STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROLLING MEADOWS PLACE	5 ROLLING MEADOWS Scott Depot, WV 25560

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E 371	Records. Advanced directives; allergies; the dates of appointments with physicians, dentists, or other health care providers; all contacts by the residence's staff with the residence's physician; and observations by licensed nurses, physicians, and others authorized to care for the resident; and Based on record review and interview the licensee, administrator and registered nurse (RN) failed to ensure a resident's file included advanced directives for one (1) of eight (8) resident's (#28). Census: 39. Findings include: 1. Review of Resident #28's file revealed the following: a. Review of the resident assessment revealed the resident had a do not resuscitate (DNR) determination and a Medical Power of Attorney. b. There was what appeared to be a DNR document which had been copied and was so black it was not legible. The document was also not printed on pink paper, which is required. 2. During exit conference, on 08/18/20 at 11:30 AM, the registered nurse stated she may make a checklist to help in making sure all of the required information was documented at admission.	E 371	E 371 Plan of Correction: Date of Survey: 08/18/2020 Resident #28's record was updated on 10/01/20 by CSM to include the required PINK PAPER DNR document. ED/Designee will audit 5 resident records per week x 4 weeks, then 3 resident records per week x 4 weeks then 3 residents records per week x 4 weeks then 3 resident records per week x 4 weeks to ensure that recipients, then 1 resident record per week x 4 weeks to ensure that residents that are a DNR will have the DNR printed on pink paper. Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued editing is necessary based on 3 consecutive months of complaince.	10/09/20
E 274	Personnel Records.	E 274	Date of Survey: 08/18/20	10/09/20

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	Evidence that each assisted living residence employee, independent contractor, or volunteer has received an eligibility fitness determination or variance from the West Virginia Clearance for Access: Registry and Employment Screening unit of the Department of Health and Human Resources, if applicable; Based on record review and interview the licensee, administrator and registered nurse failed to ensure each assisted living residence employee received an eligibility fitness determination or variance from the West Virginia for Access: Registry and Employment Screening (WVcares) unit of the Department of Health and Human Resources which had the potential to effect all residents. Census: 39. Findings include: 1. Review of Employee #2's file revealed the following: a. The employee was hired on 06/10/20. b. An application should have been submitted to Scares to be ran through the registries for a fitness of employment determination prior to hire. c. There was a fitness determination notification of eligible for hire in the file dated complete on 06/22/20. 2. During exit conference, Employee #23, the business office manager, stated,"I did not think we had to do the WV cares stuff because we cannot get anyone's fingerprints done under 'Covid'." Surveyor expalined to Employee #23 that only the fingerprint portion of the background check had been temporarily waved. The		Plan of Correction: E274 Employee #2 completed WV CARES on 06/22/20 Current employee file audit was conducted by BOM on 09/25/20 to ensure WV CARES have been completed ED/Designee will conduct audits of new hired employee files within 15 days of employment to ensure an elgibility fitness determination or variance from WV CARES has been completed x 3 months. Monitoring will be on going. Date of Completion: 10/09/20	

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	prescreening process was still required prior to hire.			
E 276	Personnel Records. A health record containing the results of a pre-employment and annual screening for tuberculosis and other communicable diseases as indicated by exposure, prevalence, or currently accepted medical practice in congregate living situations as indicated by the Secretary. (Class III) Based on record review and interview the licensee, administrator and registered nurse (RN) failed to ensure a health record for employees contained the results of a pre-employment and annual screening for tuberculosis (TB) for four (4) of seven (7) employees (#s 1, 2, 22 and 33). Census: 39. Findings include: 1. Review of Employee #1's file revealed the following: a. The employee had a date of hire (DOH) 07/14/20. b. The employee had a purified protein derivative (PPD) placed on 07/17/20 and was read on 07/20/20. c. The PPD TB screen could not be considered a complete screen until it was read by a nurse. d. The screen was required pre-employment. The employee's screen was completed seven (7)	E 276	E 276 Date of Survey: 08/18/20 Plan of Correction: Pre-employment tuberculosis screening on Employees #1, #2, #33 cannot be corrected BOM conducted audit of new hire and current employee files on 09/25/20 to ensure completion of pre employment and annual screening for TB have been completed ED/Designee will conduct audits of new hired employee files within 15 days of employment to ensure pre-employment screening for TB has ben completed x 3 months. Results of audits will be discussed in monthly QI meetng x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Date of completion: 10/09/20	10/09/20

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	days late. 2. Review of Employee #2's file revealed the following: a. The employee had a date of hire (DOH) 06/10/20. b. The employee had a purified protein derivative (PPD) placed on 07/10/20 and was read on 07/13/20. c. The PPD TB screen could not be considered a complete screen until it was read by a nurse. d. The screen is required pre-employment. The employee's screen was completed thirty-four (34) days late. 3. Review of Employee #22's file revealed the following: a. The most recent TB screen was an assessment of symptoms on 05/06/19. b. The annual TB screen should have been completed no later than 05/06/20. c. The surveyor reviewed the employee's file on 08/12/20. As of this date, the employee's TB screen was ninety-eight (98) days overdue. 4. Review of Employee #33's file revealed the following: a. The employee was hired on 12/09/19. b. There was no documentation available for review the employee had a pre-employment PPD screen.			

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	c. As of the file review date 08/11/20, there was no evidence available for review a PPD has ever been placed and read for this employee, or, the PPD was two-hundred-forty-seven (247) days overdue. 5. During interview on 08/11/20 at 2:00 PM, Employee #23, the business office manager stated,"I will have to work with the RN to ensure TBs for new employees are completed prior to hire."			
E 423	Activities. Provide a monthly calendar that lists the type, time, and duration of all social and recreational activities for the residents and documentation that activities did or did not take place. (Class III) Based on record review and interview the licensee and administrator failed to ensure they provided a monthly calendar that lists the type, time, and duration of all social and recreational activities for the residents and documentation that activities did or did not take place which had the potential to affect all residents. Facility census: 39. Findings included: 1. Per surveyor request, Employee #13 brought a copy of a monthly activity calendar for review. Surveyor had asked for the activity calendar for the month of August 2020, however, was given a three (3) day calendar (Sunday, Monday and Tuesday) for the week of August 16, 2020. Surveyor also received a monthly calendar for February 2020.	E 423	E 423 Plan of Correction Date of Survey: 08/18/20 Life Enrichment Coordinator (LEC) received training on providing a monthly calendar that lists the type, time, and duration of all social, and recreational activities for residents and documentation that activities did or did not take place which had the potential to affect all residents on 09/25/20 by Regional Director of Care Services ED/Designee will audit monthly calendars to ensure they list the type, time, and duration of all social, and recreational activites for residents and documentation that activites did or did not take place Results of audits will be discussed in monthly QI meetings x 3 months. The QI	10/09/20

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	2. During interview, on 08/17/20 at 10:00 AM, the Activities director stated,"Corporate instructed me to do a three day calendar while we are in a lock down due to Covid." 3. Surveyor asked the employee how she verified whether an activity occurred or not. During the above interview she stated,"I was not aware I had to verify whether an activity did or did not occur." 4. Review of the February 2020 monthly calendar revealed it had met the requirements of the rule prior to the changes made by the corporate entity.		committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing Date of completion: 10/09/20	
E 413	Resident Death. Staff shall immediately report the suspected death of a resident to the resident's physician, to the resident's next of kin or legal representative, and hospice staff, if applicable. Any death suspected to be the result of abuse or neglect shall be immediately reported to the coroner. (Class III) Based on record review and interview the licensee, administrator and registered nurse (RN) failed to ensure staff immediately report the suspected death of a resident to the resident's physician for one (1) of four (4) residents. Resident #C3. Facility census: 39. Findings included: 1. Review of the closed record of Resident C3 revealed the following:	E 413	E 413 Date of Survey: 08/18/20 Plan of Correction The death notification documentation form for Resident #C3 cannot be corrected. CSM provided education to LPNs in regards to the WV Death Certificate, Death information form and in the event of death documentation in resident charts on 9/18/20. CSM will audit resident charts within 72 hours post death of resident x 3 months. The QI meeting will determine if continued auditing is necessary based on 3 consecutive months of compliance.	01/22/21

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	a. Review of the death form revealed the following: (i.) The resident passed away on 02/13/20 at 7:15 AM. (ii.) There was nothing documented on the form which would verify the resident's physician was ever contacted. b. Review of the nurse notes on 02/13/20 revealed there was no documentation the resident's physician was ever notified of the death of the resident. 2. During interview on 08/17/20 at 2:20 PM, the RN stated,"We are going to have to do an inservice with our Licensed Practical Nurses (LPN) about what has to be documented upon a resident's death here at the facility. There is always an LPN onsite 24/7."		Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing	
E 417	Resident Death. Upon a resident's death, the licensee shall release all of the resident's belongings and funds to the estate administrator or executor. Documentation of release to the estate administrator or executor shall be maintained by the assisted living residence. (Class III) Based on record review and interview the licensee, administrator and registered nurse (RN) failed to ensure upon a resident's death, they released all of the resident's belongings and funds to the estate administrator or executer and documented the release of the belongings. This pracitce affected four (4) of four (4) residents (#'C1, #C2, C3# and #C4). Census: 39.	E 417	E 417 Plan of Correction Date of Survey: 08/18/20 The documentation of to whom all of the resident's belongings were released for #C1, #C2, #C3, and #C4 cannot be corrected. CSM provided education to LPNS in regards to naming the estate administrator or executor to whom the resident's belongings and funds were released in the event of death is to be documented in the resident medical carts	10/09/20

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	Findings included: 1. Review of the death forms for Residents #s C1, C2, C3 and C4 revealed there was no documentation or signatures which would indicate who received the belongings of the deceased residents. 2 Review of the last nurse notes for Residents #sC1, #C2, #C3 and #C4 revealed there was no documentation of who received the belongings of the deceased residents. 3. During interview, on 08/12/20 at 2:55 PM, the RN stated,"I was not told by anybody to do that. We are going to have to do an inservice with our Licensed Practical Nurses (LPN) about what has to be documented upon a resident's death here at the facility. There is always an LPN onsite 24/7.		on 09/18/20 CSM will audit resident charts within 72 hours post death of resident x 3 months to ensure documentation of the name of the estate administrator or executor to whom the resident's belongings and funds were released is in resident's medical records Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing Date of completion: 10/09/20	
E 381	Medications and Treatments. The licensee shall ensure that resident care is provided by appropriately licensed health care professionals, and that medications and treatments given to residents are administered as required by applicable federal and state law, including W. Va. Code §§16-5O-1, et seq. and Department of Health and Human Resources rule, "Medication Administration and Performance of Health Maintenance Tasks by Approved Medication Assistive Personnel," W. Va. Code R. §§64-60-1, et seq. (Class I) Based on record review and interview the licensee, administrator and registered nurse	E 381	E 381 Plano of Correction: Date of Survey 08/18/2020 Resident #27's MAR were updated on 08/21/20 by CSM with current physician's orders with symptoms listed for AMAPs to consider for administration and parameters for AMAPs. Resident #22 MARs were updated on 08/21/20 by CSM with current physician's orders with symptoms listed for AMAPs to consider for administration	10/09/20

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	failed to ensure that medications given to residents are administered as required by applicable federal and state law, including the Department of Health and Human Resources rule,"Medication Administration and Performance of Health Maintenance Tasks by Approved Medication Assistive Personnel (AMAP) which has the potential to effect all residents who have as needed (PRN) medication orders. Census: 39. Findings include: 1. Review of the above AMAP rule revealed the following: a. Regulation 9.5 of the AMAP rule states,"Medications ordered by the physician or a healthcare professional with legal prescriptive authority to be given as needed shall be administered only if the order is written with specific parameters which preclude independent judgement," 2. The facility has two (2) medication carts, each with a Medication Administration Record (MAR) book containing the MARs for the nurses to use for verification medications are administered as ordered. Surveyor reviewed one of the MAR manuals for assessment of how PRN orders are written. Review of these PRN orders revealed the following: a. Review of Resident # 27's MARs revealed the following PRN orders lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Omeprazole 20 milligram (mg) everyday (QD) by mouth (PO) PRN. No symptoms listed for administration consideration.		and parameters for AMAPs to consider for AMAPs to consider for administration. Resident #29's MARS were updated on 8/21/20 by CSM with current physician's orders with symptoms listed for AMAPS to consider for administration and parameters to consider for administration and parameters for AMAPs to consider for administration. Resident #30's MARS were updated on 8/21/20 by CSM with current physician's orders with symptoms listed for AMAPS to consider for administration and parameters to consider for administration and parameters for AMAPs to consider for administration. Resident #32's MARS were updated on 8/21/20 by CSM with current physician's orders with symptoms listed for AMAPS to consider for administration and parameters to consider for administration and parameters for AMAPs to consider for administration. Resident #37 MARS were updated on 8/21/20 by CSM with current physician's orders with symptoms listed for AMAPS to consider for administration and parameters to consider for administration and parameters for AMAPs to consider for administration. Resident #36 MARS were updated on 8/21/20 by CSM with current physician's orders with symptoms listed for AMAPS to consider for administration and parameters to consider for administration	

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	(ii.) Simethicone Chew 80 mg PO four (4) times a day after meals and at bedtime PRN. No symptoms listed for administration consideration. (iii.) Acetaminophen 325 mg PO every four (4) hours PRN. No symptoms listed for administration consideration. (iv.) Loratidine 10 mg PO QD PRN. No symptoms listed for administration consideration. b. Review of Resident # 28's MARs revealed the following PRN order lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Tramadol 50 mg PO two (2) times per day (BID) PRN. No symptoms listed for administration consideration. c. Review of Resident # 29's MARs revealed the following PRN orders lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Ondansetron 8 mg PO every six (6) hours PRN. No symptoms listed for administration consideration. (ii.) Rizatriptan 5 mg dissolve one (1) tablet sublingually, then swallow one (1) time a day, may repeat in two (2) hour intervals PRN. Not to exceed 30 mg in twenty-four (24) hours. No symptoms listed for administration consideration. (iii.) Tobramycin inhalation (INH) solution (SOLN) 300 mg per 5 milliliters (ml), one (1) vial nebulizer every twelve (12) hours PRN. No symptoms listed for administration consideration.		and parameters for AMAPs to consider for administration. CSM/designee audited current residents MARs on 8/19/20 to ensure each PRN medication has indicated parameters and symptoms CSM/designee will audit 5 resident records per week x 4 weeks, then 3 resident records per week x 4 weeks, then 1 resident record per week x 4 weeks to ensure that each PRN medication has indicated parameters and symptoms Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Date of Completion: 10/09/20	

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	(iv.) Tramadol 50 mg PO three times per day (TID) PRN. No symptoms listed for administration consideration. (v.) Acetominophen 650 mg PO every six (6) hours PRN. No symptoms listed for administration consideration. (vi.) Albuterol inhaler two (2) puffs every six (6) hours PRN. No symptoms listed for administration consideration. (vii.) Fioricet 50/300/40 mg PO every four (4) hours PRN. No symptoms listed for administration consideration. (viii.) Ipratropium INH SOLN 0.02% one (1) vial via nebulizer QD PRN. No symptoms listed for administration consideration. (ix.) Ondansetron 8 mg PO every six (6) hours PRN. No symptoms listed for administration consideration. d. Review of Resident # 30's MARs revealed the following PRN orders lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Meclizine 25 mg PO TID PRN. No symptoms listed for administration consideration. (ii.) Ondansetron 4 mg PO every eight (8) hours PRN. No symptoms listed for administration consideration. (iii.) Tramadol 50 mg PO BID PRN. No symptoms for administration consideration.			

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	e. Review of Resident # 32's MARs revealed the following PRN order lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Senna-s 8.6/50 mg PO QD PRN. No symptoms listed for administration consideration. f. Review of Resident # 36's MARs revealed the following PRN orders lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Mucinex 600 mg PO BID PRN. No symptoms listed for administration consideration. (ii.) Proctofoam 1% apply topically (TOP) four (4) times per day PRN. No symptoms or location listed for administration consideration. (iii.) Proctozone cream 2.5% apply TOP four (4) times per day PRN Fitch (should read for itch). g. Review of Resident # 37's MARs revealed the following PRN orders lacking parameters for AMAPs to consider when administering the PRN medication: (i.) Advil 200 mg PO every four (4) to six (6) hours PRN. No symptoms listed for administration consideration. (ii.) AZO bladder control one (1) capsule PO BID PRN. No symptoms listed for administration consideration. (iii.) Buspirone 5 mg PO BID PRN. No symptoms listed for administration consideration. (iv.) Calcium antacid chew 500 mg PO every six			

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	(6) hours PRN. No symptoms listed for administration consideration. (v.) Famotidine 20 mg PO QD PRN. No symptoms listed for administration consideration.			
E 343	Treatment. A resident has the right to prompt action by the licensee to resolve any complaints the resident has, including those with respect to the behavior of other residents. The licensee shall respond to the complainant in writing no later than four days after the complaint is filed. (Class III) Based on record review and interview the licensee and administrator failed to ensure the licensee respond to the complainant in writing no later than four (4) days after the complaint was filed which had the potential to affect all residents. Census: 39. Findings include: 1. Surveyor reviewed the facilities complaint folder. Review of ten (10) complaints revealed there was no verification which would indicate a written response had been made within four (4) days of the complaint. 2. During exit interview at 11:32 AM, the administrator stated he did not know a letter had to be sent if the complaint was resolved immediately.	E 343	E 343 Plan of correction: Date of Survey: 08/18/20 Regional director of care services educated ED on 9/25/20 regarding complaint process. ED/Designee will review complaints and respond in writing no later than 4 days after complaint is filed Ed/designee will conduct weekly audits x 12 weeks of complaints to ensure complainants have been notified in writing within 4 days. Results of audits will be discussed in monthly QI meeting. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of complaince Monitoring will be ongoing. Date of Completion: 10/30/2021	10/09/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _____ B. WING _____	08/18/2020

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E 369	Records. The names, addresses, and telephone numbers of the following, if applicable: the resident's physician, dentist, legal representative, person or agency responsible for the resident's support payments, next of kin or person to be notified in case of an emergency, and any case management agency involved in the resident's care. Based on record review and interview the licensee, administrator and registered nurse failed to ensure the names, addresses and telephone numbers of, if applicable, the resident's physician, dentist, legal representative, person or agency responsible for the resident's support payments, next of kin or person to be notified in case of an emergency are documented in the resident's record for five (5) of five (5) applicable residents (#s 18, 24, 28, 31 and 32). Census: 39 Findings include: 1. Review of Resident #18's file revealed the following: a. The name of the physician was in the file, however, there was no address or phone number documented. 2. Review of Resident #24's file revealed the following: a. There physician's name was on the outside of the resident's file, however, no address or phone number could be found in the file. There was no dentist name, address or phone number documented anywhere in the file.	E 369	E 369 Date of Survey: 08/18/20 Plan of correction Ed/Designee will audit 5 resident records per week x 4 week, then 3 resident records per week x4 1 resident record week Resident #18, #24, #31, #32 of face sheets were updated with the required informaton on 10/1/20. Resu lts of audits will be discussed monthly in committee QI meeting x 3 months. The QI committee will determine if continued auditing is necessary. Date of Completion: 10/09/20	10/30/20

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	b. The admitting physician, who is not the physician on the cover of the file, signed the admission assessment and wrote her phone number on the third page of the admission assessment document, however, there was no address found anywhere in the resident's file. c. There is documentation in the file which indicates a neighbor of the resident is the health care surrogate, however, there is no official document anywhere in the file. 3. Review of Resident #28's file revealed the following: a. There is no dentist name, address or phone number documented in the file. b. Review of the initial resident assessment reveals there is documentation which indicates the resident has a Medical Power of Attorney (MPOA) and a Durable Power of Attorney (DPOA). c. Review of the face sheet indicates there is a DPOA. d. There were no MPOA or DPOA documents in the resident's file. 4. Review of Resident #31's file revealed the following: a. There was no documentation of the resident's physician name, address or phone number available for review. b. There was no documentation of the resident's dentist address or phone number available for			

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	review. 5. Review of Resident #32's file revealed there is no documentation whether the resident had a dentist or not. 6. During exit conference on 08/18/20 at 11:30 AM, the registered nurse stated she may make a checklist to help in making sure all of the required information is documented at admission.			
E 416	Resident Death. The date, time, and circumstance of death, including the name of person to whom the body was released and any other details specific to the death. (Class III) Based on record review and interview the licensee, administrator and registered nurse (RN) failed to ensure when a resident passed away at the facility, the name of the person to whom the body was released was included in the resident's medical record for four (4) of four (4) residents (#s C1, C2, C3 and C4). Census: 39. Findings included: 1. Review of the death forms for Residents #s C1, C2, C3 and C4 revealed only the name of the funeral homes which the bodies of the residents were released to were documented. The names of the of the employees of these funeral homes who actually received the bodies of the residents were not documented. 2 Review of the last nurse notes for Residents #s C1, C2, C3, and C4 revealed there were no	E 416	E 416 Date of Survey: 08/18/20 Plan of Correction: The body release documentation on the Death information form and in the medical record for resident #C1, #C2, #C3, C4 cannot be corrected. CSM provided education to LPNs in regards to the name of person to whom the body was released in the event of death to be documented in the resident medical charts on 9/18/20. CSM will audit resident charts within 72 hours post death of resident x 3 months to ensure documentation of the name of the person to whom the body was released is in the resident's medical charts Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued	10/09/20

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	funeral home employee names documented in the notes. 3. During interview, on 08/17/20 at 2:20 PM, the RN stated,"we are going to have to do an inservice with our Licensed Practical Nurses (LPN) about what had to be documented upon a resident's death here at the facility. There was always an LPN onsite 24/7.		auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing Date of completion: 10/09/20	
E 237	General Administrative Requirements. The licensee shall develop and adopt written policies and procedures that are consistent with this rule and specific to the assisted living residence, governing the care and safety of residents, and all other policies and procedures required by this rule. The licensee shall sign and date the policies and procedures at the time of adoption and of any changes. (Class III) Based on record review and interview the licensee, administrator and registered nurse (RN) failed to ensure they implemented the policies and procedures which governs the care and safety of the residents which had the potential to effect all residents. The licensed practical nurses job descriptions required they maintained current first aid certifiecation. Three (3) LPNs had not maintained a first aid certification. Employee identifiers: #2, #5, and #11. Census: 39 Findings included: 1. Review of Employee #2's file, a licensed practical nurse (LPN), revealed the following:	E 237	E 237 Plan of Correction Date of Survey: 08/18/20 LPN #2 and #11 will obtain first aid training by 11/30/20 Audit of current licensed nurses for first aid certification conducted on 9/25/20 by Business office Manager (BOM). The executive director (ED)/designee will conduct a monthly audit of licensed nurses to ensure first aid training is current x 3 months Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Completion Date: 11/30/20	11/30/20

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	a. There was a job description for LPNs in the file. It read a LPN was required to maintain both cardio-pulmonary resuscitation (CPR) and first aid (FA) as a condition of employment. b. Review of the employee's CPR card revealed the training was completed on 08/21/18 and was good through 08/2020. c. There was no indication FA had been completed and was not indicated as such on the card. 2. Review of Employee #5's file, an LPN, revealed the following: a. Review of the employee's CPR card revealed the training was completed on 07/28/19 and was good through 07/2021. b. There was no indication FA had been completed and was not indicated as such on the card. 3. Review of Employee #11's file, an LPN, revealed the following: a. Review of the employee's CPR card revealed the training was completed on 03/12/20 and was good through 03/12/22. b. There was no indication FA had been completed and was not indicated as such on the card. 4. During exit interview on 08/18/20 at 11:15 AM, the RN stated, "I was not aware the LPN job description required they must maintain FA."			

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E 269	Employee Orientation and Training. The licensee shall provide and maintain a record of in-service training annually to all staff on the topics of resident rights, confidentiality, abuse prevention and reporting requirements, the provision of resident activities, infection control, fire safety and evacuation plans, and specialty care based on individual resident needs and service plans. (Class II) Based on record review and interview the licensee, administrator and registered nurse failed to ensure the specialty training include the topics related to catheters and blood thinners which had the potential to affect the care received for eight (8) of eight (8) applicable residents (#s 6, 21, 23, 26, 28, 33, 35 and 38). Census: 39. Findings included: 1. Review of one (1) of the two (2) Medication Administration Record (MAR) binders revealed the following residents are taking some form of blood thinners: a. Resident #21 has a physician's order for Clopidogrel 75 milligrams (mg) every day (QD), which is an antiplatelet. b. Resident #23 has a physician's order for Pradaxa 75 mg twice a day (BID), which is an anticoagulant. c. Resident #26 has a physician's order for Aspirin 81 mg QD, which is an anticoagulant. d. Resident #28 has a physician's order for Eliquis 2.5 mg BID, which is an antiplatelet.	E 269	E 269 Date of Survey: 08/18/20 Plan of Correction: Current staff received specialty training related to catheters and blood thinners on 9/18/20. Specialty training to be conducted upon new hire and annually thereafter Audit of current residents specialty care needs conducted by Care Service Manager (CSM) to ensure specialty care needs have been identified and education and training is completed by nursing staff by 10/30/20 ED/Designee will audit 5 resident records per week x 4 weeks, then 3 residents records per week x 4 weeks then 1 resident record per week x 4 weeks Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive month of compliance. Date of Completion: 10/30/20	10/30/20

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	e. Resident #33 has a physician's order for Clopidogrel 75 mg QD, which is an antiplatelet. f. Resident #35 has a physician's order for Clopidogrel 75 mg QD, which is an antiplatelet and an order for Aspirin 81 mg QD, which is an anticoagulant. 2. During interview the RN stated the facility currently have two residents who have foley catheters, Resident #6 and #38. 3. Review of the specialty training form currently used by the business office manager revealed neither catheters or blood thinners as a training either at hire or annually. 4. During exit conference the RN stated,"I have not done any training on blood thinners or catheters. I cannot speak for anyone prior to me."			
E 270	Employee Orientation and Training. The licensee shall provide training to all new employees within 15 days of employment and annually thereafter on Alzheimer's disease and related dementias. The licensee shall maintain an employee training record. The training shall be a minimum of two hours in duration and shall include all the following: basic understanding of Alzheimer's disease and other dementias; communication approaches and techniques for use when interacting with persons with Alzheimer's disease or a related dementia; prevention and management of problem behaviors; and activities and programming appropriate for these individuals. (Class II)	E 270	E 270 Plan of Correction: Date of Survey: 08/18/20 Employee #32 completed the training on 1/19/2020 Employee #33 completed the training on 12/28/2019 Current employee training records audited by BOM on 09/25/20 to ensure completion of Alzheimer's disease and related dementias training was	10/09/20

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	Based on record review and interview the licensee, administrator and registered nurse failed to ensure they provide training to all new employees within fifteen (15) days of employment on Alzheimer's disease and related dementias for two (2) of four (4) employees (#s 32 and 33). Census: 39. Findings include: 1. Review of Employee #32's file revealed the following: a. The employee was hired on 12/09/19. b. The employee should have completed new hire training on Alzheimer's and related dementias within fifteen (15) days of hire, or by 12/24/19. c. The was no evidence available for review the above training ever took place. 2. Review of Employee #33's file revealed the following: a. The employee was hired on 12/09/19. b. The employee should have completed new hire training on Alzheimer's and related dementias within fifteen (15) days of hire, or by 12/24/19. c. The was no evidence available for review the above training ever took place. 3. During interview on 08/18/20 at 11:27 AM, Employee #23, the business office manager stated,"I was not able to find any document that		completed within 15 days of hire. The Executive Director (ED) designee will conduct audits of new hired employee files within 15 days of employment to ensure Alzheimer's Disease and related dementias training has been completed within 15 days of hire x 3 months Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongiong Date of Completion: 10/09/20	

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	could prove they did their Alzheimer's training."			
E 376	Assessment and Service Plans. Each resident shall have a written, signed, and dated health assessment by a physician or other licensed health care professional, authorized under state law to perform this assessment, not more than 60 days prior to the resident's admission, or no more than five working days following admission, and at least annually after that. The admission and annual health assessment shall include screening for tuberculosis and other communicable diseases if indicated by exposure, prevalence, or risk according to current medical practice to congregate living situations as indicated by the Secretary. The licensee shall maintain documentation of the assessment in the resident's medical record. (Class II) Based on record review and interview the licensee, administrator and registered nurse failed to ensure each resident shall have a written, signed, and dated health assessment by a physician not more than sixty (60) days prior to the resident's admission, or no more than five (5) working days following admission, and at least annually after that, which shall include screening for tuberculosis (TB) and shall be maintained in the residents medical record for two (2) of seven (7) residents (#s 10 and 20). Census: 39. Findings include: 1. Review of the file of Resident #10 revealed the following: a. The resident's most recent TB screen was	E 376	E 376 Plan of Correction: Date of Survey 08/18/2020 TB scrren for Resident #10 and #20 cannot be corrected. CSM auditted current resident files to ensure TB screens were current. ED/designee will audit 5 reisdent records per week x 4 weeks , then 3 resident records per week x 4 weeks, Date of Completion: 10/09/2020	10/09/20

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	completed on 06/01/20. b. The TB screen prior to the above screen was dated complete on 04/19/19. c. The annual TB screen should have been completed no later than 04/19/20. d. The most recent TB screen was completed forty-four (44) days late. 2. Review of the file of Resident #20 revealed the following: a. The most recent annual assessment in the resident's file was dated completed on 02/19/19. b. The annual assessment should have been completed no later than 02/19/20. c. As of the file review date of 08/14/20, the annual assessment is currently one-hundred-seventy-seven (177) days late. 3. During interview on 08/14/20 at 2:30 PM, the RN stated,"we could not get a health assessment completed due to the Covid-19 shutdown." 4. The above shutdown did not occur until 03/16/20. The annual assessment was due completed no later than 02/19/20, which was twenty-six (26) days prior to the shutdown.			
E 430	Dietary Services. The licensee shall provide each resident with the amount of food and fluid on a daily basis necessary to maintain his or her appropriate minimum average weight. Staff shall weigh	E 430	E 430 Plan of Correction: Date of Survey: 08/18/20	10/09/20

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	residents upon admission and monthly thereafter and document the resident's weight in his or her record. If the staff notes an unplanned weight loss or gain of five pounds or more in the resident's record, the staff shall report it to the resident's physician. (Class III) Based on record review and interview the licensee, administrator and registered nurse failed to ensure staff weighed residents upon admission and monthly thereafter and documented the resident's weight in his or her record. The licensee, administrator and registered nurse also failed to ensure they noted an unplanned weight loss or gain of five (5) pounds or more in the resident's record, and report to the resident's physician. These practices occurred for seven (7) of seven (7) residents (#s 6, 10, 18, 20, 24, 28 and 32). Census: 39. Findings included: 1. Surveyor requested the resident's weight log for the past year. Upon receipt of the weight log surveyor noted it only went back to the beginning of 2020. Surveyor request the weight record for the months of September, October, November and December 2019. Surveyor then received the requested additional logs. Review of these weight logs revealed the following: a. Review of the weight log for Resident #6 revealed the following: (i.) The resident's weight in June 2020 was two-hundred-fifty-three (253) pounds. (ii.) The resident's weight in July 2020 was two-		Resident #6 had a weight gain of 10# in July 2020. No documentation of physician notification. This cannot be corrected. Resident #10 - no documented weights obtained in October, November, December 2019. This cannot be corrected. Resident #18 had a weight gain of #7 in February 2020. No documentation of physician notificaiton. This cannot be corrected. Resident #20 - No documented weights obtained in October, November, December 2019. This cannot be corrected. Resident #24 - No documented weight obtained in April 2020. This cannot be corrected. Resident #28- No documented weights obtained for November, December 2019. This cannot be corrected. Resident #32 had a weight loss of 5# in April 2020. No documentation of physician notification. This cannot be corrected. Current staff will be educated by CSM by 10/15/20 regarding requirements for resident weights upon admission and monthly thereafter, and that any unplanned weight loss or gain of 5# is documented	

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	hundred-sixty-three (263) pounds. (iii.) There was a weight gain of ten (10) pounds. There was no documentation available for review which could verify a physician notification occurred. b. Review of the weight log for Resident #10 revealed there were no weights recorded for the months of October, November and December 2019. c. Review of the weight log for Resident #18 revealed the following: (i.) The resident's weight in January 2020 was one-hundred-twenty-one (121) pounds. (ii.) The resident's weight in February 2020 was one-hundred-twenty-eight (128) pounds. (iii.) There was a weight gain of seven (7) pounds. There was no documentation available for review which could verify a physician notification occurred. d. Review of the weight log for Resident #20 revealed there were no weights recorded for the months of October, November and December 2019. e. Review of the weight log for Resident #24 revealed there was no weight recorded for the month of April 2020. f. Review of the weight log for Resident #28 revealed there were no weights recorded for the months of November and December 2019. g. Review of the weight log for Resident #32		ED/Designee will audit monthly weights to ensure physician notification of weight gain or loss of #5 is documented x 3 months Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing Date of completion: 10/09/20	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	revealed the following: (i.) The resident's weight in March 2020 was one-hundred-fifty-eight (158) pounds. (ii.) The resident's weight in April 2020 was one-hundred-fifty-three (153) pounds. (iii.) There was a weight loss of five (5) pounds. There was no documentation available for review which could verify a physician notification occurred. 2. During exit interview, on 08/18/11 at 11:25 AM, the registered nurse stated,"we are doing much better than those before us. I will talk with the staff about when to do monthly weights and then make sure they are reviewed shortly after."			
E 001	Initial Comments Date: 08/10/20 at 2:00 PM to 08/18/20 at 11:30 AM. Census: 39 Annual Survey	E 001	E 430 Plan of Correction: Date of Survey: 08/18/20 Resident #6 had a weight gain of 10# in July 2020. No documentation of physician notification. This cannot be corrected. Resident #10 - no documented weights obtained in October, November, December 2019. This cannot be corrected. Resident #18 had a weight gain of #7 in February 2020. No documentation of physician notificaiton. This cannot be	10/09/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _____ B. WING _____	08/18/2020

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			corrected. Resident #20 - No documented weights obtained in October, November, December 2019. This cannot be corrected. Resident #24 - No documented weight obtained in April 2020. This cannot be corrected. Resident #28- No documented weights obtained for November, December 2019. This cannot be corrected. Resident #32 had a weight loss of 5# in April 2020. No documentation of physician notification. This cannot be corrected. Current staff will be educated by CSM by 10/15/20 regarding requirements for resident weights upon admission and monthly thereafter, and that any unplanned weight loss or gain of 5# is documented ED/Designee will audit monthly weights to ensure physician notification of weight gain or loss of #5 is documented x 3 months Results of audits will be discussed in monthly QI meetings x 3 months. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _____ B. WING _____	08/18/2020

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			Date of completion: 10/09/20	