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	515104	A. BUILDING _____ B. WING _____	10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON, THE	161 BAKERS RIDGE ROAD MORGANTOWN, WV 26508

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F 000	INITIAL COMMENTS . An unannounced annual re-certification and annual re-licensure survey was conducted at The Madison from 10/21/19 through 10/24/19. The deficiencies contained in this report are based on observations, review of residents' clinical records, resident interviews, family interviews, and staff interviews, and review of other facility documentation as indicated. The facility's census on the first day of the survey was 54 residents. .	F 000	In addition to an acceptable plan of correction, submit credible evidence for all deficiency citations contained in this CMS-2567. The Madison Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 558 SS=E	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. . c) Resident #37 The care plan for Resident #37 reveals an initiated date of 10/20/19 for a focus problem of; resident requires assistance and is dependent for activities of daily living care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, and toileting due to weakness and activity intolerance related to recent lumbar/sacral surgery. On 10/22/19 at 12:35 PM observation of overhead light found only a switch to turn the light on and off.	F 558	F558 1. Resident #24, #29 and #37 had overhead light pull cords attached by the Maintenance Director (MD) immediately upon discovery. Residents #24, #29 and #37 did not experience any negative outcome. 2. All residents of the facility have the potential to be affected. The MD/designee audited all resident rooms to ensure the facility provides reasonable accommodation of needs and preferences except when to do so would endanger the health and safety of the resident or other residents in regards to their ability to turn on and off overhead lights without assistance with any corrective action immediately upon discovery on or by 11/27/19.	11/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/18/2019

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	Resident #37 explained she is in the facility for rehabilitation and to turn the light on/off she has to stand, which is not safe. She explained she has to ask the staff to turn the light on and off. . . Based on observation and resident interview, the facility failed to provide a reasonable accommodation of needs. Residents were unable to turn the overhead lights on and off, without assistance. Resident identifiers: #24, #29, and #37. There is potential to affect more than a limited number of residents. Facility census: 54 Findings included: a) Resident #24 During a Resident Council meeting on10/22/19 at 2:00 PM, Resident #24 (R #24), reported the overbed light switch is located on the wall, behind the bed. R #24 added that she uses a "grabber" to operate her light switch. R #24 does not like to use this, as there are personal belongings on the dresser, which could fall and break. The dresser is positioned in front of her light switch. b) Resident #29 Observation on 10/21/19 at 11:40 AM, found Resident #29 (R #29) had a wall switch above the bed to operate the overbed light. When asked if R #29 could reach the light switch, he replied in the negative. R #29 said he uses a wooden backscratcher to operate the light switch. R #29 is unable to get out of bed on his own to reach the wall switch.		3. All facility staff, including agency staff will be re-educated on or before 11/27/19 by the MD/designee on ensuring the facility provides reasonable accommodation of needs and preferences except when to do so would endanger the health and safety of the resident or other residents in regards to their ability to turn Ion and off overhead lights without assistance. Reeducation will include a post test to validate understanding. 1Facility staff, including agency staff, not lavailable during this time frame will be provided reeducation, including post test, by the MD/designee upon the day of return to work. New facility staff, including agency staff, will be provided education with post test during orientation by the DON/designee. Beginning 12/4/19, MD/designee will audit pull cords weekly x 4 weeks to ensure the facility provides reasonable accommodation of needs and preferences except when to do so would endanger the health and safety of the resident or other residents in regards to their ability to turn on and off overhead lights without assistance. Findings of the audit will be reported by the MD/designee to the Nursing Home Administrator daily upon completion. 4. Results of the audits will be reported by the MD/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or	

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	In an interview with the Nursing Home Administrator (NHA), on 10/23/19 at 10:15 AM, the NHA confirmed that some residents would not be able to operate the wall switch, including Resident #24 and #29. .		inservicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578	F578 1. Resident #147's Physician Orders for Scope of Treatment (POST) form was completed with a licensed nurse on 11/7/19 by the Medical Power of Attorney and the physician assistant to reflect CPR and full interventions. Resident #147 has not experienced any negative outcomes. 2. All residents of the facility have the potential to be affected. The Medical Records Coordinator/designee will audit all current residents' POST forms, Code Status and physician orders to ensure each ' resident is informed and provided written information to formulate an advanced directive with any corrective action immediately upon discovery on or by 11/27/19. 3. All licensed nursing staff, including agency nurse staff Social Service Workers (SW) and the Medical Records Coordinator will be reeducated on or before 11/27/19 by the Director of Nursing (DON)/designee regarding ensuring each resident is informed and	11/27/19

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	information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. . Based on policy and procedure review, medical record review, and staff interview, the facility failed to inform and provide written information to all adults residents to formulate an advance directive. This was true for one (1) of one (1) residents reviewed for advanced directives. Resident identifier: # 147. Facility census: 54. Findings included: a) Resident #147 A review of the policy and procedure titled "Health Care Decision Making" found the following: "It is the right of all patients to participate in their own health care decision-making, including the right to decide whether they wish to request, accept, refuse, or discontinue treatment, and to formulate or not formulate an advance directive. Centers must: - Inform and provide written information to all patients concerning the right to accept or refuse medical or surgical treatment and, at the patient's		provided written information to formulate an advanced directive with any corrective action immediately upon discovery. The reeducation will include a post test to validate understanding. Licensed nursing staff, including agency nurse staff, Social Service Workers and Medical Records Coordinator not available during this time frame will be provided reeducation, including post tests, by the DON/designee upon the day of return to work. New Licensed nursing staff, including agency nurses, Social Service Workers and Medical Records staff will be provided education with post test during orientation by the DON/designee. Beginning 11/19/19, the Medical Records Coordinator/designee will monitor POST form completion for new admissions, readmissions and/or with changes in code status daily across all shifts including weekends x2 weeks then 3 x week x 2 weeks and then randomly thereafter to ensure each resident is informed and provided written information to formulate an advanced directive with any corrective action immediately upon discovery Findings of the audit will be reported by the Medical Records Coordinator/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the Medical Records Coordinator/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for	

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	option, formulate an advanced directive; - Provide a written description of the Center's policies to implement advance directives and applicable state law; - Approach a capable patient who does not have an advance directive upon admission; the patient will be approached by the Social Worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive; - Inquire with the individual's resident representative if the patient is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law; -Honor advanced directives executed in other states, per state regulations; -Establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care." On 10/23/19 at 11:57 AM a review of the medical record found no information regarding advanced directives. Resident #147 was admitted on 10/02/19. An interview with the Assistant Director on Nursing (ADON) confirmed there was no evidence Resident #147 and/or the responsible person was asked or informed about advance directives. .		any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 584 SS=E	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584	F584 1. The floor in nutrition room was cleaned on 10/24/19 by the	11/27/19

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	but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. . Based on observation, resident interview and staff interview the facility failed to ensure a safe clean, comfortable and homelike environment. A		Housekeeping director (HD). Microdot bleach wipes were immediately removed upon discovery by the surveyor and the Director of Nursing (DON). Resident #145 did not experience a negative outcome related to the bleach wipes. 2. All residents of the facility have the potential to be affected. The Dietary Manager (DM)/designee completed a facility round on 11/18/19 auditing to ensure safe, clean, comfortable and homelike environment in regards to bleach cleaner not being accessible in resident rooms and a clean nourishment room floor with any corrective action immediately upon discovery. 3. The Nursing Home Administrator(NHA)/designee completed reeducation on or by 11/27/19 with all staff regarding ensuring a safe, clean, comfortable and homelike environment in regards to bleach cleaner not being accessible in resident rooms and a clean nourishment room floor. A posttest will be completed to validate understanding. Staff not available during this timeframe will be provided reeducation including posttests by NHA/designee upon day of return to work. Staff will be provided education with posttests to validate understanding by NHA/designee. The DM/designee will conduct audits, beginning 11/19/19 ensuring a safe, clean, comfortable and homelike environment in regards to bleach cleaner not being accessible in resident rooms and a clean nourishment room floor daily	

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	bleach cleaner was left in a resident room and, the nourishment room floor was soiled. This was random opportunities for discovery and has the potential to effect more than a limited number. Resident identifier: #145. Facility census: 54. Findings include: a) Resident #145 On 10/22/19 at 12:15 PM observation of residents room found a container of microdot bleach wipes in the window seal above the heating and cooling air conditioner. Resident #145 explained the container has been on the window seal for more than one day. At 1:00 PM on 10/22/19 the director of nursing (DON) explained the facility does not use this cleaning product in the facility. The product had to be left by an outside source. Review of the material safety data sheet for the microdot bleach wipes was obtained on-line by the director of nursing reveals the following warnings; avoid contact with eyes, skin and clothing as may produce irritation. The container had a warning to keep out of reach of children. The DON removed the product from the room and placed it in an area not accessible by facility residents or the public. b) Nourishment room On 10/22/19 at 9:00 AM observation of the nourishment/snack room found the floor to be visibly soiled and the floor under the ice machine to have numerous pieces of paper towels and		times 2 weeks including weekends, then 3 times per week times 2 weeks and then randomly thereafter. Findings of the audit will be reported by the MD/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the MD/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	

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	heavy buildup of brown substance. Maintenance staff #2 observed the floor and agreed it was soiled and in need of cleaning. .			
F 609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. . Based on resident interview, staff interview, and medical record review, the facility failed to report	F 609	F609 1. The allegation of missing property for Resident #24 was reported by the Social Service Director (SSD)/designee to the appropriate state agencies on 11/12/19. 2. All residents of the facility have the potential to be affected. Nursing Home Administrator (NHA)/designee audited allegations of missing property on 11/12/19 to ensure they were reported to all appropriate state agencies with any corrective action immediately upon discovery. 3. All staff including agency staff will be reeducated on or before 11/27/19 by the SSD/designee regarding ensuring allegations of missing property are reported to all appropriate state agencies with post test to validate understanding. All staff, including agency staff, not available during this time frame will be provided reeducation, including post test, by the SSD/designee upon the day of return to work. Newly hired staff, including agency staff, will be provided education during orientation by the SSD/designee. Beginning 11/19/19, the SSD/designee audit allegations of	11/27/19

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	allegations of missing property to all appropriate state agencies for one of one residents reviewed for missing property. Resident identifier: #24. Facility census: 54. Findings include: a) Resident #24 During resident interview on 10/21/19 at 11:55 AM, this resident stated personal property which she believed was stolen this spring included $55.00 cash, a 25 mm camera, and a Jule vape pen and box of cartridges. She said the facility did not reimburse her for any of those missing items. b) Review of the reportables found the following: 1. On 05/28/19 the resident reported that "someone stole $55.00 from her purse" in her room. The facility's corrective action was to re-educate the resident about using her lock box in her room. 2. On 06/01/19 the resident reported that her camera was stolen. She indicated the last time she saw it was shortly after a leave of absence around 04/09/19. The facility's corrective action was to re-educate the resident about using her lock box for valuables. 3. On 06/28/19 the resident reported that her vape pen was stolen. The facility's corrective action was to give her another lock box in which to store additional items. The facility added that it had previously educated the resident on using the lock box. In the first two (2) scenarios the facility listed additional referrals made by the facility included county law enforcement agency (sheriff's department) as well as the state survey agency.		missing property to ensure allegations of missing property are reported to all appropriate state agencies daily x 2 weeks, including weekends, then 3 times a week for 2 weeks and then randomly thereafter to ensure missing resident property has been identified, thoroughly investigated and reported timely to the appropriate state agencies. Findings of the audit will be reported by the SSD/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the SSD/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	

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In the third scenario, the facility listed additional referrals made by the facility included county law enforcement (sheriff's department), the state survey agency, and the ombudsman.

An interview was conducted with the administrator on 10/22/19 at 3:30 PM. He said the facility did not reimburse the resident for $55.00 cash, the camera, and the vape pen and cartridges as those items should have been stored in the lock box which the resident had in her room. He provided a copy of the facility's policy which stated that in the event the Center fails to make reasonable efforts to safeguard patient property the Center will reimburse a patient for, or replace stolen or lost patient property at its then current value. He said the facility did reimburse the resident $75.00 for missing undergarments.

A second interview was conducted with the administrator on 10/23/19 at 3 PM. We reviewed the State Operation Manual which stated in part that allegations of stolen personal items must be reported to the facility administrator and to other officials in accordance with State law, including to the state survey agency and adult protective services (APS). The administrator said the facility did not notify APS of the alleged theft of property. He said he was not aware the facility was supposed to do so. He said he notified the ombudsman of the missing vape pen and cartridges timely, but could provide no evidence the ombudsman was notified of the 05/28/19 loss of cash or the 06/01/19 loss of camera. The administrator provided a copy of a July 2019 email to the ombudsman related to the facility's recent trend of missing personal items. He said he and the ombudsman later discussed that trend by telephone.

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F 656 SS=E	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656	F656 1. Nurse aide was reeducated by the Director of Nursing (DON)/designee on or by 11/27/19 to ensure a comprehensive person-centered care plan was implemented regarding assisting resident #35 with transfers with assistance of 2 staff members. Resident #22 behavior flow chart was completed with potential side effects from Sertraline and Ativan and recommended non-pharmacological interventions by the DON/designee on 11/4/19. Resident # 20 has not experienced any negative outcome. Nurses were reeducated to ensure physicians orders for vital signs, weight gain or loss and blood glucose monitoring for Resident #20 were followed on or by 11/27/19. 2. All residents of the facility have the potential to be affected. An observation round was completed on each shift to ensure care plans were followed for current residents to ensure comprehensive I person-centered care plans in regards to appropriate transfer staff assistance, medication side effects monitoring, vital sign monitoring, blood glucose monitoring and weight gain or loss monitoring on or by 11/13/19 by Clinical Reimbursement Coordinator (CRC)/designee, with any corrective	11/27/19

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	local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. . c) Resident #20 The medical record was reviewed on 10/22/19. The care plan directed the following: 1. Access and record blood glucose levels - page twelve (12) 2. Assess and monitor vital signs as ordered and report abnormalities to physician - page seven (7) and page eight (8). 3. Weight per protocol and alert dietitian and physician to any significant loss or gain - page seventeen (17). The care plan was not followed in those three (3) areas as noted below: 1. Review of the medication administration record (MAR) for the most recent two (2) months found omissions of physician-ordered twice daily blood sugars on the day shifts on 09/02/19, 09/04/19, 09/13/19. 2. Review of the MAR for the most recent two (2) months found omissions of physician-ordered daily vital signs on 09/01/19, 09/02/19, 09/11/19, 09/13/19, 09/27/19, 10/04/19, 10/10/19. 3. Review of the medical record found this resident recently had a significant weight gain. On 09/01/19 he weighed 206 pounds. On		action immediately upon discovery. 3. Reeducation was completed with licensed nurses, including agency nurses, by the DON/designee regarding ensuring comprehensive person-centered care plans in regards to appropriate transfer staff assistance, medication side effects monitoring, vital sign monitoring, blood glucose monitoring and weight gain or loss monitoring on or before 11/27/19 'with a posttest to validate understanding. Licensed nurses, including agency nurses, not available during this time frame will be provided reeducation and posttest upon 'return to work by the DON/designee. New licensed and agency nurses will be provided education and posttest dining orientation by the DON/designee. An audit will be completed starting 11/19/19 by the DON/designee to ensure comprehensive person-centered care plans in regards to appropriate transfer staff assistance, medication side effects monitoring, vital sign monitoring, blood glucose monitoring and weight gain or loss monitoring daily across all shifts times 2 weeks including weekends, then 3 times per week times 2 weeks and then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported	

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	10/09/19 he weighed 233 pounds. This amounted to a 13.11% (per cent) weight gain in one (1) month. Review of the medical record found no evidence that the dietitian and physician were notified timely. An interview was conducted with the director of nursing (DON) on 10/22/19 at 1:00 PM. She said they should have re-weighed the resident in October following the large weight gain. She said the 10/09/19 may have been an incorrect weight. She said she would look for a possible October re-weight, and see if the physician was notified timely of the weight gain. She said she would look through the medical records to see if there were vital signs or blood glucose recordings other than on the MARs. An interview was conducted with the administrator, the DON, and the assistant director of nursing (ADON) on 10/23/19 at 1:45 PM. The DON said she found no evidence that the physician was contacted timely about the weight gain. The ADON said they weighed him last evening and he weighed 215 pounds. She said this morning he weighed 221 pounds. We discussed the omissions of fingerstick blood glucose results and vital signs on the MAR's on the dates in question in September and October 2019. The DON said she found no additional evidence to provide related to those omissions. . . Based on record review and staff interview, the facility failed to implement a comprehensive person-centered care plan for three (3) out of 14 residents reviewed. This failed practice had the potential to affect a more than a limited number of residents residing at the facility. Resident		by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	

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identifiers: #35, #22, and #20. Facility census 54.

Findings included:

a) Resident #35

During an interview on 10/21/19 at 11:56 AM, Resident #35 reported that in September using a set to stand in the shower aide could not get any help getting him to the toilet she did it alone. She did it alone, because no one would help her. He stated, that he ended up with two broken legs. He said, at the time he did not know what he was hurt that bad, because he cannot feel anything, due to his medical condition of Multiple Sclerosis (MS) (an illness that causes nerve damage disrupts communication between the brain and the body).

Care Plan
Focus:
Resident requires assistance for ADL care in bathing, grooming, dressing, bed mobility, transfer, toileting due to chronic disease (MS) compromising functional ability, bilateral hip contractures.
Interventions:
-Total lift transfer with staff assist of 2.
Date Initiated: 08/24/2018
Created on: 08/24/2018
Revision on: 09/16/2019

During an interview on 10/22/19 at 2:33 PM, Administrator was asked about the accident that occurred when a Nurse Aide (NA) #16 was using a lift alone, instead of following the care plan to use two people while using a light. He explained, that the facility did re-educate the NA #16. He provided more information on what she was re-educated on and additionally a statement from

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the NA #16, stating, that she could not get anyone to assist her the night of the accident. Administrator agreed, that NA#16 failed to implement the care plan, by not using two (2) people with the lift to transfer the resident.

b) Resident #22

During review medical records belonging to Resident #22, in the care area of unnecessary medication, his care plan on page 15 read: created: on 08/15/18, revision: on 10/21/19.
Focus:
-Resident #22 is at risk for complications related to use of psychotropic medication, Sertraline (anti=depression), and Ativan (anxiolytic)
Goals:
Resident will have the smallest most effective does without side effects.
Interventions:
-monitor for potential medication side effects (Sertraline): sedation, dry mouth, blurred vision, constipation, postural hypotension, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity, excessive weight gain.
-Ativan: sedation, morning handover, ataxia, nausea.

During an interview on 10/21/19 at 2:45 PM, Director of Nursing was asked if she could provide evidence, to show Resident #22 was being monitored for side effects for, she said, that she would like to provide that, however, the facility is not monitoring for side effects at this time. She went on to say, she was going to start having the staff use paper to monitor for side effects.

During an interview on 10/22/19 at 12:59 PM,

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	Director of Nursing (DoN) was asked about how the staff are monitoring behaviors and side effects from the psychotropic medications, Sertraline and Ativan. She stated, that if someone has a lot of behaviors the nurses will write a note, but they have just stated to educate the staff on using a paper (instead of electronic charting) to document mood/behaviors and side effects. Because they don't have any way to document in Pointclick care (electronic charting). She also stated, they do not have a system in place to monitor for side effects from these drugs. .			
F 684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. . Based on observation, staff interview and record review the facility failed to ensure care was given to prevent skin breakdown. This is true for one (1) of three (3) residents reviewed for pressure ulcers. The facility failed to complete fingersticks to obtain blood glucose level for one (1) of fourteen (14) record reviewed. Resident identifiers: #145 and #20. Facility census: 54. Findings include:	F 684	F684 1. Licensed nurse anchored resident #145 drainage tubes to his/her thigh to prevent the resident from lying on tubing. Director of Nursing (DON) notified the attending physician on 11/7/19 of the omitted blood sugars and vital signs for resident #20, no new orders, Resident #20 has not experienced any negative outcome. 2. All residents of the facility have the potential to be affected. The DON/designee completed an observation on all shifts on 11/13/19 of all residents that have orders for vital signs and blood glucose monitoring to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and residents choice	11/27/19

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	a) Resident #145 Record review found Resident #145 to have a gallbladder drain tube and a paracolic gutter abscess drain tube. On 10/23/19 at 12:15 PM observation of skin care related to these tubing's found Resident #145 was lying on the tubing and had several red deep indentations scattered over the right hip and buttocks. The shape of these indentations matched the tubing connectors. The tubing was not anchored to prevent the resident from laying on the tubing. Licensed nurse #32 commented the residents skin is sensitive and agreed the areas were most likely from the resident laying on the tubing. . . b) Resident #20 The medical record was reviewed on 10/22/19. Physician's orders directed the following: 1. Fingerstick blood glucose two (2) times per day for diabetes mellitus. Notify the physician if blood sugar is greater than 400 mg/dl (milligrams per deciliter). If blood glucose is below 70 mg/dl, initiate hypoglycemic protocol. 2. Vital Signs every shift for 72 hours, then daily every day shift. Physician's orders were not followed in those two (2) areas as noted below: 1. Review of the medication administration record (MAR) for the most recent two (2) months found		in relation to finger sticks completed to obtain blood glucose levels and vital sign monitoring with no identified concerns. DON/designee to complete an audit of all residents with drainage tubes to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and residents choice in relation to drainage tubing anchors to prevent residents from lying on drainage tubing with any corrective action immediately upon discovery. 3. . Reeducation of all licensed nurses including agency licensed staff will be completed on or before 11/27/19 to ensure 'that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and residents choice in relation to drainage tubing anchors to prevent residents from lying on catheter tubing and finger sticks completed to obtain blood glucose levels and vital sign monitoring. DON/designee with a posttest to validate understanding. Any licensed nurses including agency nurses not available during this time frame will be provided reeducation, including posttest by DON/designee upon day of return to work. New licensed nurses and agency nurses will be provided education, including posttest during orientation by the DON/designee. Beginning 11/19/19, DON/designee will audit licensed nurses to ensure that residents receive treatment and care in	

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	omissions of physician-ordered twice daily blood sugars on the day shifts on 09/02/19, 09/04/19, 09/13/19. 2. Review of the MAR for the most recent two (2) months found omissions of physician-ordered daily vital signs on 09/01/19, 09/02/19, 09/11/19, 09/13/19, 09/27/19, 10/04/19, 10/10/19. An interview was conducted with the director of nursing (DON) on 10/22/19 at 1:00 PM. She said she would look through the medical records to see if there were vital signs or blood glucose recordings other than on the MARs. An interview was conducted with the administrator and the DON on 10/23/19 at 1:45 PM. We discussed the omissions of fingerstick blood glucose results and vital signs on the MAR's on the dates in question in September and October 2019. The DON said she found no additional evidence to provide related to those omissions. .		accordance with professional standards of practice, the comprehensive person-centered ewe plan and residents choice in relation to catheter tubing anchors to prevent residents from lying on catheter tubing and finger sticks completed to obtain blood glucose levels and vital sign monitoring daily across all shifts including weekends for 2 weeks, then 3 times a week for 2 weeks, then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686	F686 1. Nurse providing pressure ulcer treatment on resident #29 was re-educated by the Director of Nursing (DON)/designee on or by 11/27/19 regarding properly cleaning the treatment area if stool is present to prevent infection. Resident #29 has not experienced any negative outcome.	11/27/19

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	demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. . Based on observation and staff interview, the facility failed to ensure pressure ulcers receives necessary treatment and services, consistent with professional standards of practice for one (1) out of three (3) residents reviewed for wound care. This failed practice had the potential to affect a limited number of residents residing at the facility. Resident identifier: #29. Facility census 54. Finding included: a) Resident #29 On 10/23/19 at 9:42 AM, an observation of pressure injury care, Licensed Practical Nurse (LPN) #32 cleaned the bedside table, closed door and window blinds. After the removal of his brief, it was noted, that he had a bowel movement (BM). She removed both dressing. She washed her hands cleaned the two wounds one on the coccyx one under the right buttock, washed her hands changed gloves, applied Inzo barrier cream, washed her hands changed gloves, replaced dressings with stool still on Resident # 29. The nurse assisting LPN#32 placed a clean brief under him, without cleaning the stool off. On 10/23/19 at 10:57 AM, during an interview with Director of Nursing (DoN) and LPN #32 about failure to clean the resident from the bowel movement, before providing wound care. LPN		2. All residents of the facility have the potential to be affected. Audit was completed across all shifts during wound dressing changes by the DON/designee on 11/5/19 to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable in regards to properly cleaning stool from the treatment area, when present with no identified concerns. 3. Licensed nurses staff including agency nurses will receive re-education from the DON/designee on or by 11/27/19 for the requirement to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable with a posttest to validate understanding. Licensed nurses and agency nurses not available during this timeframe will be receiving re-education including posttest upon return to work by the DNS/designee. All new licensed nursing staff and nursing assistants will be educated during orientation by the Nurse Practice Educator regarding the application of pressure relieving devices. Beginning 11/19/19, DON/designee will audit pressure ulcer treatments across all shifts daily x2 weeks, including	

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	#32 asked if Resident #29 was actively having a bowel movement? She was told yes, and he had stool on him and on his brief from the start to the end of the wound care. DoN could not provide any addition information for the defiant practice before the exit of this survey. On 10/23/19 at 11:30 AM, DoN asked if she should have someone to re-do the wound treatment. .		weekends, 3x per week x 2 weeks then randomly thereafter to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690	F690 1. Resident # 197 catheter was secured with a catheter strap/anchor to the thigh by licensed nurse immediately upon discovery. Resident #197 did not experience any negative outcomes. 2. All residents of the facility with Foley catheters have the potential to be affected. The Director of Nursing (DON)/designee conducted an audit on	11/27/19

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	comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. . Based on observation and staff interview, the facility failed to ensure foley catheter care was provided at a professional standard. This failed practice had the potential to affect one (1) out of one (1) reviewed in the care area of catheter care. Resident identifier: #197. Facility census 54. Findings included: a) Resident #197 During an observation of catheter care on 10/23/19 at 2:08 PM, Nurse Aide #6 provided appropriate care. However, it was noted there		all residents that currently have a Foley catheter to ensure catheter tubing is appropriately secured/anchored to thigh to prevent tension to ensure Foley catheter care is provided at a professional standard. 3. All nursing staff including agency nursing staff will be re-educated by the DON/designee on or before 11/27/19 to ensure Foley catheter care is provided at a professional standard regarding anchoring/securing resident Foley catheter tubing to prevent tension with a posttest to validate understanding. Nursing home and agency nursing staff not available during this time frame will be provided reeducation, including a posttest, by the DON/designee, upon the day of return to work. New nursing home and agency nursing staff will be provided education and posttests during orientation by the Director of Nursing (DON)/designee. Beginning 11/19/19, the DON/designee will monitor new admissions, readmissions and/ residents with Foley catheters to ensure that the catheter anchored/secured daily across all shifts times 2 weeks, including weekends, then 3 times per week times 2 weeks and then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance	

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	was not any type of a secure anchor device being used (this device is used to prevent tissue injury, tension on the indwelling Foley catheter or accidental removal). In addition, the Foley tubing was under the resident's leg (professional standards of practice is for the tubing to be on top of the thigh). This was verified with NA #6, Licensed Practical Nurse #15, and Registered Nurse Educator #72. Resident #197 stated, that he has not had a secure anchor device on his Foley while at the facility. He was admitted on On 10/23/19 at 2:48 PM, Registered Nurse Educator #72, applied an anchor to the right inner thigh and placed the tubing on top of the right thigh. She stated, that she will re-educate the nurse aides to report it to a nurse if the catheter does not have an anchor device, if tubing is under the leg, and if any dressing is missing. .		Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693	F693 1. Resident # 145 non-labeled bag and tubing was discarded immediately upon discovery by the Director of Nursing (DON) and was replaced by labeled tubing. Resident #145 did not experience any negative outcome. 2. All residents of the facility who receive enteral feeding have the potential to be affected. The DON/designee conducted an audit on 11/13/19 on all residents that currently have enteral feeding to ensure appropriate labeling of kangaroo bags	11/27/19

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	§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. . Based on observation and staff interview, the facility failed to prevent potential for complications related to a resident receiving enteral feeding. The facility failed to label kangaroo bags and the tubing used to deliver enteral feeding. This was true for one (1) of two (2) residents reviewed for tube feeding. Resident identifier: #145. Facility census: 54. Findings included: a) Resident #145 On 10/21/19 at 1:40 PM observation of the kangaroo bag to deliver enteral feeding, the kangaroo bag containing the flush and hydration and the tubing to deliver both was not labeled with the name of the enteral feed, or the date and time of hanging. At 1:50 PM on 10/21/19 the director (DON) agreed the kangaroo bags and the tubing had no labeling for content, date and time. .		and tubing used to deliver enteral feeding with no identified concerns. 3. Licensed nurses including agency nurses will be re-educated by the DON/designee on or before 11/27/19 to ensure appropriate labeling of kangaroo bags and tubing used to deliver enteral feeding with a posttest to validate understanding. Licensed nurses and agency nurse staff not available during this time frame will be provided reeducation, including a posttest, by the DON/designee, upon the day of return to work. New nursing home and agency nursing F 693 staff will be provided education and posttests during orientation by the DON/designee. Beginning 11/19/19, the Director of Nursing (DON)/designee will audit enteral feeding labeling to ensure appropriate labeling of kangaroo bags and tubing used to deliver enteral feeding daily across all shifts times 2 weeks, including weekends, then 3 times per week times 2 weeks and then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the	

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			issue is resolved and randomly thereafter as determined by the QIC.	
F 695 SS=D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. . Based on observation and staff interview the facility failed to use appropriate hand hygiene while providing tracheostomy care. This failed practice had the potential to affect one (1) out of one (1) reviewed for tracheostomy care. Resident identifier: #197. Facility census 54. Findings included: a) R#197 During an observation of Tracheostomy care for Resident #197 on 10/23/19 at 11:19 AM, Licensed Practical Nurse (LPN) #15, cleaned the bedside table, opened sterile water, applied sterile gloves without using any type of hand hygiene, removed soiled dressing, removed gloves and again did not use any hand hygiene, poured sterile water in basin, put on new sterile gloves without using hand hygiene, wiped around the trach valve, changed gloves and did not use	F 695	F695 1. The Director of Nursing (DON) reeducated LPN on appropriate hand hygiene when performing tracheostomy care on or by 11/27/19. Resident #197 did not experience any negative outcomes. 2. All residents of the facility have the potential to be affected. An audit was conducted by the DON on 11/5/19 across all shifts to determine respiratory care consistent with professional standards of practice, including but not limited to appropriate hand hygiene during tracheostomy care with no identified concerns. 3. All licensed nurses including agency nurses were reeducated on or before 11/27/19 by the DON/designee regarding providing respiratory care consistent with professional standards of practice, including but not limited to appropriate hand hygiene during tracheostomy care. A I posttest will be given to validate their I understanding. Licensed nurses and agency nurses not available during this timeframe will be provided reeducation including posttests by the NPE/designee :upon day of return to work. New licensed nurses will be provided	11/27/19

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	any hand hygiene, places gauze under tracheostomy, changed gloves, did not use any hand hygiene, cleared table off removed old cannula. replaced with new cannula. LPN #15 had nine (9) opportunities that hand hygiene should have been implemented and did not do at any time during the observation. The facility's Administrator and DoN was informed of the above findings on 10/23/19 at 12:05 PM, and no further information related to the deficient practice was provided by the end of the survey. .		education with posttests during orientation by the DON/designee. Beginning 11/19/19, the DON/designee will audit tracheostomy care to ensure respiratory care consistent with professional standards of practice, including but not limited to appropriate hand hygiene during tracheostomy care across all shifts, including weekends, daily x 2 weeks, then 3 x per week for 2 weeks and then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	

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F 744 SS=D	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. . Based on record review and staff interview, the facility failed to ensure a resident with a diagnosis of dementia receives appropriate services to attain or maintain the highest practicable physical, mental and psychosocial well-being. This is true for one (1) of five (5) residents reviewed for unnecessary medications. Resident identifier: #14. Facility census: 54. Findings include: a) Resident #14 Review of care plan with an initiated date of 02/25/14 and a revision date of 03/22/16 reveals a problem of "risk for complications related to the use of antidepressant and antipsychotic medications." The care plan goal with a revision date of 06/10/19 is, "Resident will have the smallest most effective dose without side effects through next review." The care plan interventions includes, "Complete behavior monitoring flow sheets." On 10/23/19 at 3:30 PM the director of nursing	F 744	F744 1. Resident #14's behavior monitor sheet was reviewed and updated on 11/13/19 by the Director of Nursing (DON)/designee to reflect behaviors exhibited at that time. Resident #14 has not experienced any negative outcome. 2. All residents of the facility with Dementia have the potential to be affected. Observation rounds were conducted across all shifts on 11/13/19 by the DON/designee to ensure a resident with a diagnosis of dementia receives appropriate treatment and services to attain and maintain his or her highest practicable physical, mental and psychosocial well-being regarding monitoring for risks for complications related to the use of antidepressants and antipsychotic medications this includes documentation of behaviors on behavior , flow sheets with any corrective action immediately upon discovery. 3. All licensed nurses including agency nurses will be reeducated on or before 11/27/19 by the DON/designee regarding the requirement to ensure a resident with a diagnosis of dementia receives appropriate treatment and services to attain and maintain his or her highest practicable physical, mental and psychosocial well-being regarding	11/27/19

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	explained the nursing assistants should document any behaviors which is then reported to the nurse. She also explained a behavior flow sheet is not completed/implemented according to the residents care plan. .		monitoring for risks for complications related to the use of antidepressants and antipsychotic medications this includes documentation of behaviors on behavior flow sheets with a posttest to validate understanding. Licensed nursing staff and agency nurses not available during this time will be provided re-education including post-test upon return to work. New hires during orientation will receive education and complete a post-test prior to completion of orientation. Beginning 11/19/19, DON/designee will conduct observation rounds and review behavior monitors across all shifts daily x 2 weeks across all shifts including weekends, then 3x/ week x 2 weeks then randomly thereafter to ensure a resident with a diagnosis of dementia receives appropriate treatment and services to attain and maintain his or her highest practicable physical, mental and psychosocial well-being regarding monitoring for risks for complications related to the use of antidepressants and antipsychotic medications. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-	

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			servicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 812 SS=E	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. . Based on observation and staff interview the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Kitchen equipment, and trash cans were soiled and a nourishment refrigerator freezer was soiled. This has the potential the affect more than a limited number of. Facility census: 54.	F 812	F812 1. The Dietary manager (DM) cleaned kitchen ovens, trash cans and 2 three tier carts immediately upon discovery. Dietary Aide discarded frozen ground beef and cleaned the freezer in the nourishment room upon discovery. 2. All residents of the facility have the potential to be affected. DM complete rounds on 11/18/19 including ensuring the kitchen ovens, trash e-ns, three tier carts and nourishment room freezer were cleaned appropriately and appropriate dating and labeling in the nourishment room to ensure the facility store, prepare, distribute and serve food in accordance with professional standards for food service safely with any corrective action immediately upon discovery. 3. The Administrator (NHA)/designee to reeducate all staff including agency on or before 11/27/19 on ensuring the kitchen ovens, trash cans, three tier carts and nourishment room freezer were cleaned appropriately and appropriate dating and labeling in the nourishment room to ensure the facility store, prepare, distribute and serve food in accordance	11/27/19

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	Findings included: a) During initial tour of the facility kitchen on 10/21/19 at 11:45 AM observation found the interior of two ovens with built-up dark substance, two (2) three (3) tier carts with visible soil, and two garbage cans at hand washing sinks visibly soiled. On 10/22/19 at 2:00 PM the dietary manager explained some areas were already clean and plans are in place to clean the entire kitchen. b) On 10/22/19 at 9:00 AM observation of the nourishment room freezer found a hair approximately five (5) inches long and the floor of the freezer with visible soil. The freezer also found to have frozen ground beef brought into the facility. On 10/22/19 at 9:30 dietary staff #52 observed the freezer to be soiled, removed the ground meat and cleaned the freezer. .		with professional standards for food service safely with a posttest completed to validate understanding. All staff including agency not available during this time frame will be provided re-education including post-test by the I Dietary Manager / designee, upon return Ito work. New hires will be provided education and posttests during orientation by the Regional Dietary Manager 1/designee. Beginning 11/19/19, DM / designee to audit department sanitation, including functional trash cans, kitchen ovens, three tier carts, nourishment room freezer and labeling and dating of open items in the nourishment room daily x 2 weeks including weekends then 3 x per week x 2 weeks, then randomly thereafter to ensure the kitchen ovens, trash cans and nourishment room freezer were cleaned appropriately and appropriate dating and labeling in the nourishment room to ensure the facility store, prepare, distribute and serve food in accordance with professional standards for food service safely. Findings of the audit will be reported by the DM/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the Registered Dietician/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up	

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			and/or in servicing until the issue is resolved and randomly thereafter as determined by the QIC.	
F 842 SS=D	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842	F842 1. The Director of Nursing (DON)/designee contacted the dialysis center on 11/4/19 regarding completion of dialysis communication forms. Nurses involved in completion of the dialysis communication form for resident #2 will be included in the reeducation of licensed nurses by the DON/designee on or before 11/27/19. Resident # 2 did not experience any negative outcome. New West Virginia Physician Orders for Scope of Treatment (POST) form was completed 11/7/19 with a licensed nurse to ensure appropriate dating and all sections completed. The nurse that initiated the Neurological assessment flow sheet will be reeducated by the DON/designee on ensuring assessments are properly dated including the year. 2. All residents of the facility have the potential to be affected. There are no additional residents currently requiring dialysis services. Audit conducted by the DON/designee on or by 11/27/19 on all POST and neurological assessment flow sheets to ensure a complete medical record regarding completing records in	11/27/19

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	(ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. . Based on record review and staff interview, the		their entirety with any corrective action immediately upon discovery. 3. Reeducation will be provided to licensed nurses including agency nurses by the DON/designee to ensure a complete medical record regarding completing, in their entirety, Hemodialysis communication record, POST and neurological assessment flow sheet on or before 11/27/19 with a posttest completed to validate/ understanding. Licensed nurses and agency nurses not available during this time frame will be provided reeducation posttest upon return to work by the DON/designee to include new license /nurses and dietitian during orientation. Beginning 11/18/19, an audit will be completed by the DON/designee to ensure a complete medical record regarding completing, in their entirety, 'Hemodialysis communication record, POST and neurological assessment flow sheet daily across all shifts including weekends x 2 weeks and 3 x a week x 2 weeks then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the	

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	facility failed to maintain a complete medical record in the area of Hemodialysis communication record, West Virginia Physician Orders for Scope of Treatment (POST) and Neurological Assessment Flow Sheet forms. This was true for one of one reviewed in the care area of dialysis. Resident identifier: #2. Facility census: 54 Findings included: a) Resident #2 1. Hemodialysis Communication Records for Resident #2, dated 10/14/19, 10/09/19, 10/02/19, 09/27/19, 09/25/19, 09/23/19, 09/11/19, and 09/04/19 did not have the section to be completed by Licensed Nurse post-dialysis treatment completed. 2. The POST (record of advanced directives) form for Resident #2, was not dated by Resident #2 and did not have the "Resident preferences as a guide" section completed. 3. Neurological Assessment Flow Sheet, which is completed following a fall, did not have a year listed for Resident #2. The document was simply dated 11/18 and 11/19, with no evidence of a year. During a staff interview on 10/22/19 at 10:00 AM, the Director of Nursing (DON) confirmed that the Neurological Assessment Flow Sheet for Resident #2 was not dated. Further, it should contain a year when the checks were completed. In an interview on 10/22/19 at 12:29 PM, with the Assistant Director of Nursing (ADON), the ADON confirmed that Resident #2's POST form and		QIC.	

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	Hemodialysis Communication Records were not complete. In addition, the ADON confirmed both documents should be completed in their entirety. .			
F 880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880	F880 1. Resident #145 was placed on contact isolation by a licensed nurse on 11/16/19. Exhaust fan was fixed by the Maintenance Director upon discovery to ensure ventilation flows from clean laundry room to the soiled laundry room and clean mop heads and towels were immediately re-washed upon discovery by the Laundry Aide. LPN #15 was reeducated on or by 11/27/19 by the Director of Nursing (DON) on cleaning the area for temporary medication storage and applying a barrier to ensure infection prevention and control program is designed to provide a safe, sanitary and comfortable environment and Ito help prevent the development and transmission of communicable diseases and infections. Resident #29 linens were removed from the sink immediately by the DON. 2. All residents of the facility have the potential to be affected. Observation rounds will be conducted across all shifts on 11/18/19 by the DON/designee to ensure infection prevention and control program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	11/27/19

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	(ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. . d) Resident #29 On 10/22/19 at 11:44 AM clean linens consisting of sheets, towels and wash clothes were found stacked on the sink top in Resident #29's room.		transmission of communicable diseases and infections regarding clean linen storage, appropriate isolation precautions for residents that have Multiple Drug Resistant Organisms (MDRO), ventilation flows from clean laundry room to soiled laundry room, clean mop heads and clean towels are stored in clean utility and cleaning the area for temporary medication storage and applying a barrier with any corrective action immediately upon discovery. 3. All licensed nurses including agency nurses will be reeducated on or before 11/27/19 by the DON/designee regarding ensuring infection prevention and control ' program is designed to provide a safe, sanitary and comfortable environment and,' to help prevent the development and transmission of communicable diseases and infections regarding clean linen storage, appropriate isolation precautions with residents that have MDRO, ventilation flows from clean laundry room to soiled laundry room and cleaning the area for temporary medication storage and applying a barrier with a posttest to validate understanding. Licensed nurses and agency nurses not available during this time will be provided re-education including post-test upon return to work. New hires during orientation will receive education and complete a post-test prior to completion of orientation. Beginning 11/19/19, DON/designee will audit to ensure infection prevention and	

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	The Director of Nursing (DON) with a survey team member present, at 12:10 PM on 10/22/19, verified the clean linens should not be on the sink top and immediately removed the linens. 10/21/19 11:44 AM Clean linens on sink. 12:10 PM. To DON. Verified that linen should not be on the sink top and removed the linens. . . c) Resident #32 Observation on 10/22/19 at 8:34 AM found licensed nurse #15 (LPN #15) administering a hand-held Symbiocort inhaler to this resident. Prior to this administration, LPN #15 first removed the Symbiocort inhaler from its box and laid the inhaler directly onto a folded white towel on the medication cart. This white towel was also beneath a large plastic pitcher filled with ice water used during medication administrations. Secondly, LPN #15 laid the Symbiocort inhaler directly onto the resident's overbed tray while the resident took her oral medications. This had the potential for transmitting pathogens from the tray onto the inhaler. Thirdly, after the resident placed her mouth onto the Symbiocort inhaler spacer for two (2) successive inhalations of the medication, LPN #15 then returned to the medication cart and laid the Symbiocort inhaler directly onto the same white towel. This had the potential of transmitting and spreading pathogens from the inhaler to the towel, and subsequently onto any other items which came into contact with that towel. On 10/23/19 at 12:30 PM an interview was conducted with the assistant director of nursing (ADON) related to inhaler administration specifically as related to infection control. She		safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections regarding clean linen storage, appropriate isolation precautions with residents that have MDRO, ventilation flows from clean laundry room to soiled laundry room and cleaning the area for temporary control program is designed to provide a medication storage and applying a barrier across all shifts daily x 2 weeks across all shifts including weekends, then 3x/ week x 2 weeks then randomly thereafter. Findings of the audit will be reported by the DON/designee to the Nursing Home Administrator daily upon completion of the audit. 4. Results of the audits will be reported by the DON/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	

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said she would look for their policy.

An interview was conducted with licensed nurse #38 (LPN #38) on 10/23/19 at 1:30 PM. She said nurses change the pitchers of water and the towels beneath the pitchers at the start of each shift. She said the towels help collect condensation from the large plastic pitchers of ice water.

On 10/23/19 at 1:45 PM an interview was conducted with the director of nursing (DON) and the administrator. The potential for cross contamination from placing inhalers directly onto unclean surfaces in residents' rooms, and placing potentially contaminated patient-used inhalers directly onto clean objects on the medication cart was discussed. The administrator said the nurse should have placed a barrier to lay the inhaler upon. The DON said their policy does not specify putting down a barrier.

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Based on record review, staff interview and observation, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) out of one (1) residents reviewed for Multidrug Resistant Organisms (MDROs). This failed practice had the potential to affect more than a limited number of residents residing at the facility. Also, random opportunities for discovery in the areas of the laundry room, Resident #29's room, linens on the sink, and for one (1) out of 34 during an observation of medication administration, Resident identifiers: #145, #32 and #29. Facility census 54.

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Findings included:

a) Resident #145

During an interview with Assistant Director of Nursing (ADoN) on 10/23/19 at 4:12 PM, she was asked if there was anyone in the facility at this time who is in transmission-based precautions. She stated, that there was no one at this time. At this time a review of the infection control book (used for tracking, trending, and surveillance, revealed, Resident #145 currently has active CRE (Carbapenem-resistant Enterobacteriaceae) a Multi-drug Resistant Organism (MDRO) and is not in Contact

She stated, that she and the attending physician discussed the fact that Resident #145 cannot be treated with any antibiotic, because the ones that are not resistant, caused him to have an allergic reaction. She went on to say, that they decided to not place Resident #145 in Contact Precautions. She was asked about how was the staff providing care and were they using PPEs'. Her response was, "I informed the staff of his condition, and told them if they feel like they had to or needed to use any type of PPE's they can do so." She was asked if there was signage on the door to alert staff and visitors and if the PPE's were placed outside the resident's door. She stated, that there was no sign on the door and the PPE's were kept in a drawer inside the resident's room.

In addition, it was observed on 10/23/19 at 12:15PM, by another surveyor, observing wound care on the abdomen, he had three drainage tubes, feeding tube, a colostomy and the site of the infection was from a surgical wound located

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on his abdomen had serotinous drainage. Licensed Practical Nurse #32 is also the treatment nurse for all the resident's residing in the facility, "did not wear a gown while providing wound care" even though the resident is currently positive for CRE.

b) Center of Disease Control (CDC) recommendations for MDROs'

The Center of Disease Control (CDC) states the following:
o Invasive infections (e.g., bloodstream infections) caused by CRE have been associated with
high mortality rates (up to 40 to 50% in some studies).
o In addition to \'e2-lactam/carbapenem resistance, CRE often carry genes that confer high levels of resistance to many other antimicrobials, often leaving very limited therapeutic options. "Pan resistant"
CRE have been reported.
o CRE have spread throughout most parts of the United States and other countries and have the potential to spread more widely.
o Currently in the United States, CRE are primarily identified among patients with healthcare
exposure, but there is potential for CRE to spread outside of healthcare settings, given that Enterobacteriaceae are a common cause of community-associated infections.

The CDC recommend, in general, standard interventions designed to prevent the transmission of multidrug resistant organisms (MDROs) (e.g., hand hygiene, Contact Precautions) should be
implemented.

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Contact Precautions:
Precautions:
Proper Use of Contact Precautions Includes:
o Performing hand hygiene before donning a gown and gloves
o Donning gown and gloves before entering the affected patient's room
o Removing the gown and gloves and performing hand hygiene prior to exiting the affected patient's room.

Examples of when gowns and/or gloves to be used include the following:
o Bathing residents
o Assisting residents with toileting
o Changing residents' briefs
o Changing a wound dressing
o Manipulating patient devices (e.g., urinary catheter)

b) Laundry room

During a tour of the laundry room on 10/23/19 at 9:07 AM, Laundry Worker #58 was present, she verified the facility was storing and drying clean mop heads and cleaning towels in the soiled laundry room. Also, at this time it was noted that the exhaust fan in the soiled laundry room was not on, thus causing the airflow to flow into the clean laundry room. This was verified with Laundry Worker #58, by placing a tissue at the bottom and sides of the door dividing the two areas. Standing in the soiled side of the door, the tissue was being pulled into the clean laundry room. There were gaps around the door and a gap approximately one (1) to two (2) inches on the bottom of the door.

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	On 10/23/19 at 10:08 AM, an review with Administrator and Maintenance Worker #1, provide information concerning the airflow going form soiled room to the clean room was due to the exhaust fan was not functioning properly. Maintenance worker #1 stated, that the exhaust fan was clogged up, but is now working properly. .			
F 921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. . Based on observation and staff interview the facility failed to provide a clean, safe, functional, and sanitary environment in the facility's only medication storage room. The medication storage room had no accessible soap for hand-washing. This was a random opportunity for discovery. This had the potential to affect more then a limited number of residents. Facility census: 54. Findings include: a) Medication Storage room Observation of the facility's only medication storage room was conducted on 10/23/19 at 10:15 AM, while accompanied by licensed nurse #40 (LPN #40). A small, narrow, hand-washing sink was located immediately to the right as one entered the medication storage room. A sign above the sink	F 921	F921 1. Maintenance Director (MD) relocated the wall-mounted soap dispenser in close proximity to the hand sink immediately upon discovery. 2. All residents of the facility have the potential to be affected. Director of Nursing (DON)/designee to observe soap dispenser in Medication room to ensure the facility provided a clean, safe, functional and sanitary environment in the facility's only medication room in regards to having a soap dispenser is in close proximity to the hand sink on 11/16/19. All licensed nurses including agency nurses will be reeducated on or before 11/27/19 by the DON/designee regarding the requirement to ensure the facility provided a clean, safe, functional and sanitary environment in the facility's only medication room in regards to having a soap dispenser is in close proximity to the hand sink with a posttest to validate understanding. Licensed nurses and	11/27/19

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	contained directives for proper hand-washing, which included the application of soap. However, there was no soap dispenser at the sink. There was no alcohol-based hand sanitizer in the room. LPN #40 said they used to have soap and alcohol-based hand sanitizer by the sink. She said she did not know what happened to them. Immediately to the left of the hand-washing sink sat a large, white, heavy, compact white refrigerator upon the countertop. Immediately to the left of the refrigerator was a long line of wall-mounted cabinets. LPN #40 soon found a wall-mounted liquid soap dispenser directly behind the refrigerator on the left side of the hand-washing sink. The refrigerator was pushed as far back as possible to the wall so as not to hang over the countertop in the front. This refrigerator completely obscured the view of the soap dispenser, and made the soap dispenser inaccessible. LPN #40 agreed that someone would have to physically pull the refrigerator out from the wall and hold on to it while a second person obtained soap from the dispenser. At 11 AM on 10/23/19 the director of nursing (DON) stood at the door of the medication storage room. The maintenance director moved the wall-mounted soap dispenser from behind the refrigerator. He relocated it in close proximity to the hand-washing sink. The soap dispenser was full. The DON said it was dispensing soap slowly, so the maintenance director was obtaining new batteries for the dispenser. An interview was conducted with the administrator and the DON on 10/23/19 at 1:45 PM. The issue of not having soap available in the		agency nurses not available during this time will be provided re-education including post-test upon return to work. New hires during orientation will receive education and complete a post-test prior to completion of orientation. Beginning 11/18/19, DON/designee will audit the soap dispenser in the medication to ensure the facility provided a clean, safe, functional and sanitary environment in the facility's only medication room in regards to having a soap dispenser is in close proximity to the hand sink weekly x 4 weeks, then randomly thereafter. Findings of the audit will be reported by the MD/designee to the Nursing Home Administrator daily upon completion for the audit. 4. Results of the audits will be reported by the MD/designee monthly to the Quality Assurance Performance Improvement Committee (QAPIC) for any additional follow-up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC.	

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	medication storage room for hand-washing was discussed. The DON said it is now corrected. .			