Change in condition noted related to Resident noted laying in a pool of blood at 0530 when phlebotomist entered to draw blood. Writer entered room noted resident 911 without respirations or pulse. This change in condition started on [DATE]. Since this started it has stayed the same. Other relevant information 911 called. According to Facility Reported Incident (FRI) dated [DATE] Resident #212 had a BIMS of 99 and requires minimal assistance with care. The FRI also stated: Upon investigation and based on the findings per family, dialysis center, and the staff at [Facility Name] the resident had a history of picking at dialysis site and removing dressing. [Resident name] removed her dialysis dressing and port caps causing her to bleed excessively. We do not feel evidence supports any other cause that contributed to this unfortunate event of [Resident Name]. On [DATE] at 5:00pm, an interview with the DON was conducted. The DON stated she was not in the facility when the Resident was there The DON was asked what the expectation for nurses and CNA's for a Cognitively Impaired Resident with a known history of pulling at her dialysis port. The DON stated she wound expect frequent rounding, a bandage might cause her to pick at it more. When asked what is frequent, the DON stated every 2 hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 5:10 pm an interview was conducted with the Administrator. The administrator stated that they do not have any other cognitively impaired residents that pull at the dialysis port. She stated she was aware the staff made routine rounds every two hours on all Residents. On [DATE] 520 pm, an interview was conducted with RN A. When asked what the facility did about the Resident pulling at the dialysis port, RN A stated, we used to wrap it in gauze and tape it. When asked if it was a deterrent to the Resident, RN A stated, Not really it slowed her down but didn't really stop her from doing it. When asked is resident education an appropriate intervention for a Resident with a BIMS of 99, RN A answered, no we could tell her but she wouldn't understand. On [DATE] the Administrator was made aware of the issue and no further information was provided. 40452 2. For Resident #72, the facility staff failed to follow physician's orders for No straws associated with aspiration risk. Resident #72 was observed drinking water at bedside, unsupervised, through a straw. Also, the discharge diet recommendation from occupational therapy dated [DATE] included supervision. Resident #72, a [AGE] year old female, had an initial admitted [DATE]. Diagnoses include cerebrovascular disease, cerebral infarction, hemiplegia, dysphagia (oropharyngeal phase), schizophrenia, schizoaffective disorder, and a history of pneumonitis due to inhalation of food and vomit. Resident #72's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] was coded as an annual assessment. Resident #72's Brief Interview for Mental Status (BIMS) was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Functional status for eating was coded as requiring limited assistance from staff. Functional status for dressing, toileting, and personal hygiene were coded as requiring extensive assistance from staff. On [DATE] at 8:13 AM, Resident #72 was observed seated in front of her tray table in her room. Her breakfast tray and water pitcher (with a straw inserted through the top of it) was on the tray table. A spoon was on the plate and the plate was empty except for some small bits of scrambled eggs and sausage. The milk carton was open and empty on the tray. The apple juice was unopened. Resident #72 was observed picking up her water pitcher and sipping water from it through the straw. There was no staff in the room. The tray card had Resident #72's name on it and under Texture, it was documented, Mech (mechanically) Altered (NDD2)(National Dysphagia Diet, Level 2) Bread Allowed. Under Special Diets, it was documented, HCC/CCHO (high calorie consistent carbohydrate). Under Adaptive Equipment, it was documented, No straws. On [DATE] at 8:32 AM, Resident #72 was observed sleeping in her bed, lying on her right side. She was wearing a pink shirt and covered with her blankets. The tray table had her water pitcher on it with a rigid plastic straw inserted through the top of the pitcher. On [DATE] at 8:35 AM, the physician's orders were reviewed. A current order with a range of [DATE] through [DATE] documented under Diets, Mech (mechanically) altered (NDD2), HCC/CCHO, thin (liquids), no straws. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:44 AM, CNA B was asked where she finds information about what Resident #72 needs for eating and she stated, The kardex. Looking at the Kardex together, we saw it was documented, No straws. When CNA B was asked why Resident #72 could not have straws, she stated, Because she could aspirate. On [DATE] at 9:40 AM, Resident #72 was observed sitting up in front of her tray table. There was bits of French toast and sausage left on the plate. The water pitcher with a straw was also on the tray and the end of the straw had a lipstick stain on the end. There was no staff in the room. An aide entered the room to take the tray away and placed the water pitcher (with the straw inserted through the top) in front of Resident #72. On [DATE] at 12:47 PM, RN A and this surveyor reviewed the current physician's diet order (including no straws) together. RN A and this surveyor then entered Resident #72's room. The water pitcher with a straw was on Resident #72's tray table. When asked about the water pitcher, RN A picked up the water pitcher and placed it back on the table and stated, She can have thin liquids. When asked about the straw, she stated, oh, the straw. RN A removed it from the water pitcher, and threw it in the trash. The speech therapy notes were reviewed. The resident was seen in [DATE] by speech therapy. The referral stated to see if the resident was on the least restrictive diet. At the time the resident was on mechanically altered diet. At the end of speech therapy that ranged from [DATE] to [DATE], the discharge plan dated [DATE] documented, Discharge planned for this patient. Recommendations discussed with patient and/or caregivers include Regular textured solids and thin liquids. Swallow strategies to include alternate solids/liquids and take small bites/sips. For speech therapy services with a range of [DATE] through [DATE], a speech therapy note dated [DATE] documented in the 'Reason for Referral' section, The LTC (long-term care) resident was recently hospitalized for UTI (urinary tract infection) at which time she was also treated for aspiration PNA (pneumonia). readmitted on mechanically altered diet and thin liquids. Skilled Speech Therapy evaluation is indicated to assess swallowing function and ensure patient is on safest and least restrictive diet. Under Prior hospitalization , the dates listed were [DATE] to [DATE]. In the 'Underlying Impairments' section, it was documented, MBS (modified barium swallow) completed inpatient on [DATE]: flash penetration of thin liquid trial by straw, no penetration/aspiration of other trials, thin, nectar, puree, or solid; Rec'd (recommended) mechanically altered diet with thin liquids and no straws. Limited natural dentition. A speech therapy note dated [DATE] documented under 'Discharge Plans & Instructions', Discharge planned for this patient. Recommendations discussed with patient and/or caregivers include NDD2 mechanically altered solids and thin liquids with supervision for carryover of compensatory swallow strategies. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at approximately 10:15 AM, an interview with Employee F, a speech therapist, was conducted. As Employee F looked at Resident #72's electronic medical record, she stated that Resident #72 was seen by speech therapy beginning [DATE] to evaluate if Resident #72 was on the least restrictive diet. Employee F stated that Resident #72 was on a mechanically altered diet at the time. Employee F stated that upon discharge from speech therapy services on [DATE], it was recommended that Resident #72 advance to a diet of regular textured solids and thin liquids. When asked about the physician's diet order that included no straws, Employee F stated that must be based on the recommendation from the results of the modified barium swallow when (Resident #72) was an inpatient. She also verified that the speech therapy diet recommendation on [DATE] was mechanically altered diet with supervision. The current physician's orders were reviewed. There was no order for diet with supervision. The care plan was reviewed. For the focus of Imbalanced nutrition and fluid imbalance, an intervention initiated on [DATE] and revised on [DATE] documented, Provide diet as ordered NDD2/bread allowed HCC/CCHO, thin, NO STRAWS. An intervention initiated on [DATE] documented, Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals. On [DATE] at approximately 6:30 PM, the Administrator and DON were notified of findings and offered no further information or documentation.

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F 0697 Level of Harm - Minimal harm or potential for 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** 40026 Based on Resident interview, staff interview, clinical record review and facility documentation the facility failed ensure adequate pain management for 1 Resident (Resident # 151) in a survey sample of 59 Residents. For Resident #151, the facility failed to address the pain she was experiencing in her mouth and face, in spite of her complaining to facility staff and her Psychiatric Nurse Practitioner (NP). The findings include: Resident #151 a [AGE] year old woman was admitted to the facility on [DATE] with diagnoses of but not limited to Asthenia (Muscle Weakness), Hypertension, Anemia, Dysphagia, Hypothyroidism, Trigeminal Neuralgia, and Dementia. The most recent (Minimum Data Set) MDS was a quarterly dated 2/1/19 and coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 6 indicating severe cognitive impairment. On 2/20/19 at 12:30 PM, during initial tour of the building an interview was conducted with Resident #151. Resident #151 stated, My teeth hurt and whatever they are giving me don't help. When asked if she had been to the dentist she stated No I haven't been to a dentist in years and that's just what I need to do. On 2/20/19 at 12:45 am, an interview was conducted with LPN F. LPN F stated that Resident # 151 complains about her teeth hurting but it's really not her teeth she gets treated with medication for Trigeminal Neuralgia. On 2/20/19 at 12:55 am, an interview was conducted with the Psychiatric Nurse Practitioner who stated Yes [Resident 151] is one of my patients, and in my opinion she is cognitively aware enough to report accurately that she is in pain and the location of the pain and if it is ongoing. A clinical record review was then initiated and it was found that the Resident has a history of Trigeminal Neuralgia, (A condition which affects the trigeminal facial nerve, is very painful and causes mouth, jaw, ear and facial pain) A Psychiatric Evaluation dated 11/29/18 read, She reports having no conflict with staff or other residents. Patient was also concerned with trigeminal neuralgia symptoms in her face. When asked to rate her pain patient was not able to cognitively perform this and was only able to provide a concrete response such as BAD. A Psychiatric Evaluation dated 1/24/19 stated, Today patient reports having some dysphoria in the context of facial pain. She states having periodic sadness and anxiety however this is basically linked to her facial pain complaints. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #151's care plan was reviewed. The care plan stated Resident #151 was at risk for pain due to Trigeminal Neuralgia. However in spite of repeated complaints of pain the Resident was not taken to a dentist to rule out dental pain. Or to the Neurologist to follow up on Trigeminal Neuralgia pain. The review of the Medication Administration Record shows Resident #151 has an order for (AS NEEDED) PRN Tylenol and PRN Diclofenac (anti-inflammatory) that was administered only 2 times in the month of January and not at all in February in spite of the complaints of pain. Pain monitoring sheet was coded with all 0 indicating no pain even on the 2 days she received the PRN medication. On 2/21/19 it was requested from facility, any consults Resident #151 has had with a Dentist or Neurologist. On 2/22/19 it was requested again from DON any consults Resident #151 has had with a Dentist or Neurologist. On 2/25/19 an interview was conducted with the DON. The DON stated I have looked myself and there are no Dental or Neurology consults that I can find in the chart or in the computer system. When asked if she was aware the Resident was having mouth pain, the DON stated, well she does take medication for her Trigeminal Neuralgia. When asked how she could be sure it was the Trigeminal Neuralgia or a Toothache, the DON stated she could not be sure. When asked if Resident #151 had a routine dental check in the past year, the DON stated that she had not. When asked if she has had a follow up for her Trigeminal Neuralgia in the past year, the DON stated no. On 2/25/19 at the end of day conference, the Administrator was made aware and no further information was 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41449 Based on staff interview and facility documentation the facility failed to ensure staff have the appropriate competencies and skills sets for 6 of 7 employees, (CNA's B, I, K, M, N AND P). CNA B, CNA I, CNA K, CNA M, CNA N, and CNA P were found to have abuse training and other training on dates that they didn't work or were coded as having more inservice hours than they actually worked on the day of the inservice. The findings include: Employee CNA I whose hire date is 2/20/18, was recorded on individual employee education record as attending 7 hours of orientation training on 2/21/18. Review of payroll records indicate CNA I worked 5.75 orientation hours on 2/21. There was no other non-computer based documented training for CNA I for the remainder of the 2018 calendar year other than on 2/20/18-2/21/18. CNA B whose hire date was 12/18/18, was recorded on the individual employee education record as attending 8 hours of education/orientation training on 12/18/18. Review of facility payroll records indicate CNA B had no hours for the date of 12/18/18. For CNA K the facility failed to provide education and training CNA K with a hire date of 11/30/18, was recorded on the individual employee education record as attending 12 hours of education/orientation on 11/30/18 and review of facility payroll records indicate CNA K worked 4.75 hours of orientation time on 11/30/18. CNA M whose hire date is 12/1/03, was recorded on the individual employee education record as attending 12 hours of training on 10/17/18, review of payroll records indicate CNA M worked 7.75 hours that day. She had one hour of training on 9/25/19 and 2 hours of training on 12/18/19. There was no other record of non-computer based training for the remainder of the year. CNA N whose hire date is 8/7/18, was recorded on the individual employee education record as attending 3 hours of training on 8/9/18 and 2 hours on 8/10/18. Review of payroll records for CNA N indicate no hours worked on 8/9/18 or 8/10/18. CNA P whose hire date is 3/12/18 was recorded on the individual employee education record as attending 6 hours of training on 3/12/18 and 6 hours which training on 3/13/18. Review of employee payroll records for CNA P indicate no hours worked on 3/12/18 and worked 4 hours on 3/13/18. Review of employee education attendance records indicate an inservice was provided on personal care with 6 employees in attendance. There was no information as to the content of the inservice, objectives, date presented, who presented, or the instructional method. Review of employee education attendance record indicates as inservice topic on Identification of changes in condition was held and 13 staff members attended. There was no information as to the content of the inservice, objectives, date presented, who presented, or the instructional method. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/19 15:23 interview with RN D about the training records and hours recorded she stated these hours on here are wrong then, I can not verify when these people did it. When asked about the signature on the forms as to who signed off that the training is complete RN D stated that is my signature. Review of the facility 2018 Annual Education Plan indicates online and offline training is to be held monthly on a continual basis. The Administrator and DON were made aware of the findings on 2/25/19. No further information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure medications were available for administration for one Resident (Resident # 131) in a survey sample of 59 residents. Resident #131 was readmitted to the facility from the hospital on 1/22/2019 for treatment of Infection of PEG (Percutaneous Endoscopic Gastrostomy) tube and Urosepsis. The potassium reducing medication, Kayexalate, was unavailable from the pharmacy on 2/22/2019. Another potassium reducing medication, Veltassa, was ordered. Veltassa was not available until 2/25/2019 until 3:30 PM. The findings included: Resident #131, an [AGE] year old, was admitted to the facility on [DATE] an readmitted on [DATE]. Diagnoses included but were not limited to: Urosepsis, Infection of PEG (Percutaneous Endoscopic Gastrostomy) tube, Fluid Retention, Hypertension, Diastolic Heart Failure, Diabetes, Chronic Renal Failure, Anemia, and Lymphocytosis. Resident # 131's most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/29/2019. The MDS coded Resident # 131 with a BIMS (Brief Interview for Mental Status) Score of 7 indicating severe cognitive impairment; Resident # 131 was coded as requiring extensive assistance of one staff member of Activities of Daily Living. Resident # 131 had an indwelling urinary catheter and was always incontinent of bowel. Review of the clinical record was conducted on 2/22/2019 and 2/25/2019. Review of the Nursing Progress Notes revealed documentation which included: On 2/22/2019 at 1600 (4:00 PM), Kayexalate 30 grams in PEG (Percutaneous Endoscopic Gastrostomy) one dose with BMP (Basic Metabolic Profile) on Monday. On 2/23/2019 at 14:25 (2:25 PM) N.O.(new order) D/C (discontinue) Kayexalate 30 g (grams) via peg. Start Veltassa 8.4 g (grams) via peg for 1 dose. may give when arrives RP (Responsible Party) aware. On 2/24/2019 14:56 (2:56 PM) New order: D/C BMP on Monday 2/25/19. May draw BMP on Tuesday 2/26/19. MD/RP aware On 2/24/2019 22:21 (10:21 PM) NP aware of Veltassa. Per NP (Nurse Practitioner) to give when arrive from pharmacy. RP aware. The 2/22/19 Kayexalate order was included on the February 2019 Medication Administration Record (MAR). The one time dose of Kayexalate was scheduled to start 2/23/19 at 2:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new order for Veltassa 8.4 g (grams) via PEG x 1 dose May give when arrives with an order date of 2/23/19 was included in Resident #131's orders. The new order was included on the February 2019 MAR. Review of the Laboratory values revealed Potassium levels (Normal range is 3.5-5.3) 2/14/19 Potassium= 5.6 (high) handwritten note: Noted 2/15/19 no new orders, MD/RP aware and initials 2/18/19 Potassium= 6.0 (high) handwritten note: Noted 2/19/20 (sic) no new orders, MD/RP aware and initials 2/21/19 Potassium= 5.6 (high) handwritten 2120 and initials On 2/25/2019 at 11:42 AM, Licensed Practical Nurse (LPN) F was overheard talking on the telephone to the Pharmacy. LPN F asked when the medication Veltassa would be delivered to the facility. LPN F stated the medication would come that day on the next delivery from the pharmacy. Review of the facility Emergency Box contents revealed the Medications Kayexalate and Veltassa were not included in the contents listed. On 2/25/19 at 3:30 p.m., LPN F was interviewed and asked if Resident # 131 had received the Veltassa dose yet. LPN F stated the pharmacy had just delivered the medication and it was going to be administered by the 3-11 nurse. LPN F stated that the pharmacy had been contacted over the weekend about the medication but it was not delivered until 2/25/19 and that the nurse practitioner was made aware of the delay. When asked if she knew why Resident #131's Veltassa was not delivered until 3:30 PM on 2/25/19, LPN F stated that she did not know why it had taken that long. On 2/25/2019 at 3:32 PM, the 3-11 nurse (LPN G) was observed at her medication cart. An interview was conducted with LPN G who stated she was preparing to administer the medication, Veltassa, right now. According to WEBMD, hyperkalemia (high potassium) is defined as if you have hyperkalemia, you have too much potassium in your blood. The body needs a delicate balance of potassium to help the heart and other muscles work properly. But too much potassium in your blood can lead to dangerous, and possibly deadly, changes in heart rhythm. Also stated Your body should maintain a specific amount of potassium in the blood, ranging from 3.6 to 5.2 millimoles per liter (mmol/L). accessed online at https://www.webmd.com/a-to-z-guides/hyperkalemia-causes-symptoms-treatments#1on 2/26/2019 On 2/25/19 at 4:32 p.m., the DON was asked why the original Kayexalate order was discontinued. The DON stated that the Kayexalate was not available from the Pharmacy. The doctor was notified and a new order was given. The medication order was changed to Veltassa 8.6 grams via the PEG tube for one dose on 2/23/2019. The medication,Veltassa, did not arrive from the pharmacy until 2/25/2019 at 3:30 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was reviewed with the DON that Resident #131 did not receive potassium reducing medication until 72 hours after the first medication, Kayexalate, was ordered and 48 hours after the order was changed to Veltassa. At the end of day meeting on 2/25/19, the Administrator, DON and Corporate Nurse were notified of the issue. All three stated it was not acceptable for the medication, Veltassa to be delivered over 48 hours after being ordered by the physician. No further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27662 Based on observation, resident interview, staff interview, facility documentation and clinical record review the facility failed to ensure Residents were free from unnecessary psychotropic medications for 3 Residents (#120, #25 and # 212) in a survey sample of 59 Residents. 1. Resident #120's antipsychotic medication (Risperdal) had no GDR (gradual dose reduction), excessive doses; Resident #120 had a diagnosis of dementia (no psychotic disorders). 2. Resident #25 has been on the same dosage of Zyprexa (antipsychotic) since 11-22-17 for mood disorder. She has a diagnosis of dementia with no behaviors warranting the use of an antipsychotic. 3. For Resident # 212 the facility failed to ensure Resident had proper diagnosis for administration of Zyprexa (anti-psychotic medication) and no gradual dose reduction attempted. The findings included: 1. Resident #120's antipsychotic medication (Risperdal) had no GDR (gradual dose reduction), excessive doses; Resident #120 had a diagnosis of dementia (no psychotic disorders). Resident #120 was admitted to the facility on [DATE]. Diagnoses included; dementia, psychosis, diabetes and high blood pressure. Resident #120's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-24-19 was coded as a quarterly assessment. Resident #120 was coded as having severe memory deficits, refused care 1-3 during the lookback period, wandered 4-6 days. The Resident was also coded as needing extensive assistance of one to staff members to perform activities of daily living, such as bed mobility and eating. No pressure wounds were documented. On 2/20/19 at 12:51 PM, Resident #120 was observed leaning over in wheel chair (w/c), her hand was almost on the floor. A CNA (certified nursing assistant) was attempting to get resident to reposition. TV on in room. The resident continued to lean. On 2/25/19 at 10:30 AM, Resident #120 was observed in her room, up in w/c. Leaning forward in w/c, almost doubled over. She did not respond to verbal commands. On 2/25/19 at 12:50 PM, Resident #120 was observed in her room. She continued to have severe leaning and her head resting on her bed. On 2/25/19 at 1:05 PM, An interview was conducted with LPN (licensed practical nurse-A). She stated the resident requires assistance with meals. She also stated she did not think the leaning was due to lethargy, but was caused by her dementia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/19 at 1:37 PM: Review of the nurse's notes in September 2018, Resident's had an SBAR (situation, background, assessment, review) done for lethargy. Seroquel and Ativan were discontinued. The resident continued on Risperdal 2 mg (milligrams) twice daily according to the physician's order sheet (signed by physician), However, the resident is actually receiving 4 mg every 12 hours since 7-29-18. Review of the resident's psychiatry notes, MD notes, medication administration records and orders since July, 2018 was conducted. In June, the resident had exhibited behaviors that were aggressive to staff and other residents. The following are the antipsychotic medications changes starting in July, 2018 to present. 7-1-18: Quarterly review of antipsychotic drug monitoring: Diagnosis- acute delirium psychosis. Seroquel changed from 50 mg to 25 mg twice daily. 7-4-18: Risperdal added at 1 mg every 12 hours x one week, then Risperdal 2 mg every 12 hours. 7-28-18: Risperdal (antipsychotic) increased to 4 mg every 12 hours. The resident was also taking Ativan 1 mg three times daily. 8-11-18: Depakote 250 mg twice daily for one week. The medications was stopped 8-21-18. Seroquel 25 mg twice daily, and Risperdal 4 mg every 12 hours continued. 9-17-18: Ativan as well as the Seroquel was discontinued. 9-20-18: The psychiatric NP (nurse practitioner) noted in his notes that the resident is currently taking Risperdal 2 mg every 12 hours and is doing well on this dose. However, the resident is actually on Risperdal 4 mg every 12 hours. 10-1-19 through current date the resident continues receiving Risperdal 4 mg twice daily. 12-27-18: Psychiatric NP notes document weight loss. Again, it was noted by NP the resident is on Risperdal 2 mg every 12 hours. However, the resident is actually on Risperdal 4 mg every 12 hours. 2-21-19: MD notes documented reducing meds in schizophrenia most likely to lead to deterioration and poor quality of life. However, the resident's diagnosis is dementia, not schizophrenia. Review of the care plan dated 12-12-18 revealed the following behaviors: Agitation, yelling/cursing, banging on bathroom, threatening to harm roommate, wandering, packs and unpacks belongings. Interventions included: Administer meds per order, attempt psychoactive medications per physician orders, room change, send to ER, encourage rest periods, hydration. Review of the care plan dated 12-12-18 regarding nutritional status and significant weight loss revealed there have been no new interventions since 10-4-18. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of [NAME] Nursing Drug Handbook, 2011, pages 984- 986 revealed the following information for Risperdal: Indications for use: management of manifestations of psychotic disorders (e.g. schizophrenia, bipolar disorder. There is a black box warning for elderly patients with dementia related psychosis, increased risk of mortality in elderly patients with dementia, mainly due to pneumonia, heart failure. Dosage in the elderly: initially 0.5 mg twice daily, may increase slowly at increments of no more than 0.5 mg twice a day. On 2/25/19 at 3:10 PM: The Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings. The corporate nurse stated, We identified we had an issue with psychotropic medications on the mock survey. 2. Resident #25 has been on the same dosage of Zyprexa (antipsychotic) since 11-22-17 for mood disorder. She has a diagnosis of dementia with no behaviors warranting the use of an antipsychotic. Resident #25 was admitted to the facility on [DATE]. Diagnoses included; dementia, psychosis, high blood pressure and anemia. Resident #25's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-6-18 was coded as a quarterly assessment. Resident #25 was coded as having severe memory deficits and no behaviors during the lookback period. The Resident was also coded as needing standby to extensive assistance of one staff member to perform activities of daily living, such as bed mobility and eating. On 2/25/19 at approximately 10:00 AM, Resident #25 was observed in the activity room. She stated, I am going to make these. On 2/25/19, review of the clinical record, psychiatry notes and medication administration records revealed the resident was currently taking Zyprexa for mood disorder of 2-5 milligrams (mg) at bedtime since 11-22-17. Review of the quarterly psychotropic drug review dated 12/20/18 read: Do not attempt to taper/reduce the dose of this drug for the reason: necessary to mange unexpected harmful behavior that cannot be managed without medications. This was signed by the physician. Review of the care plan dated 1-9-19 read: Mood/behavior: Resident has history of paranoid behavior which will result in agitation. She has history of refusing care/showers/to change her clothes. She has history of being suspicious of family. Update: Resident noted with increased confusion, pacing, and crying and difficult to redirect. Resident observed with extreme agitation, verbally and physically aggressive to staff. Review of the psychiatry notes dated 12-27-18 by the psychiatric nurse practitioner (NP) revealed no behavior issues. The NP wrote: Psychotropic medication dose reduction attempts will most likely cause psychiatric decompensation of patient and decrease psychiatric functioning. Review of psychiatry notes dated 4-5-18 revealed: Continue medication as prescribed, the patient is stable at current dose and /or needs more time to see beneficial effects. Dose reduction attempted and or reduction will cause decompensation of patient. No documentation of GDR in past was provided. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of [NAME] Nursing Drug Handbook, 2011, pages 853-855 revealed the following information for Zyprexa: Indications for use: management of manifestations of psychotic disorders (e.g. schizophrenia, bipolar disorder. There is a black box warning for elderly patients with dementia related psychosis, increased risk of mortality in elderly patients with dementia, mainly due to cerebrovascular effects. Rationale for Recommendation : The FDA has issued a BOXED WARNING for antipsychotics posing an increased risk of mortality in elderly individuals dementia related psychosis. Additionally the are associated with potentially serious adverse effects including movement disorders metabolic abnormalities and Orthostatic Hypotension. Older adults are at increases risk of harm from these medication. On 2/25/19 at 3:10 PM: The Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings. 40026 3. For Resident # 212 the facility failed to ensure Resident had proper diagnosis for administration of anti-psychotic medication and (gradual dose reduction) GDR was attempted. Resident #212 an [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to(End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia. Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on 10/19/18 and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment she was also coded under G0110 as #3 Extensive Assistance- Resident involved in activity, staff provide wt. bearing and support was coded as #2 One person physical assist. On 2/21/19 during a clinical record review, it was noted that according to the (Physicians Order Sheet) POS dated signed 9/1/19 the Resident had an order for Remeron 15 [Milligrams] MG by mouth at bedtime for Depression, and Zyprexa (an antipsychotic) 5 mg by mouth daily for Mood. A review of the Psychiatric Evaluations was conducted and it on 4/19/18 the report states: Chief Complaint - Depression History of Present Illness- Patient is an [AGE] year old Hispanic female currently being treated for dementia and depression and mood disorder. On 5/31/18 the Psychiatric Evaluation report states: Chief Complaint - Cognitive Impairment History of Present Illness- Patient is an [AGE] year old Hispanic female currently being treated for dementia and depression and mood disorder. Review of the Quarterly Antipsychotic Drug Monitoring Sheet dated 2/16/18 revealed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current Therapy and Dosage - Zyprexa 2.5 mg by mouth daily [Dosage is actually 5 mg. Daily two (2) 2.5 mg tabs] Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES Diagnosis / Behavior - MOOD D/O [Disorder] Side Effects - [None selected] Gradual Dose Reduction: A gradual dose reduction has been attempted - NO The date of last attempt [left blank] Dosage: Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO Findings: [Box checked]- Justification of anti-anxiety, antidepressant or hypnotic. Also dated 2/16/18- Quarterly Anti-Anxiety, Antidepressant and Hypnotic Monitoring Sheet: Current Therapy and Dosage - Remeron 15 mg by mouth at bedtime Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES Diagnosis / Behavior - Depression Side Effects -[None selected] Gradual Dose Reduction: A gradual dose reduction has been attempted - NO If a gradual dose reduction is medically contraindicated, the reason stated on the clinical record is: [left blank] Dosage: Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: [box checked]- Justification of anti-anxiety, antidepressant or hypnotic. Review of the Quarterly Antipsychotic Drug Monitoring Sheet dated 5/4/19 revealed: Current Therapy and Dosage Zyprexa 2.5 mg by mouth daily [Dosage is actually 5 mg. Daily two (2) 2.5 mg tabs] Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES Diagnosis / Behavior - MOOD D/O [Disorder] Side Effects - [None selected] Gradual Dose Reduction: A gradual dose reduction has been attempted - NO The date of last attempt [left blank] Dosage: Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO Findings: [Box checked]- Justification of anti-anxiety, antidepressant or hypnotic. Quarterly Anti-Anxiety, Antidepressant and Hypnotic Monitoring Sheet dated 5/4/19 Current Therapy and Dosage - Remeron 15 mg by mouth at bedtime Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES Diagnosis / Behavior - Depression Side Effects - [None selected] Gradual Dose Reduction: A gradual dose reduction has been attempted - NO (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If a gradual dose reduction is medically contraindicated, the reason stated on the clinical record is: [left blank] Dosage: Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO Findings: [Box checked]- Justification of anti-anxiety, antidepressant or hypnotic. The exact same answers were filled in for 7/20/18 and 10/19/18 The facility submitted Quarterly Psychotropic Drug Review all state the same answers Dated 2/16/18, 5/4/18, 7/20/19, and 10/19/18 Medication and dosage: Zyprexa 5 mg by mouth daily (mood d/o) Remeron 15 mg by mouth at bedtime (depression) Do not attempt to taper/reduce the dose of this drug for the reason: [Box checked] Previous reduction trials have been unsuccessful Review of clinical record could find no record of GDR trial. On 2/25/19 during end of day meeting Administration was made aware of findings and no further information was offered.

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Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on facility documentation review and clinical record review the facility staff failed to ensure residents are free of significant medication errors for 2 of 59 residents. 1. For resident # 510 the facility failed to provide insulin as per physician's orders on 4 occasions. 2. For Resident # 131, the facility staff failed to obtain medication prescribed to treat too much potassium in the body. The findings include: 1. Resident #510, a [AGE] year old male, was admitted to the facility on [DATE]. His diagnosis included but are not limited to: chronic pulmonary edema, Muscle weakness, Difficulty in walking, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit, heart failure, type 2 diabetes, sepsis, morbid obesity, hypertension, atherosclerotic heart disease, acute respiratory failure with hypoxia, disorder of kidney and ureter, and shortness of breath. Resident #510 did not have a complete MDS (minimum data set) (an assessment tool) due to being a new admission. Review of the resident's Diabetic Flow Sheet on 2/11/19 at 9pm showed resident #510 had a blood sugar level of 249 and no insulin was provided. Per the physician orders he should have received 6 units. On 2/13/19 at 4:30pm resident #510 had a blood sugar level of 288 and was given 15 units of insulin. He should have been administered 9 units of insulin. On 2/13/19 at 9pm resident #510 had a blood sugar of 200 and received 6 units of insulin. He should have been given 3 units of insulin. On 2/19/19 at 6:30am resident #510 had a blood sugar of 127 and received 3 units of insulin. He should not have received any insulin. On 2/21/19 review of resident #510's physician orders dated 2/9/19 and signed by the physician on 2/11/19 orders are as follows: accuchecks AC (before meals) & HS (bedtime), notify MD (medical doctor) if BS (Blood sugar)is less than 60 or greater than 400. The same orders also state: Humalog Insulin 100 units/ml injection solution per sliding scale: blood sugar reading of 151-200= 3 units of insulin to be given blood sugar reading of 201-250= 6 units of insulin to be given blood sugar reading of 251-300= 9 units of insulin to be given (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar reading of 301-350=12 units of insulin to be given blood sugar reading of 351-400= 15 units of insulin to be given blood sugar reading of 400 or greater= 18 units of insulin to be given and call MD The Administrator and Director of Nursing were informed on 2/25/19 of the failure of the staff to ensure the physician's orders for insulin were carried out as ordered. No further information was provided. 34894 2. For Resident # 131, the facility staff failed to obtain medication as ordered by a physician to treat too much potassium in the body. Resident #131, an [AGE] year old, was admitted to the facility on [DATE] an readmitted on [DATE]. Diagnoses included but were not limited to: Urosepsis, Infection of PEG (Percutaneous Endoscopic Gastrostomy) tube, Fluid Retention, Hypertension, Diastolic Heart Failure, Diabetes, Chronic Renal Failure, Anemia, and Lymphocytosis. Resident # 131's most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/29/2019. The MDS coded Resident # 131 with a BIMS (Brief Interview for Mental Status) Score of 7 indicating severe cognitive impairment; Resident # 131 was coded as requiring extensive assistance of one staff member of Activities of Daily Living. Resident # 131 had an indwelling urinary catheter and was always incontinent of bowel. Review of the clinical record was conducted on 2/22/2019 and 2/25/2019. Review of the Nursing Progress Notes revealed documentation which included: On 2/22/2019 at 1600 (4:00 PM), Kayexalate 30 grams in PEG (Percutaneous Endoscopic Gastrostomy) one dose with BMP (Basic Metabolic Profile) on Monday. On 2/23/2019 at 14:25 (2:25 PM) N.O.(new order) D/C (discontinue) Kayexalate 30 g (grams) via peg. Start Veltassa 8.4 g (grams) via peg for 1 dose. may give when arrives RP (Responsible Party) aware. On 2/24/2019 14:56 (2:56 PM) New order: D/C BMP on Monday 2/25/19. May draw BMP on Tuesday 2/26/19. MD/RP aware On 2/24/2019 22:21 (10:21 PM) NP aware of Veltassa. Per NP (Nurse Practitioner) to give when arrive from pharmacy. RP aware. The 2/22/19 Kayexalate order was included on the February 2019 Medication Administration Record (MAR). The one time dose of Kayexalate was scheduled to start 2/23/19 at 2:00 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new order for Veltassa 8.4 g (grams) via PEG x 1 dose May give when arrives with an order date of 2/23/19 was included in Resident #131's orders. The new order was included on the February 2019 MAR. Review of the Laboratory values revealed Potassium levels: (Normal range is 3.5-5.3) 2/14/19 Potassium= 5.6 (high) handwritten note: Noted 2/15/19 no new orders, MD/RP aware and initials 2/18/19 Potassium= 6.0 (high) handwritten note: Noted 2/19/20 (sic) no new orders, MD/RP aware and initials 2/21/19 Potassium= 5.6 (high) handwritten 2120 and initials On 2/25/2019 at 11:42 AM, Licensed Practical Nurse (LPN) F was overheard talking on the telephone to the Pharmacy. LPN F asked when the medication Veltassa would be delivered to the facility. LPN F stated the medication would come that day on the next delivery from the pharmacy. Review of the facility Emergency Box contents revealed the Medications Kayexalate and Veltassa were not included in the contents listed. On 2/25/19 at 3:30 p.m., LPN F was interviewed and asked if Resident # 131 had received the Veltassa dose yet. LPN F stated the pharmacy had just delivered the medication and it was going to be administered by the 3-11 nurse. LPN F stated that the pharmacy had been contacted over the weekend about the medication but it was not delivered until 2/25/19 and that the nurse practitioner was made aware of the delay. When asked if she knew why Resident #131's Veltassa was not delivered until 3:30 PM on 2/25/19, LPN F stated that she did not know why it had taken that long. On 2/25/2019 at 3:32 PM, the 3-11 nurse (LPN G) was observed at her medication cart. An interview was conducted with LPN G who stated she was preparing to administer the medication, Veltassa, right now. According to WEBMD, hyperkalemia (high potassium) is defined as if you have hyperkalemia, you have too much potassium in your blood. The body needs a delicate balance of potassium to help the heart and other muscles work properly. But too much potassium in your blood can lead to dangerous, and possibly deadly, changes in heart rhythm. Also stated Your body should maintain a specific amount of potassium in the blood, ranging from 3.6 to 5.2 millimoles per liter (mmol/L). accessed online at https://www.webmd.com/a-to-z-guides/hyperkalemia-causes-symptoms-treatments#1on 2/26/2019 On 2/25/19 at 4:32 p.m., the DON was asked why the original Kayexalate order was discontinued. The DON stated that the Kayexalate was not available from the Pharmacy. The doctor was notified and a new order was given. The medication order was changed to Veltassa 8.6 grams via the PEG tube for one dose on 2/23/2019. The medication,Veltassa, did not arrive from the pharmacy until 2/25/2019 at 3:30 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was reviewed with the DON that Resident #131 did not receive potassium reducing medication until 72 hours after the first medication, Kayexalate, was ordered and 48 hours after the order was changed to Veltassa. At the end of day meeting on 2/25/19, the Administrator, DON and Corporate Nurse were notified of the issue. All three stated it was not acceptable for the potassium reducing medication, Veltassa, to be delivered over 48 hours after being ordered by the physician. No further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, staff interview, and facility documentation review, the facility staff failed to lock and secure two medication carts on one of three nursing units. 1. The facility staff failed to secure medications, in a locked compartment, on unit 1 nursing station medication and ensure only authorized personnel have access. 2. LPN A failed to lock and secure her assigned hall medication cart, on unit 1, during the course of medication administration. The findings included: 1. The facility staff failed to secure medications, in a locked compartment, on unit 1 nursing station medication and ensure only authorized personnel have access. On 4/10/19 at 10:58am a medication cart at the 100 wing nursing station was observed to be unlocked. The cart was approximately 4 feet tall, 2 feet deep and 3 feet wide, with multiple drawers that held blister packs of 30 days worth of medication in each blister pack. Blister packs were filed by dividers for each of 30 residents residing on a hallway. Observation of the cart revealed hundreds of medications, insulin syringes, alcohol prep pads, and other supplies such as bandages in the cart and accessible to anyone walking by. During observation of the unsecured cart 13 residents, 14 visitors and 21 staff were observed to walk by the cart. The cart was unsecured from 10:58am until 11:41am. At 11:41am the QA (Quality Assurance) nurse, LPN B was asked to observe if she saw anything wrong. Once the medication cart was pointed out to her, she stated, it is not locked. She acknowledged that they do have confused residents that could have accessed the cart. She stated, LPN A is assigned to the cart and the only person that has the key. RN A, a Supervisor, approached the cart and stated she had observed the surveyor at the desk for an extended period of time and I can't believe I didn't notice it, I've come up here several times. Review of the facility policy titled, Storage of Medications, version date 1.1(H5MAPL0851), read, compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. The Administrator and Director of Nursing were informed of the failure of the staff to ensure medications are secured, in a locked compartment, and ensure only authorized personnel have access on 4/11/19 at 10:01am. No further information was provided. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41450 2. LPN A failed to lock and secure her assigned medication cart during the course of medication administration. On 04/10/2019 at approximately 11:05 AM, while performing the Medication Administration Task, LPN A was observed leaving her medication cart unlocked and unsecured in the common hallway on Unit 1, between rooms [ROOM NUMBERS], and entered room [ROOM NUMBER] to administer medications to Resident #103. When asked how the medication cart should be left while administering meds, she replied It should be locked when I am away from it. On 04/10/2019 at approximately 11:40 AM, the Unit Manager (RN A) verified that LPN A was the only staff member assigned to medication administration for the current shift on Unit 1 and was responsible for 2 out of 2 medication carts located on Unit 1. On 04/10/2019 at approximately 11:45 AM, an unattended medication cart located outside of room [ROOM NUMBER] on Unit 1 was observed to be unlocked and unsecured. At 11:50, LPN A was observed exiting from room [ROOM NUMBER]. She locked the cart and rolled it down the hallway in the direction of the Unit 1 Nursing Station. On 04/10/2019 a copy of the facility policy regarding medication administration and medication storage was requested and provided by the DON (Director of Nursing, Employee B). Line item #2 of the facility's policy entitled Medication Administration, General Guidelines for the Administration of Medications (effective date: January 2015) read, While administering medications, the nurse ensures that the medication cart is locked any time it is out of his/her direct line of vision. Line item #7 of the facility's policy entitled Storage of Medications (revised April 2007) read, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 04/10/2019 at approximately 4:00 PM, the DON (Director of Nursing, Employee B) was interviewed. When asked what was normally kept in the medication carts, she replied medications, alcohol swabs, glucometer [device used to check blood sugars], insulin syringes [a syringe with a pre-attached needle], and a secured sharps container [a container used to dispose of sharp items such as used needles]. When asked about her expectations with respect to securing medication carts as well as the need to secure them, she replied They should be locked if not right there working at them. They are secured to ensure that nobody can access them that is not authorized or assigned to them. On 04/10/2019 at approximately 5:00 PM, the Administrator (Employee A) and the DON (Director of Nursing, Employee B) were notified of the findings. No further information was received.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on Resident interview, staff interview, clinical record review and facility documentation the facility failed to provide dental care to 1 Resident (Resident # 151) in a survey sample of 59 Residents. The findings include: Resident #151 a [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to Asthenia (Muscle Weakness), Hypertension, Anemia, Dysphagia, Hypothyroidism, Trigeminal Neuralgia, and Dementia. Her most recent (Minimum Data Set) MDS was a quarterly dated 2/1/19 coded Resident as having a (Brief Interview of Mental Status) BIMS score of 6 indicating severe cognitive impairment. On 2/20/19 at 12:30 PM during initial tour of the building an interview was conducted with Resident #151 and she stated My teeth hurt and whatever they are giving me don't help. When asked if she had been to the dentist she stated No I haven't been to a dentist in years and that's just what I need to do. On 1/20/19 Interview with Other Employee A who stated Yes I see [Resident 151] and in my opinion she is cognitively aware enough to report accurately that she is in pain and the location of the pain and if it is ongoing. A clinical record review was then initiated and it was found that the Resident has a history of Trigeminal Neuralgia, (A condition which affects the trigeminal facial nerve and is very painful and causes mouth, jaw, ear and facial pain) On 2/21/19 it was requested from facility, any consults resident has had with Dentist or Neurologist. On 2/22/19 it was requested again from DON any consults Resident 151 has had with a Dentist or Neurologist. On 2/25/19 in an interview with the DON she stated I have looked myself and there are no dental or Neurology consults that I can find in the chart or in the computer system. When asked if she was aware the Resident was having mouth pain the DON stated well she does take medication for her Trigeminal Neuralgia. When asked if she could be sure if it was the Trigeminal Neuralgia or a Toothache the DON stated that she could not. When asked if Resident #151 had a routine dental check in the past year the DON stated that she had not. When asked if the resident has had a follow up for her Trigeminal Neuralgia in the past year the DON stated no. On 2/25/19 at the end of day conference the Administrator was made aware and no further information was provided.

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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** 41450 Based on observation, staff interview, and facility documentation review, the facility staff failed to administer medications in a manner to prevent the spread of infection for 1 resident (Resident #103) in a sample size of 11 residents. For Resident #103, LPN A failed to wash her hands prior to putting on non-sterile gloves in preparation for the administration of his eye drops. The Findings included: Resident #103, an [AGE] year old male who was admitted to the facility on [DATE] with diagnoses to include but not limited to previous stroke, atrial fibrillation (abnormal heart rhythm), dementia, cataracts, and depression. Resident #103's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2019 was coded as a Quarterly Assessment. Resident #103 was coded with a Brief Interview of Mental Status (BIMS) score of 9 out of possible 15 indicating moderately impaired cognition. On 04/10/2019 at approximately 11:30 AM, LPN A was observed preparing to administer eye drops to Resident #103. She put on her non-sterile gloves but did not wash her hands prior to putting them on. She administered the eye drops and washed her hands after removing her gloves. When asked about her handwashing procedures, LPN A stated, I should have washed my hands prior to putting my gloves on, I usually do but I must have forgot, I'm sorry. On 04/10/2019 a copy of the facility policy regarding handwashing was requested and provided by the DON (Director of Nursing, Employee B). The facility policy entitled Handwashing/Hand Hygiene (reviewed 03/04/2019) had a Policy Statement that read, This facility considers hand hygiene the primary means to prevent the spread of infections. The Handwashing/Hand Hygiene facility policy also contained a subheading, Policy Interpretation and Implementation with line item #2 that read, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors and line item #7 that read, Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: (b.) Before and after direct contact with residents and (c.) Before preparing or handling medications. Line item #9 read, The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. The Handwashing/Hand Hygiene facility policy also contained a subheading, Procedure--Applying and Removing Gloves line item #1 that read, Perform hand hygiene before applying non-sterile gloves. On 04/10/2019 at approximately 4:00 PM, the DON (Director of Nursing, Employee B) was interviewed. When asked about her expectations with respect to handwashing during the administration of medications she stated, Before and after and in between and wash hands before putting on gloves to do eye drops and if there is a glove change, and after taking them off. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2019 at approximately 5:00 PM, the Administrator (Employee A) and the DON (Director of Nursing, Employee B) were notified of the findings. No further information was received.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 27662 Based on observation, staff interview, facility documentation and clinical record review, the facility failed for one resident (Resident #40) in a survey sample of 59 residents, to maintain equipment in a safe operating condition. Resident #40's wheel chair pedals were padded with towels and duct tape. The findings included: On 2/21/19 at 4:06 PM Resident #40's wheelchair pedals were observed to be padded with towels and duct tape. On 2/22/19 at 12:57 PM Resident #40's wheelchair were observed to have towels and duct tape to pad the w/c pedals. On 2/25/19 at 11:00 AM, the resident was observed in bed and the wheelchair had new cushions on the pedals. Resident #40 stated, I like it. On 2/25/19 at 3:10 PM, the Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings.