STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. Building B. Wing	11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Healthcare Center	8111 Tiswell Drive Alexandria, VA 22306

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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 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** 34894 Based on observation, staff interview, and clinical record review, the facility staff failed to maintain respect and dignity for one resident (Resident #261) in a sample size of 43 residents. The findings included: 1. For Resident # 261, the facility staff failed to ensure a dignified experience during an admission skin assessment. Resident # 261 was woken up between 1:00 am and 1:30 am for a skin assessment. Resident # 261 was a [AGE] year old female admitted to the facility on [DATE] with the diagnoses of, but not limited to, Anxiety Disorder, Insomnia, Gastroesophageal Reflux Disease, Wedge Compression Fracture of first Lumbar Vertebra, Low Back Pain, muscle weakness and lack of coordination. Resident #261 did not have a Minimum Data Set (MDS) because she had only recently been admitted . Resident # 261 stayed in the facility for 3 days and was discharged on [DATE]. Review of the clinical record was conducted on 11/6/2019 at 2:30 PM. Review of a Facility Reported Incident (FRI) dated 6/25/2018 revealed: The report stated that on 6-25-18, the Administrator received a voicemail from Resident # 261's son on 6/25/2018 reporting that his mother (Resident # 261) alleged that she had been violated by a staff member on 6-22-2018, day of admission. Per the son, ____(Resident # 261) called him the morning of 6/23/18 to report that nurse _____ (LPN E) had performed a cavity search on her without her consent and was indelicate during the procedure. The son reports that his mother denied any penetration occurred during the alleged cavity check but was alarmed by the forced examination and expressed pain and discomfort in her back as result of being turned and repositioned. The son requested a change in caregiver and it was facilitated; however, he elected not to disclose the rationale for this request with the staff on duty. The son admitted that he waited to share the details of the incident with facility management. Local law enforcement was called and reported to the facility on [DATE]. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The son requested to have his mother moved to another SNF (Skilled Nursing Facility). Facility complied with this request and discharged the patient on 6/25/18 to the facility chosen by the patient and her son. Patient discharged at approximately 7:30 p.m. Review of the FRI update form dated 6/29/2018 revealed the following documentation: We are unable to substantiate the patient's claim that she was subjected to a forced cavity check by Nurse (LPN E) or any other staff member. The facility has initiated education for all staff on reporting and escalating allegations of abuse to the appropriate personnel in real time. We have also begun educating all nurses on the proper method to admit a patient, including performing all assessments with another caregiver present, explaining all procedures to the patient in a manner that is easily understood, and ensuring the patient is fully awake and coherent before commencing with any tests, procedures, or medication administration. On 11/7/2019 at 10:10 a.m., an interview was conducted with the Administrator who stated he remembered the incident and FRI that was submitted to the State Agency. The Administrator was asked to present the investigation file of the FRI for Resident # 261 for the surveyor to review. The Administrator returned with the investigation file at approximately 10:25 a.m. Review of the investigation file included the Facility Reported Incident forms, several witness statements and documentation of portions of the clinical record. Review of typed witness statements revealed documentation included but not limited to statements from Resident # 261, the nurse accused of performing a cavity search LPN (Licensed Practical Nurse) E, the nurse who actually performed the skin assessment (LPN F), the RN (Registered Nurse) Supervisor, the Acting Director of Nursing (Employee G) and the Administrator. Review of a typed statement from Resident # 261 revealed this statement: I came to the center from _____(name of hospital) on Friday, 6/22/2018 after 6 pm. I was walking trying to do some exercise on the hallway and to the second floor dining room on and off till approximately 11:30 pm and went to sleep. I asked ____ (LPN E) to give me my flexeril and she told me she was in the process of getting it form (sic) the pharmacy which later on gave it to me before I went to bed. I also met most of the staff and patients on the hallway and in the nursing station. At 1:30 am, the nurse,_____ (LPN E) woke me up from my deep sleep and she was ripping off all my clothes rough without asking for permission and she rolled me on my side which caused me to have pain and muscle spasm on my back surgical site. I was yelling at ___ (LPN E) what she was doing and to leave me alone and I tried to push her away and she was strong. Again, I asked her why are you doing this to me again and again and she told me she was checking my skin. I told her that she was lying and she was not checking my skin and she was trying to put something in my rectum, she stopped. Then I called my son at around 1:50 am and gave him all the details of what happened. I did not go to sleep till 7 am in the morning, I was frightened. On Saturday 6/23/2018, my son called _____ (RN-Registered Nurse G), the nurse who was taking care of me on the day shift and told him that LPN E the nurse should not come back to my room and if that happened he will call a police. On the night shift of 6/24/2018, the nurse ____(LPN H) took care of me and he was good. The name of Resident # 261 was typed at top and the bottom of the statement. It was not signed and was not dated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the typed witness statements from the nurse who actually performed the skin assessment (LPN F), revealed documentation: On 6/23/2018, approximately 12 am, I took report from the outgoing nurse _____ (LPN E) about _____ (Resident # 261). _____(Resident # 261) was admitted to the facility on [DATE] around 6:30 pm to room _____(room number) per the outgoing nurse report. Approximately between 1:00 am and 1:30 am, _____(Resident # 261) was sleeping and I woke her up and I told her that my name was _____. (LPN F) her nurse and I explained to her that I was performing admission head to toe assessment and she gave the ok and I started taking her pant off first and her top and all her clothing. _____(Resident # 261) assisted me with the process by raising her bottom and rolling over to the side. First, I assessed the upper part of her body and I asked her to roller over on her side so that can see her back surgical scar and her bottom. While she was on her side, I assessed her buttocks, coccyx, and the sacrum. I opened her buttock and assessed her inner buttock to make sure she did not have any pressure injury. _____ Resident # 261 was asking me why I was checking her buttocks and if I was looking for drugs. I explained to _____(Resident # 261) that I was completing the skin assessment and it was a part of my duty to complete skin assessment. _____(Resident # 261) was repeatedly telling me that I was searching drugs and I again told her that I was not looking for drugs. After the completion of my skin assessment, I gave her gown and helped her to put it on. Again _____(Resident # 261) was telling me I was doing drug search and again I told her sorry that I was doing skin assessment. The whole time I was completing the skin assessment, ____ (Resident # 261) did not scream or raise her [NAME].(sic) After 10 minutes, I went back to her room with the vital sign machine and obtained her vitals. While I was checking her vitals, _____ (Resident # 261) was telling me that _____(LPN E) the nurse woke her up and ripped her cloth (sic) off her and she was upset about it. I explained to _____(Resident #261) that ____(LPN E) left the floor before midnight and I was the one I who woke her up and did the skin assessment however _____(Resident #261) stated that (LPN E) was the one who ripped her cloth (sic) off of her. I again told her that I was the one and she stated that I was not the one. I told her that I am (LPN F). _____(Resident # 261) seems ok the whole time except that she was repeating about the drug search and her cloth (sic) was stripped off of her by (LPN E). The form had the typed name of LPN F at the top and the bottom of the form. It was not signed. There was no date on the form indicating when the statement was typed. On 11/7/2019 at 3:35 p.m., an interview was conducted with the Administrator who stated the facility had the expectation for admission skin assessments to be completed within a certain number of hours after admission. The Administrator stated he would check the facility policy to determine the exact time frame for admission skin assessments to be completed. The Administrator returned to the conference room and stated that the admission skin assessments should be completed within the first 24 hours and presented a copy of the facility policy on Admission assessments. The Administrator stated the nurse had time to wait until a more appropriate hour to complete the skin assessment. The Administrator stated after he became aware of the situation on 6/25/2018 and completed the investigation, he made changes to the admission process. The Administrator stated the nurse (LPN F) should have had another staff member with her during the assessment and could have waited until later to complete the assessment since the resident was asleep. The Administrator stated the nursing staff had been educated on completing assessments with another staff member present, making sure the resident is fully awake, alert and understands the assessment and gives consent. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy entitled Admission Evaluation Effective: 1/24/2007, Revised: 10/30/2013, 9/21/2016. Reviewed: 5/29/2019 revealed the definition: Admission: the first 24 hours the resident is in the facility or returning to the facility. Under Policy was written: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center. Procedure: 1. Complete the admit/Readmit/Quarterly Screener assessment and appropriately triggered assessments electronically as soon as feasible but within 24 hours. On 11/7/2019 at 4:05 p.m., an interview was conducted with the Assistant Director of Nursing (Employee F). Employee F stated the resident (Resident # 261) nurses should perform nursing assessments with another staff member present after they obtain consent for the assessment. Employee F stated Resident # 261 was assessed by her physician at the facility and transferred to another skilled nursing facility. Employee F stated the resident and her son were upset. Review of the Nurses Notes revealed no documentation of the skin assessment performed by LPN F and/ or the response by Resident # 261. Review of the Admission Assessments (Admission Observation Tool and Skin Grid Pressure Assessment revealed both were dated 6/23/2018 were signed by LPN F. There was no documentation either of those documents of Resident # 261's response during the assessments. LPN F was no longer employed at the facility at the time of survey. Two attempts to reach her via telephone were unsuccessful-voicemail message stated voicemail is full. On 11/8/2019 at 12:30 PM, attempt to reach Resident # 261's son via telephone was unsuccessful. The phone rang several times but no voicemail was available. Another attempt to reach Resident # 261's son via telephone, the son answered but stated it was not a convenient time. The resident's son stated he would return the call to the surveyor. During the end of day debriefings on 11/7/2019 and 11/8/2019, the facility Administrator and Director of Nursing were informed that the facility staff performed an admission skin assessment between 1:00 am and 1:30 am, and continued with the assessment when the resident was upset indicated by the fact that she verbalized more than once that she thought it was a drug search. No further information was provided.

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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** 41449 Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to assess a Resident to determine if they were safe to administer medications, before leaving medications at the bedside for one Resident (Resident #86) in a survey of 43 Residents. The findings included: For Resident #86 the facility staff left medications at the bedside for the Resident when the Resident had not been assessed or determined to be clinically appropriate to self administer medications. Resident #86 was admitted to the facility on [DATE]. Resident #86's diagnoses included but were not limited to: Spinal Stenosis, Urinary tract infection, obstructive and reflux uropathy, degenerative disease of the nervous system, cirrhosis of liver, acute kidney failure, hemochromatosis, hydronephrosis, and muscle weakness. Resident #86's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/15/19 was coded as an admission assessment. Resident #86 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated intact cognitive skills. Resident #86 was coded as required extensive assistance in transfers, bed mobility, dressing, personal hygiene, and toileting. Resident #86 was coded as having been frequently incontinent of bowel and occasionally incontinent of bladder. On 11/6/19 at 9:19 AM during facility rounds, Resident #86 was observed to not be in his room. Observation of the room revealed, on the over-bed table at the bedside, was a medicine cup with a small, 1/2 of a white, round pill and a cup of water beside it. No staff were present. On 11/6/19 at approximately 9:40 AM, RN D was asked to accompany Surveyor C to Resident #86's room. When RN D was asked what the cup was, RN D stated I didn't give him his meds [medications] but I think it is Metoprolol. When Surveyor C asked RN D if it is routine to leave medications at the bedside, RN D stated, usually we stand there to make sure they taken them. RN D was asked if Resident #86 self-administers medications, RN D stated No. On 11/6/19 at approximately 9:50 AM, RN D and Surveyor C returned to the nursing station. RN D approached LPN D and told LPN D, he left this at his bedside, we have to call the doctor and let him know. LPN D confirmed the 1/2 of a pill was metoprolol. On 11/6/19 a review of Resident #86's current physician orders revealed an order Metoprolol Tartrate Tablet, give 12.5 mg by mouth two times a day for HTN [hypertension]. The order date was 10/10/19 and continued as an active order for Resident #86. On 11/6/19 a complete review of Resident #86's entire clinical record was conducted, to include the careplan and revealed no assessment of, or determination that Resident #86 had been assessed for self-administration of medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/19 at 11:37 AM, a request was made for any assessments or determination that Resident #86 had been assessed to self administer medications. The facility Director of Nursing stated they had no such documents. On 11/07/19 at 04:31 PM the facility Administrator was asked his expectations regarding medication administration, the Administrator stated, I expect them to follow the 7 rights of medication administration. When asked if medications can be left at the bedside, the Administrator stated, of course not, she has to observe the resident take the meds. On 11/8/19 at 9:00 AM a review of Resident #86's electronic clinical record revealed a nursing note dated 11/6/19 at 10:52 AM, written by RN D that read, Patient was given his morning medications today, however, it was noted that he did not take his blood pressure medication metoprolol 12.5mg. Medication was noted on his bedside table, and patient went down for therapy. MD was called and informed of the above. New order given to re-check patient's blood pressure upon return on the floor since patient blood pressure this morning was within normal limit (124/79), and to give the blood pressure medication after. Another nursing note entry was made by LPN D at 12:34 PM that read, patient returned to the floor, was informed that he had not taken his blood pressure medication, patient its oh I didn't, it must have been stick [sic] to the bottom of the cup. Review of the facility policy titled Resident Self-Administration of Medications with a review date of 5/29/19 read on page 2, a. Resident may not self-administer medication until the assessment is completed by the IDT team and determined to be safe to do so. Review of the facility policy titled Medication Administration with a review date of 5/29/19 read on page 4, remain with resident until the medication is swallowed, do not leave medication at bedside. The facility administrator and Director of Nursing (DON) were advised during an end of day meeting on 11/7/19 at 4:31 PM and again at end of day meeting on 11/8/19, of medications being left at the bedside of Resident #86. No further information was provided.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41450 Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to provide accommodations to call for assistance for 1 resident (Resident #41) in a survey sample of 43 residents. The findings include: For Resident #41, the callbell was located beyond his reach, making it unavailable for him to call for assistance. Resident #41, an [AGE] year old male who was admitted to the facility on [DATE] with diagnoses to include but not limited to muscle weakness, anemia, and contracture of the right knee. Resident #41's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/18/2019 was coded as an annual assessment. Resident #41 was coded with a Brief Interview of Mental Status (BIMS) score of 9 out of possible 15, indicating moderately impaired cognition. He was coded requiring extensive assistance for all of his ADL's (activities of daily living). On 11/5/19 at approximately 10:15 am during initial tour, Resident #41 was observed lying awake in his bed with his callbell located on the wall to the right of the head of his bed, wrapped around a soap dispenser. He stated that he did not know where his callbell was located and when it was pointed out that it was dangling from the soap dispenser on the wall, he stated, I have no idea how it ended up there, I didn't put it there, I cannot get out of bed or even reach over there. Employee A was observed in the hallway and asked to come into Resident #41's room. An interview was conducted with Employee A with regard to the location of Resident #41's callbell and he stated, I do not know why the callbell is hanging off the wall, he is not on my assignment today. When asked if he thought Resident #41 could reach his callbell to call for assistance, he stated No, it should be kept within his reach at all times so he can use it. Employee A removed the callbell from the wall and secured it to Resident #41's bedspread. On 11/6/19, a facility policy regarding callbells was requested and received. The facility policy entitled, Resident Rights, policy #NS 1021-00, dated 8/11/2017, page 2, item c(i) read, Call light or bell access will be within reach of the resident as one method to communicate needs to staff.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 41449 Based on observation, staff interview, the facility staff failed to post and have readily accessible the results of the survey reports for the three preceding years, to include any plan of corrections. The facility only had two of the last three years available. In addition the facility did not have plans of corrections that were finalized for two of the three surveys that were available. The findings included: On 11/6/19 at approximately 3:00 PM, the survey binder was observed to be located on a table on the first floor as you enter the nursing facility through the lobby. The binder contained survey results from the following surveys: * May 2018 Standard Survey * June 2018 Life Safety Survey * March 2017 Standard Survey On 11/7/19 at 9:11 AM the survey binder was observed to contain the following surveys: * 5/22/18- 5/24/18 Emergency Preparedness Survey and Standard Survey which had a watermark that read POC [plan of correction] not final * 6/15/18 Life Safety Survey * 3/7/17-3/9/17 Standard Survey and Biennial State Licensure Survey report, which revealed the biennial state licensure survey report had a watermark that read POC [plan of correction] not final On 11/7/19 at 3:53 PM, during an end of day meeting the facility Administrator was asked about the survey results binder. The Administrator stated it is located in the lobby at the nurses station. When asked about the contents, the Administrator stated it is our last survey results and plan of correction for the last 2 years. When asked if he was aware that the regulations require it to include the last 3 years of results, the administrator stated, I should have been. The Administrator was given the survey results binder during this meeting. On 11/8/19 at approximately 8:10 AM, the facility survey results binder was observed again and revealed the following survey information, and the three years of survey results had not been included: * 5/22/18- 5/24/18 Emergency Preparedness Survey and standard survey which had a watermark that read POC [plan of correction] not final * 6/15/18 life safety survey (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	* 3/7/17-3/9/17 standard survey and biennial state licensure survey report, which revealed the biennial state licensure survey report had a watermark that read POC [plan of correction] not final No further information was provided.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 40452 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to: 1) provide notification of non-coverage in a timely fashion for one of three sampled residents (Resident #315) and 2) complete an Advanced Beneficiary Notice (ABN) for one of three sampled residents (Resident #12) The findings included: A review of Resident #315's Notice to Medicare Provider Non-Coverage (NOMNC) while on survey revealed that the effective date coverage would end was 07/17/2019 and Resident #315 signed and dated the NOMNC 07/16/2019. A review of the ABN for Resident #12 revealed that although it was signed and dated by the responsible party, an option pertaining to the care and cost was not selected. On 11/08/19 at 09:33 AM, an interview with Employee P, the social worker, was conducted. When asked about the process for issuing NOMNCs and ABNs, Employee P stated that the NOMNC and ABN should be signed 48 to 72 hours, mostly 72 hours in advance. When asked why it was important to have more than a one day notice, Employee P stated To have enough notice for the appeal process. When Employee P was informed Resident #315 signed the NOMNC the day before services would end and the option selection on the ABN for Resident #12 was not completed, Employee P stated I can get back with you on that. Policies for obtaining NOMNCs and ABNs were requested. On 11/08/2019 at approximately 1:00 PM, the administrator and DON were notified of findings. The administrator verified that the facility does not have a policy pertaining to obtaining NOMNCs and ABNs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, Resident and staff interview facility documentation and clinical record review the facility staff failed to develop and implement a comprehensive care plan for 3 Residents (#73, 75, #66) in a survey sample of 43 Residents. The findings included: 1. For Resident #73 the facility staff failed to care plan scheduled nebulizer treatments and changing of tubing for nebulizer. Resident #73, a [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to Chronic Respiratory Failure, COPD (chronic obstructive pulmonary disease), Trach, G-Tube, dysphagia, dementia, major depressive disorder, psychosis, anxiety disorder, and seizures. Resident # 73's most recent MDS (minimum data set) with an ARD (assessment reference date) of [DATE] codes the Resident as being extensive assist with 2 person physical assistance for bed mobility, transfers and dressing and total assistance with physical assistance of 1 for bathing, feeding, and mobility. Resident #73 uses a wheel chair for transport and is unable to propel herself, she has a g-tube for feeding and a trach. On [DATE] at 3:00 PM during tour noted that Resident # 73 had undated tubing to her nebulizer. On [DATE] at approximately 3:05 PM an interview was conducted with LPN A and she stated the tubing should be changed weekly by night shift. On [DATE] at 9:55 AM during clinical record review it was noted that the Residents care plan addressed the trach care and oxygen usage along with the scheduled tube changing weekly however they omitted the nebulizer treatment on the care plan. 2. For Resident # 75 the facility staff failed to develop and implement plan to include nebulizer treatments and scheduled tubing change. Resident #75 a [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to CHF (Congestive Heart Failure), acute respiratory failure, major depressive disorder, COPD, Acute Kidney Failure and heart disease of coronary artery. Resident #75's most recent MDS (minimum data set) with an ARD (assessment reference date) of [DATE] codes resident #75 as having a (Brief Interview of Mental Status) BIMS of 15 indicating no cognitive impairment. The Resident was also coded as needing extensive assistance of 2 person physical assistance for bed mobility and transfers and unable to walk. She required extensive assistance of 1 person physical assist for bathing dressing and hygiene and toileting. On [DATE] at 3:00 PM during tour noted that Resident # 75 had a nebulizer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record review and it was noted that the Residents care plan addressed the PRN use of oxygen along with the scheduled tube changing weekly however it omitted the nebulizer treatment on the care plan. On [DATE] at 1:00 PM an interview was conducted with RN A who stated all treatments should be care planned. She also stated that Nebulizer tubing like oxygen tubing should be dated and changed weekly by night shift staff. The facility policy for Continuous Aerosol Therapy [nebulizer] read: Page # 2 Paragraph II. Equipment and Maintenance a. Aerosol/Trach masks are to be changed once a week and PRN b. Disposable aerosol tubing and drain bags are to be changed once a week and PRN. c. Non - refilled nebulizers are to be changed 3 times a week and filled as needed by respiratory or nursing staff d. Refilled nebulizers are to be changed when empty or once a week. On [DATE] at 2:30 PM the DON stated that it was her expectation that the Nebulizer tubing be changed weekly and care planned as such. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 41449 3. For Resident #66 the careplan did not address the current infections of osteomyelitis, C-Diff, receiving IV antibiotics, being on contact precautions, the need for assistance with ADL's, the presence of wounds, the need for wound care, the use of an anticoagulant or history of falls as identified in the comprehensive assessment Resident #66 was admitted to the facility on [DATE], with a readmitted [DATE]. Resident #66's diagnoses included but were not limited to: chronic osteomyelitis with draining sinus of right femur, pyogenic arthritis, infection following a procedure, broken internal right knee prosthesis, local infection of the skin and subcutaneous tissue, pressure ulcer of the sacral region stage 4, and enterocolitis due to clostridium difficile (C-Diff). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #66's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of [DATE] was coded as an admission assessment. Resident #66 was coded as having had a BIMS (brief interview for mental status) score of 14, which indicated intact cognitive skills. Resident #66 was coded as having required extensive assistance for dressing, personal hygiene, bed mobility and toileting. Ambulation and transfers were coded as having not occurred. Resident #66 was coded as having been always incontinent of bowel and bladder. This same MDS was also coded to indicate Resident #66 had diagnoses of deep vein thrombosis and received anticoagulants (blood thinner), received scheduled pain management regimen, and had a fall in the month prior to admission. On [DATE] during rounds it was observed that contact isolation supplies were outside of Resident #66's room. The nurse was asked about this and indicated that Resident #66 was on contact precautions due to C-Diff. On [DATE] review of the electronic clinical record for Resident #66 revealed that the careplan did not address the current infections of osteomyelitis, C-Diff, receiving IV antibiotics, being on contact precautions, the need for assistance with ADL's, the presence of wounds, the need for wound care, the use of an anticoagulant or history of falls as identified in the comprehensive assessment. On [DATE] at 5:10 PM an interview was conducted with RN F, who was the MDS Coordinator who writes the electronic careplan's. When asked about the process for developing and initiating careplan's, RN F stated, we do a 48 hour baseline careplan and after 21 days we put it in the computer. When asked what should be careplanned, RN F stated diagnosis, health conditions, medications like psychotropic, if have falls or behaviors the nurse taking care of the patient takes care of that. When asked where the paper careplans can be found, RN F stated, the unit manager has a binder with it. When shown the careplan for Resident #66 that included only the 3 focus areas of: discharge, CPR and weight changes, RN F stated, his careplan should be on paper, his assessment was done [DATE]. On [DATE] at approximately 5:15 PM, an interview was conducted with RN C, Charge Nurse. RN C was asked what the importance of a careplan is, RN C stated, the careplan is to give information to the staff to be able to take care of a resident, it is like a guideline. On [DATE] at approximately 5:20 PM, surveyor C asked the Unit Manager, RN E for the paper careplan for Resident #66. RN E provided a document titled 48 hour baseline careplan V3- V 3, which had an effective date of [DATE]. There were multiple handwritten entries on page 7 which read, Focus problems safety/fall precautions infection control skin/wound care management, prevent surgical wound complications emotional support, prevent emotional breakdown monitor PICC site to prevent complications pain management with appropriate interventions as indicated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist with d/c planning needs monitor ABT [antibiotic] therapy with interventions as indicated On the back of page 7 the following was written: monitor ext [external] fixator and do pin site as indicated contact precautions/isolation It was observed that none of these entries were dated as to when written and failed to have measurable objectives and timeframes to meet the Resident's medical and nursing needs. On [DATE] at 5:28 PM an interview was conducted with the facility DON (Director of Nursing) and RN E. The DON and RN E were asked when the handwritten entries were made on the 48 hour baseline careplan and the DON stated, we write on it during the clinical meeting that was held when it was signed which had a date of [DATE]. However, the contact precautions were not ordered until [DATE] so this wasn't the case. On [DATE] a review of the facility policy titled Plan of Care Overview with a review date of [DATE] read, for the purpose of this policy the plan of care, also care plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of persona-centered care planning and that this planing includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the their [sic] daily routines and goals to potentially return to a community setting. On [DATE] during an end of day meeting the facility Administrator and Director of Nursing were made aware of the facility staff's failure to develop a comprehensive person-centered careplan. No further information was provided.

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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** 29128 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed, for one resident (Resident # 79) in the survey sample of 43 residents, to review and revise the plan of care. The Findings included: 1. For Resident #79, the facility staff failed to review and revise the care plan after the development of unstageable pressure ulcers on his left ankle and left heel. Resident #79 was a [AGE] year old who was admitted to the facility on [DATE]. Resident #79's diagnoses included Cerebral Infarction, Generalized Muscle Weakness, Dementia, Major Depressive Disorder Hypertension, and Congestive Heart Failure. The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 10/11/19 was reviewed. Resident #79 had a Brief Interview of Mental Status Score of 12, indicating mildly impaired cognition. He was coded as requiring the extensive physical assistance of at least two people for bed mobility, and transfers. Resident #79's range of motion was impaired in both of his upper and lower extremities. He was coded as having unstageable pressure ulcers. His previous MDS, which was a Quarterly Assessment, with an Assessment Reference Date of 8/26/19 was reviewed. He was not coded for any pressure ulcers. On 11/5/19 a review was conducted of Resident #79's clinical record. According to a wound care note, on 9/11/19, an unstageable pressure ulcer was initially identified by a wound care physician. Resident #79's care plan was reviewed. It did not document anything regarding his pressure ulcers, including their existence or treatment. The Plan of Care Overview policy dated 5/30/19 was reviewed. An excerpt read, Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care. Review care plans quarterly and/or with significant changes in care. Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants. On 11/6/19 an interview was conducted with the facility Administrator (Employee A) in the conference room. When asked about his expectation about when a care plan must be revised, he stated that it should be revised within 24 hours of the change in condition, with focused goals and interventions to mitigate further pressure injuries.

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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** 41449 Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to follow professional standards for three Residents (Resident #86, #107, #2) in a survey sample of 43 Residents. The findings included: 1. For Resident #86 the facility staff failed to following nursing standard of practice by failure to observe a Resident (Resident #86) take medication, and left medication at the bedside. Resident #86 was admitted to the facility on [DATE]. Resident #86's diagnoses included but were not limited to: Spinal Stenosis, Urinary tract infection, obstructive and reflux uropathy, degenerative disease of the nervous system, cirrhosis of liver, acute kidney failure, hemochromatosis, hydronephrosis, and muscle weakness. Resident #86's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/15/19 was coded as an admission assessment. Resident #86 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated intact cognitive skills. Resident #86 was coded as required extensive assistance in transfers, bed mobility, dressing, personal hygiene, and toileting. Resident #86 was coded as having been frequently incontinent of bowel and occasionally incontinent of bladder. On 11/6/19 at 9:19 AM during facility rounds, Resident #86 was observed to not be in his room. Observation of the room revealed on the over-bed table at the bedside, was a medicine cup with a small, 1/2 of a white, round pill and a cup of water beside it. No staff were present. On 11/6/19 at approximately 9:40 AM, RN D was asked to accompany Surveyor C to Resident #86's room. When asked if it is routine to leave medications at the bedside, RN D stated, usually we stand there to make sure they taken them. On 11/6/19 a review of Resident #86's current physician orders revealed an order Metoprolol Tartrate Tablet, give 12.5 mg by mouth two times a day for HTN [hypertension]. The order date was 10/10/19 and continued as an active order for Resident #86. On 11/07/19 at 04:31 PM the facility Administrator was asked his expectations regarding medication administration, the Administrator stated, I expect them to follow the 7 rights of medication administration. When asked if medications can be left at the bedside, the Administrator stated, of course not, she has to observe the resident take the meds. Review of the facility policy titled Medication Administration with a review date of 5/29/19 read on page 4, remain with resident until the medication is swallowed, do not leave medication at bedside, medications will be charted when given, medications that are refused or withheld or not given will be documented. The DON stated the facility uses [NAME] as their nursing standard of practice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guidance from [NAME]'s Nursing Center.com (www.nursingcenter.com) Rights of Medication Administration 1. Right patient Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use technology (for example, bar-code system). 2. Right medication Check the medication label. Check the order. 3. Right dose Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well. 4. Right route Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route. 5. Right time Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use. 8. Right response Make sure that the drug led to the desired effect. If an anti-hypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). [NAME] & [NAME]: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 3/8/18. The facility administrator and Director of Nursing (DON) were advised during an end of day meeting on 11/7/19 at 4:31 PM and again at end of day meeting on 11/8/19, of medications being left at the bedside of Resident #86. No further information was provided. 2a. For Resident #107 the facility staff failed to administer insulin as ordered by the physician on 6 of 16 scheduled doses. Resident #107, was admitted to the facility on [DATE]. Resident #107's diagnoses included but were not limited to: sepsis, osteomyelitis of vertebra sacral and sacrococcygeal region, pressure ulcer sacral region stage 4, pressure ulcer of right upper back stage 4, unspecified dementia without behavioral disturbance, type 2 diabetes mellitus without complications, and hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #107's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/26/19 was coded as an admission assessment. Resident #107 was coded as having not been interviewable for a BIMS (brief interview for mental status) score. The staff assessment indicated the Resident is severely cognitively impaired. Resident #107 was coded as required total assistance of staff for transfers, bed mobility, dressing, personal hygiene, toileting, and bathing. Resident #107 was coded as having been always incontinent of bowel. On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed a physician order dated 10/21/19 that read, Toujeo Solostar Solution Pen-Injector 300 unit/ML (insulin Glargine) Inject 14 unit subcutaneously at bedtime for DM [diabetes mellitus]. Review of the Medication Administration Record (MAR) for October and November 2019 revealed that Resident #107 was not administered 6 of the scheduled 16 doses, (10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19) which were due from admission on 10/21/19 through 11/5/19. On 11/8/19 at 8:45 AM, an interview was conducted with LPN C. LPN C was asked about the physician order for Resident #107's Toujeo, LPN C stated, she gets 14 units at bedtime. When asked if this is every night, LPN C stated, yes, she gets it every night. LPN C was asked if there was any indications as to when he would not give the scheduled medication, LPN C stated, it depends on the blood sugar, if the blood sugar is very low, I would hold it and confirm with the doctor. LPN C was asked if that would be documented in the clinical record, LPN C stated, yes. On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked what NC on the MAR for Toujeo indicated. RN B looked at the legend attached to the MAR and indicated it meant no insulin coverage required. RN B added, if the blood sugar falls below certain range they don't give. Surveyor C asked what that range was, RN B stated, I will have to look. RN B went on to state, the nurse does the accu check and long acting insulin doesn't have a range so they use their judgement, if they hold it they call the doctor. RN B was asked if it would be expected that a nursing note entry would be entered into the clinical record regarding this and RN B stated, I believe so, yes. A review of the nursing notes for Resident #107 revealed no notes on the dates of 10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19 to indicate why the Toujeo was not administered as per the physician order. On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, those days are the same nurse [referencing the dates of the missed medication], the sliding scale insulin has parameters but the long acting does not. That nurse is a new nurse and just finished orientation, he is the only nurse recording NC and I didn't see any communication with the doctor. RN B was asked if she would have administered the Toujeo on the days in question, RN B stated, yes I would have given, I wouldn't have just held without communicating with the doctor. RN B was asked why it is important to give insulin as ordered, RN B stated, this is important for them to see if they need to make adjustments to insulin doses. Before we hold a medication we need to consult the doctor. RN B also stated that she had attempted to reach the nurse that had failed to administer the insulin but didn't reach them via telephone but would be doing some education upon their return to work for their next shift. 2b. For Resident #107 the facility staff failed to administer IV antibiotics for sepsis, osteomyelitis and wound infection, for 28 doses (four times daily/every 6 hours on 10/24/19-10/30/19), as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed the following physician orders: *On 10/22/19 an order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis. This order was discontinued on 10/22/19. The MAR for October revealed that this order was administered to Resident #107. * On 10/22/19 another order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19. This order was carried out and administered on 10/23/19 at 12:48 AM, 5:02 AM, 1:28 PM. The order was then discontinued on 10/23/19 at 12:22 PM. * On 10/23/19 an order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for sepsis, osteomyelitis until 10/23/19, which was in error. This order was carried out and administered on 10/23/19 at 6:00 PM. * On 10/30/19 an order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for wound infection for 6 weeks. This order was then carried out and administered as ordered for the duration of the month of Oct. and through the time of this review. A nursing note entry dated 10/22/19 at 18:53 read, unasyn Solution Reconstituted 3 (2-1) GM use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19, confirming the order was to continue this medication. It further stated that the facility was awaiting pharmacy to deliver. On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked about Resident #107's multiple IV antibiotic orders. RN B stated, someone entered it wrong, so as an interdisciplinary team we go back and change it. RN B was asked to clarify what she meant that it was entered wrong, RN B stated, it didn't have a stop date, we like all of our antibiotics to have an end date. RN B was then questioned about the multiple days that Resident #107 didn't receive the IV antibiotics, RN B stated, I don't know unless there was a delay from the pharmacy and agreed to look into this further. On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, when this medication was first ordered it said every 5 hours, that was communicated with the doctor and it had not stop date. The doctor was called and an order was given to change to every 6 hours until 10/29/19 and then consult infectious disease. The nurse that entered the order had a start date of 10/23/19 and had a stop date of 10/23/19, so it didn't populate to the MAR and it was caught on review on 10/30/19 and infectious disease gave the order to continue it for 6 weeks. Review of the facility policy titled Physician Orders with a review date of 5/30/19 read on page 2, taking the order: a. do not try to memorize the order b. write down the order as stated, c. provide a read-back to validate, d. spell out/clarify sound alike drugs, e. discontinue any previous contradicting order, f. place orders in the electronic medical record, g. print copy for physician to sign and place in paper chart, h. contact pharmacy for changes. The facility Director of Nursing indicated that the facility staff uses [NAME] as their nursing standard of practice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lippincott Manual of Nursing Practice eighth edition, states on page 18, box 2-3 Common Legal Claims for Departure from Standards of Care as failure to implement a physician order properly or in a timely fashion. Fundamentals of Nursing, by [NAME], stated The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients. Guidance is given from [NAME] Solutions, Safe Medication Administration Practices, General 10/02/2015. Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. The Administrator and Director of Nursing were informed on 11/8/19 during a end of day meeting held in the Administrator's office with Surveyor C of the facility staff's failure to following nursing standards of practice. No further information was provided. 41450 3. For Resident #2, the facility staff failed to administer cardiac medication (Diltiazem) as scheduled. Resident #2, a [AGE] year old female, was admitted to the facility on [DATE]. Her diagnoses included but are not limited to heart rhythm abnormality, congestive heart failure, high blood pressure, stroke, dementia, and inability to speak. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/2019 was coded as a quarterly review. Resident #2 was coded with severely impaired cognition. On 11/7/19 at approximately 3:15 PM, a family interview was conducted with Resident #2's son who was also her Responsible Party. He expressed concern that Resident #2's medications were occasionally given later than scheduled on the night shift. On 11/7/19, clinical record review was conducted for Resident #2. The physician orders dated 1/28/2019 read, Diltiazem HCl tablet 30mg, give 30 mg via G-Tube every 6 hours for high blood pressure/chest pain. Her dose was scheduled to be given at 6:00 AM, 12:00 PM, 6:00 PM, and 00:00 AM every day. A Medication Administration Audit Report for the month of November 2019 was requested and provided by facility staff. Resident #2 received Diltiazem HCl as follows: 11/01/19, time scheduled 00:00 AM, time administered 05:14 AM 11/01/19, time scheduled 6:00 AM, time administered 05:15 AM 11/04/19, time scheduled 00:00 AM, time administered 02:23 AM 11/04/19, time scheduled 6:00 AM, time administered 05:39 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/16/19 at approximately 9:45 AM, the Director of Nursing (DON, Employee B) was interviewed and stated, my expectations for med pass include [medication to be given] one hour before and one hour after [the] scheduled time. When asked about the possible outcomes if Diltiazem HCl is not given as ordered at the scheduled time intervals for Resident #2, she stated, if the resident does not receive the Diltiazem as scheduled at the correct times, it could cause problems with her blood pressure. If it is administered too close together, it could cause her blood pressure to drop too much, that would not be good and I expect the medication nurses to document the actual time that medication is administered. Review of the facility's policy entitled, Medication Administration (revision date 12/14/17), under subheading Procedure, item ff, Medications will be administered within the time frame of one hour before up to one hour after time ordered.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interviews, facility documentation and clinical record review the facility staff failed to provide care to promote healing prevent infection and prevent new pressure ulcers from forming for 2 Resident (#161 and #79) in a survey sample of 43 Residents. The findings included: 1. For Resident #161 the facility staff failed to identify a pressure ulcer to the coccyx before it was found at an advanced stage with necrotic tissue. In addition, the resident went the hospital and the coccyx wound was diagnosed with an infection. Resident #161, a [AGE] year old woman admitted to the facility on [DATE] with diagnoses of but not limited to Multiple Sclerosis, arthritis, cellulitis, reflux and muscle weakness. Resident #161's most recent MDS (minimum data set) coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #161 was also coded as needing extensive assistance of 2 person physical assistance for bed mobility, toilet use, dressing and personal hygiene. She was coded as total dependence with 2 person physical assistance for transfer, and extensive assistance with 1 person physical assistance for mobility on and off unit via wheel chair. On 11/7/19 during clinical record review it was discovered Resident #161 developed pressure ulcers. The progress notes read: 10/24/18 - New skin issue and 10/24/18 6:51 AM - Redness and open areas noted on bilateral buttocks and left inner thigh area However, the progress notes also show the discovery of another wound. The note reads; 11/1/18 3:05 AM new skin issue Resident has open area on the coccyx area approximately 4 cm [centimeters] circular area with necrotic tissue present 2.5 cm depth and has foul odor present with moderate amount of dark foul smelling drainage. Area cleaned with wound cleansed and covered with dry dressing. Resident is followed by wound team. Resident has dressing intact to the bilateral buttocks open areas no drainage noted to these areas. This note shows that the coccyx area was a new area not previously known and it shows that the area was found with necrotic tissue. The wound care physician notes read: 11/7/18- At the request of the referring provider [MD name redacted} a thorough wound care assessment and evaluation was performed today. She has a stage 4 pressure wound to coccyx of at least 1 day duration. There is moderate serous exudate. Stage 4 Pressure Wound Coccyx (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Etiology - Pressure MDS 3.0 Stage - 4 Wound Size - 4 x 2 x 3.5 cm Thick adherent devitalized necrotic tissue - 20% Granulation Tissue - 80% Surgical Excisional Debridement Procedure The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 1.6 cm of devitalized tissue and necrotic muscle and surrounding facial fibers were removed. In addition, Resident #161 went to the local hospital on 11/12/18 and was discharged on [DATE] excerpts from the hospital record are as follows. Discharge Diagnosis: Principal Diagnosis : Sepsis due to Methicillin resistant Staphylococcus Aureus.(MRSA) Sacral Ulcer Hospital Course: [AGE] year old female with history of multiple sclerosis, chronic lower extremity ulcers / wounds who was brought in from nursing facility with altered mental status and new sacral ulcers. The change in mental status was due to metabolic Encephalopathy in the setting of infected sacral ulcer. Patient underwent debridement and irrigation with sacral wound VAC placement on 11/15/19. Wound culture positive for MRSA, E-Coli and Proteus. Patient seen by ID [Infectious Disease]. Discharge recommendation is Vancomycin, Rocephin and Flagyl for 4 weeks followed by Bactrim for 4 weeks. She will continue to have wound VAC changed 3 times per week. On 11/8/19 an interview was held with the DON who stated that ideally wounds should be found before a stage IV. She stated that wounds are usually found during bathing by the CNA or on skin assessment by the nurse. On 11/8/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 29128 2. For Resident #79, the facility staff failed to prevent the development of a pressure wound on the left ankle, and identify the wound prior to it becoming unstageable. In addition, the facility failed to prevent and identify a pressure ulcer on his left Lateral Tibia prior to it becoming Stage 3. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #79 was a [AGE] year old who was admitted to the facility on [DATE]. Resident #79's diagnoses included Cerebral Infarction, Generalized Muscle Weakness, Dementia, Major Depressive Disorder Hypertension, and Congestive Heart Failure. The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 10/11/19 was reviewed. Resident #79 had a Brief Interview of Mental Status Score of 12, indicating mildly impaired cognition. He was coded as requiring the extensive physical assistance of at least two people for bed mobility, and transfers. Resident #79's range of motion was impaired in both of his upper and lower extremities. He was coded as having unstageable pressure ulcers. His previous MDS, which was a Quarterly Assessment, with an Assessment Reference Date of 8/26/19 was reviewed. He was not coded for any pressure ulcers. On 11/5/19 a review was conducted of Resident #79's clinical record. According to a nursing progress note dated 9/5/19, a weekly skin assessment was completed. No findings were documented in the note, or on a skin assessment form. According to a wound care note, on 9/11/19, an unstageable pressure ulcer was initially identified by a wound care physician. An excerpt from the note read, Location: Left Lateral Malleolus. Etiology: Pressure injury/ulcer - Unstageable Pressure Injury. Dressing used: Santyl. Wound Description: Odor-None, Exudate - Scant Serous, Periwound - Stable, Wound Edge - Normal, Pain- 0/10. Tissue: 50% Granulation, 50% Necrotic. Length 0.5 x Width 1.0, Depth 0.1. Wound Progress - First Visit. For the week prior to 10/2/19, there was no documentation of a skin assessment, including the nursing progress notes. An excerpt from another wound care note read, 10/2/19. Location: Left Lateral Heel. Etiology: Pressure injury/ulcer - Unstageable Pressure Injury. Dressing used: Betadine and Paint with Betadine daily and float heels. Wound Description: Odor-None, Exudate - None, Wound Edge - Eschar, Tissue- 100% Eschar - Length 0.5 x Width 1.7, Depth Undetermined. Wound progress - Undetermined: First Visit. In addition, Resident #79's care plan was reviewed. It did not document anything regarding his pressure ulcers, including their existence or treatment. On 11/6/19 at 11:20 A.M., an observation was conducted of Resident #79's pressure ulcers by Surveyor D (Registered Nurse). The pressure ulcer on his left outer ankle measured 2 cm x 2 cm x .1 cm. It was unstageable, with a black center, and contained slough. It had rolled edges, and moderate drainage. In addition, Resident's left outer leg pressure ulcer had a reddened area, necrotic center with slough. It was unstageable. It measured 3 cm x 2.8. cm no depth, moderate serous, sanguineous (bloody) drainage. On 11/06/19 at 2:09 P.M., an Interview was conducted with the Director of Nursing (DON Employee B). She was asked about her expectation of when pressure ulcers are identified. She stated that they do weekly skin assessments. They have different disease processes. It may be found at unstageable. She stated, our job was to prevent any pressure wounds, to find them at stage 1, and resolve them quickly. The DON further stated that sometimes they floated the residents' heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #79's diet orders were reviewed. Since 4/18/19, his order was as follows: Regular Diet, Regular Texture, Thin consistency, No pork, Prefers fish. The dietary orders related to wound healing were initiated on 7/9/19. Prostat 30 ml 2 x daily for wound healing. (Resident #79 was admitted with a sacral wound that healed and reopened) On 11/6/19 a review of facility documentation was conducted, revealing a Skin Care & Wound Management Policy dated 5/30/19. An excerpt read, The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident is evaluated upon admission and weekly thereafter for changes in clinical condition, prior to transfer to the hospital and upon return from the hospital. On 11/6/19 an interview was conducted with the facility Administrator (Employee A) in the conference room. He stated that on October 1, 2019 the facility changed wound care providers. He further stated that the facility had a wound care nurse until mid-October.

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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 one Resident (Resident #107) in a survey sample of 43 Residents. The findings include: 1a. For Resident #107 the facility staff failed to administer insulin as ordered by the physician on 6 of 16 scheduled doses. Resident #107, was admitted to the facility on [DATE]. Resident #107's diagnoses included but were not limited to: sepsis, osteomyelitis of vertebra sacral and sacrococcygeal region, pressure ulcer sacral region stage 4, pressure ulcer of right upper back stage 4, unspecified dementia without behavioral disturbance, type 2 diabetes mellitus without complications, and hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side. Resident #107's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/26/19 was coded as an admission assessment. Resident #107 was coded as having not been interviewable for a BIMS (brief interview for mental status) score. The staff assessment indicated the Resident is severely cognitively impaired. Resident #107 was coded as required total assistance of staff for transfers, bed mobility, dressing, personal hygiene, toileting, and bathing. Resident #107 was coded as having been always incontinent of bowel. On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed a physician order dated 10/21/19 that read, Toujeo Solostar Solution Pen-Injector 300 unit/ML (insulin Glargine) Inject 14 unit subcutaneously at bedtime for DM [diabetes mellitus]. Review of the Medication Administration Record (MAR) for October and November 2019 revealed that Resident #107 was not administered 6 of the scheduled 16 doses, (10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19) which were due from admission on 10/21/19 through 11/5/19. Review of Resident #107's careplan revealed a focus initiated on 10/30/19 that read [Resident name redacted] has diabetes mellitus, the interventions stated diabetes medication as ordered by doctor. On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked what NC on the MAR for Toujeo indicated. RN B looked at the legend attached to the MAR and indicated it meant no insulin coverage required. RN B added, if the blood sugar falls below certain range they don't give. Surveyor C asked what that range was, RN B stated, I will have to look. RN B went on to state, the nurse does the accu check and long acting insulin doesn't have a range so they use their judgement, if they hold it they call the doctor. RN B was asked if it would be expected that a nursing note entry would be entered into the clinical record regarding this and RN B stated, I believe so, ,yes. A review of the nursing notes for Resident #107 revealed no notes on the dates of 10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19 to indicate why the Toujeo was not administered as per the physician order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, those days are the same nurse [referencing the dates of the missed medication], the sliding scale insulin has parameters but the long acting does not. That nurse is a new nurse and just finished orientation, he is the only nurse recording NC and I didn't see any communication with the doctor. RN B was asked if she would have administered the Toujeo on the days in question, RN B stated, yes I would have given, I wouldn't have just held without communicating with the doctor. RN B was asked why it is important to give insulin as ordered, RN B stated, this is important for them to see if they need to make adjustments to insulin doses. Before we hold a medication we need to consult the doctor. RN B also stated that she had attempted to reach the nurse that had failed to administer the insulin but didn't reach them via telephone but would be doing some education upon their return to work for their next shift. 1b. For Resident #107 the facility staff failed to administer IV antibiotics for sepsis, osteomyelitis and wound infection, for 28 doses (four times daily/every 6 hours on 10/24/19-10/30/19), as ordered by the physician. On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed the following physician orders: *On 10/22/19 an order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis. This order was discontinued on 10/22/19. The MAR for October revealed that this order was administered to Resident #107. * On 10/22/19 another order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19. This order was carried out and administered on 10/23/19 at 12:48 AM, 5:02 AM, 1:28 PM. The order was then discontinued on 10/23/19 at 12:22 PM. * On 10/23/19 an order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for sepsis, osteomyelitis until 10/23/19, which was in error. This order was carried out and administered on 10/23/19 at 6:00 PM. * On 10/30/19 an order read, Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for wound infection for 6 weeks. This order was then carried out and administered as ordered for the duration of the month of Oct. and through the time of this review. A nursing note entry dated 10/22/19 at 18:53 read, unasyn Solution Reconstituted 3 (2-1) GM use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19, confirming the order was to continue this medication. It further stated that the facility was awaiting pharmacy to deliver. On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked about Resident #107's multiple IV antibiotic orders. RN B stated, someone entered it wrong, so as an interdisciplinary team we go back and change it. RN B was asked to clarify what she meant that it was entered wrong, RN B stated, it didn't have a stop date, we like all of our antibiotics to have an end date. RN B was then questioned about the multiple days that Resident #107 didn't receive the IV antibiotics, RN B stated, I don't know unless there was a delay from the pharmacy and agreed to look into this further. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, when this medication was first ordered it said every 5 hours, that was communicated with the doctor and it had not stop date. The doctor was called and an order was given to change to every 6 hours until 10/29/19 and then consult infectious disease. The nurse that entered the order had a start date of 10/23/19 and had a stop date of 10/23/19, so it didn't populate to the MAR and it was caught on review on 10/30/19 and infectious disease gave the order to continue it for 6 weeks. Review of the facility policy titled Physician Orders with a review date of 5/30/19 read on page 2, taking the order: a. do not try to memorize the order b. write down the order as stated, c. provide a read-back to validate, d. spell out/clarify sound alike drugs, e. discontinue any previous contradicting order, f. place orders in the electronic medical record, g. print copy for physician to sign and place in paper chart, h. contact pharmacy for changes. The Administrator and Director of Nursing were informed on 11/8/19 during a end of day meeting held in the Administrator's office with Surveyor C of the facility staff's failure to provide essential medications to Resident #107 as ordered by the physician. No further information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to maintain an accurate clinical record for one Resident (Resident #86) in a survey sample of 43 Residents. The findings included: For Resident #86 the facility staff documented administration of medication which had been left at the bedside and was not taken. Resident #86 was admitted to the facility on [DATE]. Resident #86's diagnoses included but were not limited to: Spinal Stenosis, Urinary tract infection, obstructive and reflux uropathy, degenerative disease of the nervous system, cirrhosis of liver, acute kidney failure, hemochromatosis, hydronephrosis, and muscle weakness. Resident #86's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/15/19 was coded as an admission assessment. Resident #86 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated intact cognitive skills. Resident #86 was coded as required extensive assistance in transfers, bed mobility, dressing, personal hygiene, and toileting. Resident #86 was coded as having been frequently incontinent of bowel and occasionally incontinent of bladder. On 11/6/19 at 9:19 AM during facility rounds, Resident #86 was observed to not be in his room. Observation of the room revealed on the over-bed table at the bedside, was a medicine cup with a small, 1/2 of a white, round pill and a cup of water beside it. No staff were present. On 11/6/19 at approximately 9:40 AM, RN D was asked to accompany Surveyor C to Resident #86's room. When RN D was asked what the cup was, RN D stated I didn't give him his meds [medications] but I think it is Metoprolol. When Surveyor C asked RN D if it is routine to leave medications at the bedside, RN D stated, usually we stand there to make sure they taken them. RN D was asked if Resident #86 self-administers medications, RN D stated No. On 11/6/19 at approximately 9:50 AM, RN D and Surveyor C returned to the nursing station. RN D approached LPN D and told LPN D, he left this at his bedside, we have to call the doctor and let him know. LPN D confirmed the 1/2 of a pill was metoprolol. On 11/6/19 a review of Resident #86's current physician orders revealed an order Metoprolol Tartrate Tablet, give 12.5 mg by mouth two times a day for HTN [hypertension]. The order date was 10/10/19 and continued as an active order for Resident #86. On 11/6/19 a complete review of Resident #86's entire clinical record was conducted, to include the medication administration record (MAR). The MAR had been recorded as Resident #86 being administered his Metoprolol on 11/6/19 at the 9 AM dose. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Administration with a review date of 5/29/19 read on page 4, remain with resident until the medication is swallowed, do not leave medication at bedside, medications will be charted when given, medications that are refused or withheld or not given will be documented. The facility administrator and Director of Nursing (DON) were advised during an end of day meeting on 11/7/19 and again at end of day meeting on 11/8/19 of medications being left at the bedside of Resident #86 and documented as being administered by nursing staff. No further information was provided.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41449 Based on observation, resident interview, and staff interview, the facility staff failed to maintain shower equipment and the shower room in a sanitary manner to prevent the spread of infection in 1 of 4 shower rooms. The findings included: On 11/6/19 at approximately 2:18 PM during the group Resident Council meeting, it was shared that the shower room on the 2nd floor was dirty. The Resident council reported specifically that the floor drain was clogged and the shower bench was dirty and discolored. On 11/6/19 at 2:47 PM the bathing suite on the 2nd floor was observed and the following was noted: * the shower drain was obstructed with a gray matter covering 1/2 of the drain holes in the floor drain of the shower stall. * the shower bench back was observed and revealed heavy discoloration of pink and black substances throughout the entire back. On 11/6/19 at approximately 3:15 PM, Employee N, the housekeeping supervisor accompanied the surveyor to the 2nd floor bathing suite. When asked about the process for cleaning, the housekeeping supervisor stated, we do the toilet and floors, the nurses are supposed to wipe down the shower chairs when they are done. I just took that project on, on Monday [referencing shower equipment, such as shower chairs/bench]. When asked about the shower drain, Employee N stated, I will get them right on that. When asked about the shower bench and Employee N was asked to observe the back of the shower bench, the housekeeping supervisor stated, my housekeeper brought that to my attention yesterday and we have ordered a new one. On 11/6/19 during the end of day meeting the facility Administrator was made aware of the shower room's lack of sanitary conditions as expressed by Resident Council. The Centers for Disease Control and Prevention (CDC) recognizes in their Emerging Infectious Disease article Volume 25, Number 11-November 2019 Serratia marcescens, which can cause nosocomial outbreaks, and urinary tract and wound infections, is abundant in damp environments. It can be easily found in bathrooms, including shower corners and basins, where it appears as a pink-orange-red discoloration, due to the pigment known as prodigiosin. article accessed online at : https://wwwnc.cdc.gov/eid/article/25/11/et-2511_article No further information was provided.