DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health

DATE SURVEY COMPLETED: December 20, 2021

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from December 8, 2021 through December 20, 2021. The facility census the first day of the survey was 57. During this period an Emergency Preparedness Survey was also conductec by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed December 20, 2021 The federal tags werecited:F580,F584,609,657,677,679, 686,689,690, 842.		

Provider's Signature _____ Title_____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from December 8, 2021 through Dember 20, 2021. The facility census was 57 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from December 8, 2021 through December 20, 2021. The facility census the first day of the survey was 57. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. Abbreviations and Definitions used in Survey: NHA - Nursing Home Administrator; CNA - Certified Nursing Assistant: DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; RD (Registered Dietitian) - A food and nutrition expert who helps individuals make smart dietary and lifestyle choices;	F 000		

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

Electronically Signed | 01/18/2022

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

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F 000	Continued From page 1 Accessory Muscles- shoulders, neck and/or abdominal muscles used to assist with breathing when not getting enough oxygen; Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADL Self-Performance: - Extensive Assistance - resident involved in activity, staff provide weight-bearing support; - Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; - Total Dependence - full staff performance every time activity performed; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 -15. 13-15: Cognitively Intact 8-12 Moderately Impaired 0-7 Severe Impairment; Blood pressure (BP) - the measure of the force of blood against the walls of a blood vessel; Braden Scale - test used to determine risk for developing pressure ulcers (score 15-18 is at risk; score 14 and under is high risk); cc - cubic centimeter; Coccyx - tailbone; Dementia - condition that causes problems with thinking, behavior, and memory; Diabetes Mellitus (DM) - disease with high levels of sugar in the blood; Division of LTCRP - State of Delaware Department of Health and Social Services, Division of Long Term Care Residents Protection (now known as Division of Health Care Quality); Dysphagia - difficulty swallowing; Hydrocolloid dressing - dressing that forms a gel with water/fluid; Incontinence - inability to control bowels and/or	F 000		

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F 000	Continued From page 2	F 000		

bladder;
Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance;
Moisture barrier - skin protectant cream;
Neuro checks/Neurological assessments - series of simple questions and physical tests to determine if the nervous system is impaired;
Offloading/Offload - removal of pressure from an area;
Ombudsman - person who investigates resident complaints and helps to achieve agreement with the facility;
Perineal care - cleansing of area between the thighs, external genitals and anus;
Periwound - area immediately around the wound;
POA (Power of Attorney) - person to act in your place for medical care and/or finances;
Pneumonia - lung infection;
Pressure injury - sore area of skin that develops when blood supply to it is cut off due to pressure;
PRN - as needed;
MAR (Medication Administration Record) - record of medication given to the resident, may be electronic, (EMAR);
MDS (Minimum Data Set) assessment - standardized assessment form used in nursing homes;
mL-milliliter;
Santyl - ointment to help remove dead tissue;
Shear/Shearing Force - friction with reduced blood flow to the tissue under the skin from sliding down in, or being pulled across, the bed;
Slough - yellow, tan, gray, green or brown dead tissue;
Stage 2 Pressure Injury - blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present.

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F 000	Continued From page 3 Stage 3 Pressure Injury - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible but does not hide the extent of tissue loss. Unstageable Pressure Injury - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed; Vital signs - clinical measurements (i.e., pulse rate, temperature, respiration rate, blood pressure); Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days; Wound bed - bottom of a wound.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		2/8/22

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F 580	Continued From page 4 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R25) out of two sampled residents reviewed for hospitalization, the facility failed to consult the practitioner when R25 had a significant change in status. Findings include:	F 580	R25 continues to reside in the community. Upon physician notification, resident received medical treatment and has remained stable. Current residents with a significant change in condition have the potential to	

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F 580	Continued From page 5 Review of R25's clinical record revealed: 8/3/21 - R25 was admitted to the facility after a stroke. 9/26/21 12:01 PM - A nursing progress note documented that at on 9/26/21 at approximately 10:30 AM, R25 was assessed by staff and had low oxygen levels, abnormal lung sounds and was using accessory muscles to breath. Staff then turned up the amount of oxygen that R25 was receiving by machine. Then on 9/26/21 at approximately 11:45 AM, R25 was reassessed, and her lung sounds remained abnormal, her breathing rate had increased, and the use of accessory muscles had increased since the last assessment. R25 had become "anxious and fidgety" (sic.), (R25 was struggling more to breath.) 9/26/21 approximately 10:30 AM through 11:45 AM - It was unclear that a practitioner was consulted when R25 initially had a significant change in status. 12/20/21 10:02 AM - During an interview, E1 (NHA in Training) reported/confirmed that she had no evidence to confirm that the practitioner was notified of a change in R25's condition at 10:30 AM. The facility failed to have evidence of notification of a practitioner at 10:30 AM when R25's change of condition first occurred. The practitioner was not notified of R25's significant change in status for approximately one hour and fifteen minutes later when her condition had become progressively worse.	F 580	be affected. An audit of current residents' medical records has been conducted from the previous 30 days for timely physician notification and documentation of notification. A root cause analysis determined that re-education is needed regarding timely physician notification documentation. Licensed staff will be re-educated by Staff Development Director/designee on Change in Condition policy which includes timely physician notification and documentation for residents with a significant change in condition. DON/designee will complete an audit of 5 residents with a significant change in condition to ensure physician timely notification. Audits will be completed daily x5 until 100% compliance is verified, then, weekly x4 until 100% compliance is verified, then, monthly x 2 with 100% compliance verified. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 580	Continued From page 6 Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director), E5 (ADON), E9 (Regional Nurse), and E30 (Ombudsman) participated by telephone.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including 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);	F 584		1/31/22

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F 584	Continued From page 7 §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. This REQUIREMENT is not met as evidenced by: Based on random facility observations it was determined that the facility failed to provide a clean and homelike environment in two out of twenty-nine rooms (301 and 305) on the long term care unit and for two residents on the transitional care unit (R45 and R59). Findings include: The following observations were made on the long term care unit: 1. Room 301 12/8/21 11:00 AM - A chair was observed in room 301 with a dark brown unidentified stain on it. 12/14/21 10:09 AM - A chair was observed in room 301 that had a dark brown unidentified stain on it. 12/14/21 10:15 AM - An interview with E8 (CNA) confirmed that the chair stain was unidentifiable and that a work order would be submitted to maintenance to address the problem. 2/14/21 10:41 AM - An observation revealed an unidentified staff member removing the chair	F 584	The identified chair in room 301 was removed, cleaned, and stained removed. The identified dividing curtain in room 305 was removed, laundered, and returned with no stains or substance. R45 and R59 did not have a negative affect from eating off of institutional trays in the dining room in the 100 unit. Current residents' rooms have the potential to be affected. An audit of all chairs and dividing curtains was conducted to ensure all chairs and dividing curtains were clean and stain free. Current residents in the dining room on the 100 unit have the potential to be affected by meals served on institutional trays. An audit was conducted to ensure residents were not being served on institutional trays for meals. A root cause analysis was conducted and revealed that the implementation of Room Inspections by the Housekeeping Supervisor is needed. The Housekeeping Supervisor will be re-educated by the	

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F 584	Continued From page 8 from room 301. 2. Room 305 12/8/21 11:05 AM - The dividing curtain in room 305 had a large stain with an unidentified substance stuck on it. 12/14/21 10:10 AM - The curtain in room 305 had a stain with an unidentified material stuck on it. 12/14/21 10:15 AM - E8 (CNA) confirmed that the curtain in room 305 was stained and had an unidentifiable substance on it and a work order to clean the curtain would be placed to maintenance. 12/14/21 10:41 AM - An observation revealed an unidentified staff member removing the curtain from 305. 3. Dining Room On 12/10/21 12:45 PM, 12/14/21 9:02 AM, and 12/20/21 1:25 PM - During random dining observations, R45 and R59 were in the 100 unit dining room and were served their meals on institutional trays. Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director) and E5 (ADON). E9 (Regional Nurse) and E30 (Ombudsman) participated by telephone.	F 584	NHA/designee on the Room Inspection audit which includes the inspection of dividing curtains and chairs. The root cause analysis regarding meals served on institutional trays was conducted and revealed the need for re-education with the Dining Services Director and Cook Supervisors. NHA/designee will conduct re-education on resident dining experience that will be home-like and not use institutional trays. The Housekeeping Supervisor/designee will complete Room Inspections to ensure chairs and dividing curtains are maintained in order to provide a safe, clean, and comfortable home-like environment for residents. Audits will be completed daily x5 days until 100% compliance is verified, then, weekly x4 until 100% compliance is verified, then, monthly x2 until 100% compliance is verified Results of the audits will be presented at the Quality Assurance Improvement Committee for review and recommendations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		2/8/22

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F 609	Continued From page 9 §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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for two (R2 and R210) out of four sampled residents reviewed for abuse, the facility failed to identify two allegations of abuse which resulted in delayed reporting to the State Agency. Findings include: 1. Review of R210's clinical record revealed:	F 609	R2 and R210 no longer reside at the community. Current resident incidents/complaints have the potential to be affected by this practice. A review of resident incidents/complaints for the last 14 days has been audited for potential abuse/neglect. No other	

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F 609	Continued From page 10 5/4/21 - R210 was admitted to the facility with dementia. 5/10/21 - An admission MDS assessment documented that R210 was severely cognitively impaired. R210 could walk with supervision and had wandering behaviors. 5/25/21 4:00 AM (Date and time of the incident) - A facility internal investigation was initiated for an allegation of resident to resident abuse involving R210 wandering into R15 and R17's rooms multiple times. Both residents verbalized being scared/fearful. 5/28/21 4:02 PM - The facility submitted a report to the State Agency three days after the incident occurred. The facility failed to identify the 5/25/21 incident involving R210 wandering into R15's and R17's rooms, and their statements of fear as an allegation of resident ot resident abuse. 12/15/21 9:15 AM - During an interview E1 (NHA in Traning) confirmed that the 5/25/21 resident to resident allegation of abuse involving R210 was not reported to the State Agency until 5/28/21 because there was " no resident injury." 2. Review of R2's clinical record revealed: 6/8/21 - R2 was admitted to the facility with a diagnosis of a broken back. 6/14/21 - An admission MDS assessment documented that R2 was cognitively intact, and required extensive assistance with her activities	F 609	incidents/complaints were identified with potential abuse/neglect. A root cause analysis revealed a knowledge deficit on the identification of abuse or neglect and required timing of reporting submissions to the Division. Re-education will be provided by the Corporate Clinical Representative/designee to the NHA, DON, ADON, RNAC, and licensed staff of the community on abuse/neglect identification and timely reporting requirements. The DON/designee will complete an audit of resident incidents relating to abuse or neglect to ensure proper identification of abuse and neglect is accomplished along with timely reporting to the Division. Audits will be completed daily x5 days until 100% compliance is verified, then, weekly x2 until 100% compliance is verified, then monthly x2 until 100% compliance is verified. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 609	Continued From page 11 of daily living. 7/10/21 9:00 AM (date and time of the incident) - An incident report submitted to the State Agency on 7/12/21 at 8:42 AM included: "CNA reported that she heard a staff member yelling at a resident stating (sic.) at the nursing station." 7/16/21 - A 5-day follow up submitted by the facility to the State Agency included: "E19 (CNA) reported to E20 (RN Supervisor) E21 (LPN) was yelling at a resident (R2)." The facility failed to identify that the report of yelling at R2 by a staff member was an allegation of abuse. The facility failed to report the incident to the State Agency within the required 24-hour time frame. The incident occurred on 7/10/21 and was not reported until two days later on 7/12/21 at 8:42 AM. 12/20/21 approximately 12:30 PM - E1 confirmed that the incident that occurred on 7/10/21 involving R2 allegedly being yelled at by a staff member was not immediately reported to the State Agency. Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director), and E5 (ADON). E9 (Regional Nurse) and E30 (Ombudsman) participated by telephone.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		2/8/22

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F 677	Continued From page 12 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that, for two (R1 and R19) out of four residents sampled for bladder and bowel incontinence, the facility failed to provide incontinent care to a dependent resident. Findings include: Cross Refer F686, Example 1 and F690, Example 2. 1. Review of R19's clinical record revealed: 9/28/21 - A Significant Change MDS assessment documented that R19 was always incontinent and was dependent on staff for toileting and transfer with a mechanical lift (Hoyer lift). Observations of R19 being up in his wheelchair without incontinence care or being offered to use a urinal: - 12/8/21: 9:00 AM - 1:55 PM (4 hours and 55 minutes). - 12/9/21: 9:10 AM - 2:00 PM (4 hours and 50 minutes). - 12/10/21: 8:55 AM - 1:18 PM 4 hours and 23 minutes). - 12/15/21: 8:50 AM - 1:50 PM (5 hours). - 12/16/21: 8:59 AM - 1:44 PM (4 hours and 45 minutes). - 12/17/21: 9:25 AM - 1:35 PM (4 hours and 10 minutes). 10/8/21 - R19's care plan for ADLs documented that R19 was that dependent on staff for toileting. 10/8/21 - A care plan for altered bowel and	F 677	R1 and R19 continue to reside at the community with care plans updated to reflect their current incontinent needs. Current dependent incontinent residents have the potential to be affected by this practice. An audit of current dependent incontinent resident care plans was completed to ensure the care plan reflects the residents individualized incontinent care needs. A root cause analysis revealed the need for re-education on timely incontinent care. Licensed staff and certified staff will be re-educated by the Staff Development Director/designee on performing timely incontinence care according to the residents' individualized incontinent plan of care. The DON/designee will conduct an audit of 5 random dependent incontinent residents to ensure incontinent care is provided timely and according to the resident's individualized incontinent plan of care. Audits will be conducted daily x5 days until 100% compliance is verified, then, weekly x4 until 100% compliance is verified, then monthly x2 until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendations.	

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F 677	Continued From page 13 bladder elimination included the intervention to provide incontinence care as needed, to keep clean and dry and to apply barrier cream. Offer urinal on routine rounds and as needed was added 11/22/21. 12/17/21 1:35 PM - During an observation of R19's incontinent care revealed that when the disposable brief was removed, it was extremely wet with urine along with soft bowel movement (BM) on his bottom. 12/17/21 2:17 PM - During an interview with E22 (MDS Nurse) and E9 (Corporate Nurse) to describe observations of R19 being up in the wheelchair from before breakfast until after lunch without incontinent care, E9 said, "I understand. I know what you mean." 2. Review of R1's clinical record revealed: 6/10/21 - R1's care plan for ADLs included the intervention for two staff to use the mechanical lift for transfer and to turn an reposition around every 2 hours as tolerated. 6/10/21 - The care plan for alteration in bowel and bladder elimination included to check and change as needed, and to change soiled linen, clothes and briefs promptly as needed to maintain dignity and comfort. 8/31/21 - A Quarterly MDS assessment documented that R1 was dependent on staff for toileting and was always incontinent. Observations of R1 being in her wheelchair without incontinent care. - 12/08/21: 9:55 AM - 2:00 PM (4 hours and 5	F 677		

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F 677	Continued From page 14 minutes). - 12/15/21: 9:35 AM - 2:09 PM (4 hours and 34 minutes). 12/17/21 2:17 PM - During an interview with E22 (MDS Nurse) and E9 (Corporate Nurse) to describe observations of R1 being up in the wheelchair from before breakfast until after lunch without incontinent care, E9 said, "I understand. I know what you mean." Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director) and E5 (ADON). E9 (Regional Nurse) and E30 (Ombudsman) participated by telephone.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that, for two (R1 and R45) out of eight residents investigated for activities, the facility failed to support residents in their activities of interest. Findings include:	F 679	R1 and R45's comprehensive activity assessment have been revised and implemented. Updated revisions have been effectively implemented to ensure R1 and R45 are supported to	2/8/22

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F 679	Continued From page 15 1. Review of R1's clinical record revealed: 6/13/20 - A Significant Change MDS assessment documented R1's Responsible Party (F2) responses for R1's preferences including listening to music (very important), doing things with groups of people and going outside when weather is good (somewhat important). 3/6/21 - A Significant Change MDS documented staff assessment of R1's preferences included listening to music, participating in favorite activities and going outside when weather is good. 8/31/21 - A Quarterly MDS assessment identified R1 had dementia with severe cognitive impairment and was dependent on staff to transfer in and out of bed and to move about the unit (needed to be pushed in the wheelchair). 12/8/21 12:51 PM - During a family interview, when asked if the staff encourages R1 to attend activities, F2 said, "Yes they do, but not as often as I would like .... I have a care conference Thursday (12/9/21)" and will talk about it. 12/10/21 - R1's care plan for activities was revised to bring the resident out of the room to be around other people. The Resident Care Sheet which provided guidance for the CNAs found the addition of bringing R1 out of her room. 12/10/21 12:40 PM - During an interview, F2 explained that he brought up at the care conference that he" wants staff to get [R1] out of the room and see other people." F2 did not specify a time frame for getting R1 out of her	F 679	attend/participate in their activities of interest. Current residents have the potential to be affected. The Activity Director will conduct an audit of all current residents' activity care plans to ensure they accurately reflect the residents' activity of choice. Identified revisions will be updated on the resident care plan and implemented. A root cause analysis revealed the need for re-education regarding residents' support to participate in their activities of interest. The Staff Development Director/designee will re-educate the Activity Director, Activity staff, licensed nursing staff, and certified nursing staff on the Recreation/Community Life Programming Policy to ensure residents are supported to attend and participate in their activities of choice/interest. The Activity Director/designee will conduct a random audit of 7 resident activity participation logs to verify their participation aligns with their identified interests of choice. Audits will be completed daily x5 days until 100% compliance is verified, then, weekly x4 weeks until 100% compliance is verified, then monthly x2 months until 100% compliance is verified. Results from the audits will be presented to the Quality Assurance Process Improvement team for review and recommendations.	

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F 679	Continued From page 16 room, just that R1 "should not be in the room all the time." 12/14/21 10:28 AM - During a random observation, F2 was present and looking for staff to get R1 out of bed to attend the music program that was starting at 10:30 AM. F2 said, "If I wasn't here, they would not do it.' By 10:40 AM, R1 was lifted into her wheelchair with the mechanical lift and F2 pushed R1 to the music activity. December 2021 - Observations during the survey revealed staff did not take R1 out of her room in the morning or afternoons on December 14, 15, 16 and 17. 12/17/21 10:06 AM - During an interview, when asked how she was informed about changes in the care plan, E17 (CNA) said, "The nurse tells me." 2. Review of 45's clinical record revealed: 8/4/21 - R45 was admitted to the facility with dementia. 10/28/21 - R45's activity care plan included: "Present interest: watching tv (television) like Westerns, Little House on the Prairie, and Walker Texas Ranger. Past interest: dancing, traveling and working." 12/7/21 - A quarterly MDS assessment documented that R45 was severely cognitively impaired. 12/8/21 2:52 PM - During an observation and interview, R45 was noted dozing in a chair in front	F 679		

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F 679	Continued From page 17 of the television playing on the 100 unit. During an interview, E27 (CNA) reported that they do not really have activities on the 100 unit. E27 stated that the activities department can come and get the residents to go to the long term care unit where they have more activities, but R45 is a wander and fall risk, and that there is not enough supervision for R45 to participate safely. 12/10/21 11:11 AM; 12/10/21 11:38 AM; 12/14/21 11:00 AM; 12/14/21 11:47 AM; 12/14/21 1:33 PM; 12/15/21 10:19 AM; 12/15/21 1:25 PM - During random observations R45 was noted in a chair in front of the television playing on the 100 unit. R45 did not appear engaged in the program. The facility failed to engage R45 in her activities of interest. Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director) and E5 (ADON). E9 (Regional Nurse) and E30 (Ombudsman) participated by telephone.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §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 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		2/8/22

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F 686	Continued From page 18 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that, for two (R19 and R25) out of three residents sampled for pressure ulcer/injury, the facility failed to provide services to prevent further development of pressure injuries. In addition, for R19, the facility failed to accurately perform pressure ulcer assessments. Findings include: National Institute of Health defined a pressure injury as the breakdown of skin integrity from some types of unrelieved pressure and a prolonged period of repeated friction and shearing pressure of the skin overlying the bony prominence's along with loss of skin fragility, decreased blood flow, poor nutrition and moisture from bowel and/or urinary incontinence. https://www.ncbi.nlm.nih.gov/bocks/NBK532897/ (Accessed 12/28/21). 2019 - National Pressure Injury Advisory Panel (NPIAP) documented that a patient sitting in the chair for a really long time, was at risk for developing a pressure injury on the coccyx bone (tailbone) by exerting upward pressure on bottom skin layers. Prevention strageties include to "reposition weak or immobile individuals in chairs hourly ... avoid positioining the indivudal on body areas with pressure injury ... ensure that the heels are free from the bed ... continue to reposition an individual when placed on any support surface ... use heel offloading devices or polyurethane foam dressings on individuals at	F 686	R19 and R25 continue to reside in the community. Their wounds assessments have been completed and are accurate and their pressure injury prevention care plans have been updated and implemented. Current residents at risk for pressure injury or who currently have a pressure injury have the potential to be affected by this practice. An audit of current residents with pressure injury will be conducted to ensure pressure ulcer assessments are accurate. An audit of residents assessed to be at risk for pressure injury will be conducted to ensure interventions are implemented to prevent pressure injury. A root cause analysis revealed the need for re-education on accurate pressure ulcer assessments and timely implementation of interventions to help prevent further development of pressure injury. Licensed staff will be re-educated by Staff Development Director/designee on the Wound Care Policy which focuses on wound assessment, accurate documentation of assessment findings and implemenation of interventions to help prevent further injury. Additionally, certified staff will be re-educated by the Staff Development Director/designee on the importance of preventative measures.	

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F 686	Continued From page 19 high-risk for heel ulcers." https://cdn.ymaws.com/npiap.com/resource/resmgr/events/NPIAP_Permobil_WC_Seating_Po.pdf (Accessed 12/28/21). https://npiap.com/page/PreventionPoints (Accessed 1/5/21). Cross Refer F677, Example 1 and F689. 1. Review of R19's clinical record revealed: Review of Braden Scale assessments showed prior to going to the hospital on 9/18/21 R19 was not at risk for developing a pressure injury. It was not until he returned from the hospital on 9/22/21 that R19 was assessed as being at high risk for the development of pressure injury. 9/28/21 - A Significant Change MDS assessment after hospitalization for a broken neck documented that R19 was always incontinent and was dependent on staff for toileting and transfer with a mechanical lift (Hoyer lift). 10/8/21 - A care plan for being at risk for pressure injury was developed and included interventions to turn and reposition around every 2 hours as tolerated, to apply barrier cream to peri (perineal, between the thighs, external genitals and anus) area with every incontinence episode and as needed, to keep skin clean and dry and to float heels (elevate off f the mattress) when in bed. Air mattress added 10/25/21. Boc y pillows/ wedge for turning/positioning when in bed added 10/26/21. a. Positioning Observations of R19 being up in his wheelchair without repositioning, pressure relief or incontinence care. During these time frames staff fed R19 breakfast and lunch and he attended OT	F 686	The DON/designee will conduct Pressure Injury and Documentation Audits on all resident with pressure injuries to ensure pressure ulcer assessments are accurate, appropriate interventions are in place, and to verify timely wound prevention documentation according to the resident plan of care. These audits will be conducted daily x5 days until 100% compliance is verified, then, weekly x4 weeks until 100% compliance is verified, then, monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendations.	

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F 686	Continued From page 20	F 686		

for right arm strengthening.
- 12/8/21: 9:00 AM - 1:55 PM (4 hours and 55 minutes).
- 12/9/21: 9:10 AM - 2:00 PM (4 hours and 50 minutes).
- 12/10/21: 8:55 AM - 1:18 PM 4 hours and 23 minutes).
- 12/15/21: 8:50 AM - 1:50 PM (5 hours).
- 12/16/21: 8:59 AM - 1:44 PM (4 hours and 45 minutes).
- 12/17/21: 9:25 AM - 1:35 PM (4 hours and 10 minutes).

12/14/21 8:30 AM - R19 was observed in bed laying on his back until he was gotten out of bed around 11:00 AM.

12/17/21 1:35 PM - During an observation of R19 receiving incontinent care revealed when his disposable brief was removed, it was extremely wet with urine and R19 had had a soft bowel movement (BM) on his bottom. R19 required total assistance by two staff to turn him on his side. After incontinent care, no barrier cream was applied prior to placement of a new brief. Only three thin pillows were available for floating (lifting) heels and positioning. R19 was positioned on his back with all three thin pillows piled on each other to lift R19's heels off the mattress.

12/17/21 2:17 PM - During an interview with E22 (MDS Nurse) and E9 (Corporate Nurse) to describe observations of R19 being up in the wheelchair from before breakfast until after lunch without pressure relief or incontinent care, E9 said, "I understand. I know what you mean." The Surveyor explained about observing incontinent care and how R19's brief was extremely wet with

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F 686	Continued From page 21 urine and the presence of BM. E22 stated that R19 could barely move when he came back from the hospital. The Surveyor discussed the observation of three thin pillows and no wedges available for positioning R19 off of his back. E22 offered no additional information. b. Inaccurate Wound Assessment 10/8/21 - A care plan for behaviors was initiated and included resisting ADL care, refusing meals, and becoming combative and agitated. 10/11/21 - Review of a facility incident report revealed R19 developed a "sheared area due to pressure on the coccyx" measuring 2.5 cm by 2.0 cm. October 2021 - November 2021 - Review of E6's (ADON) Wound Round assessment notes revealed the following regarding the pressure injury to R19's coccyx (tailbone): - 10/13/21: "The area is not pressure, it presents as a superficial skin shearing, partial thickness wound, wound bed red and visible." The wound should have been assessed as a Stage 2 pressure injury. - 10/20/21 (late note for 10/19/21): no depth (how deep was the wound), "75% thin slough, partial thickness wound." The wound should have been assessed an an unstageable pressure injury since the depth could not be measured. - 10/27/21 (late note for 10/26/21): no depth, "75% thin slough, partial thickness wound." The wound should have been assessed as an unstageable pressure injury. 'Vesicles (blisters) erupted on the right and left buttocks." Blisters	F 686		

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F 686	Continued From page 22 (intact or open) over bony areas should have been assessed as Stage 2 pressure injuries. - 11/3/21 (late note for 11/2/21): "100% slough, full thickness wound. Left and right buttocks now with three areas, all with 100% slough. " All wounds should have been assessed as unstageable pressure injuries. - 11/14/21 (late note for 11/9/21): "100% slough, full thickness wound, healing Stage 3." There were "four open areas on buttocks, none of the wound beds were visible due to slough." All wounds should have been assessed as unstageable pressure injuries. - 11/18/21 (late note for 11/17/21): "full thickness wound, healing Stage 3, 100% slough. Buttocks with four wounds with 100% slough." All wounds should have been assessed as unstageable pressure injuries. - 11/26/21 (late note for 11/23/21): "full thickness wound, healing Stage 3. Buttocks with three wounds, one area had healed. All open areas with 100% slough. All wounds should have been assessed as unstageable pressure injuries. - 12/1/21 (late note for 11/30/21): "buttock areas healed, coccyx with 100% slough, full thickness wound, healing Stage 3." The wound should have been assessed as unstageable pressure injury. - 12/8/21 (late note for 12/7/21): "full thickness wound, healing Stage 3, 100% slough." The wound should have been assessed as unstageable pressure injury. 12/20/21 10:46 AM - During an interview, E6	F 686		

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F 686	Continued From page 23	F 686		

(ADON) confirmed R19's wound that started on his coccyx (tailbone) which she assessed as not being pressure on her 10/13/21 wound assessment. When asked, "What was it?" E6 had no response. E6 confirmed the facility contracted with an outside company for wound assessment and management. The Surveyor explained that the NPIAC identified wounds over a bony prominence should be assessed as a pressure ulcer and that friction, shearing and moisture just makes the skin more likely to open. The Surveyor asked when E6 identified the coccyx wound with 100% slough as a healing Stage 3, why was it labeled as full thickness wound. E6 confirmed it should have been assessed as an unstageable pressure injury.

12/20/21 - Review of the wound assessment, dated 12/14/21, by the NP from the contracted company revealed it was the only assessment that accurately identified the unstageable pressure injury with incontinence as a contributing factor.

2. Review of R25's clinical record revealed:

4/13/2020 - A facility wound care prevention policy (last revised 4/13/2020) included: Float heels to prevent any further pressure.

8/3/21 - R25 was admitted to the facility after a stroke.

8/9/21 - An admission MDS assessment documented that R25 was severely cognitively impaired, dependent on staff for ADLs, and was admitted with pressure ulcers / injuries and wounds from poor circulation.

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F 686	Continued From page 24 10/6/21 - R25's care plan documented that R25 was at risk for developing further pressure injuries and identified the following risk factors: incontinence with diarrhea and stroke with right sided weakness. Interventions included: Prevent skin area from prolonged contact, air mattress, turn and reposition around every two hours side to side as tolerated and bilateral heel float boots. R25's care plan did not include the need for offloading of the heels (raising heels off the mattress). 12/10/21 11:54 AM and 12/14/21 11:44 AM - During random observations, R25 was noted in bed with bilateral protective heel boots on, but heels were not offloaded. 12/16/21 3:12 PM - During an observation R25's heels were not offloaded. 12/17/21 9:03 AM - During an additional random observation, R25 was in bed wearing heel boots and turned toward the right side. The outer side of R25's left foot was pressed into the bed and not offloaded. 12/17/21 11:40 AM - During an interview with E31 (OT) to discuss offloading R25's heels, E31 stated that she offloading heels was not needed with an air mattress. October - December 2021 - Review of CNA documentation revealed the lack of evidence that R25 was turned due to numerous blanks or "No" responses to the task to "turn and reposition Q 2 hrs (every two hours) as tolerated, side to side" on the following dates on the day, evening and night shifts: a. No	F 686		

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F 686	Continued From page 25 - October: Nights - 10 - November: Days - 5. Evenings 13 and 27. Nights 3, 6, 19, 20, 21 and 29. b. Blank - October: Days 8, 9, 10, 18 and 31. Nights 11, 13, 15 and 16. - November: Days 4, 10 and 25. Nights 7, 22, and 25. - December: Days 8, 17 and 18. Nights 2, 4, 8, 9, 10, 13 and 18. 12/20/21 12:17 PM - During an interview, E16 (NHA in Training) and E22 (MDS Nurse) confirmed the lack of evidence of consistent pressure injury prevention measures were implemented for R25. Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director), and E5 (ADON), E9 (Regional Nurse), and E30 (Ombudsman) participated by telephone.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation	F 689	R19 continues to reside at the	2/8/22

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F 689	Continued From page 26 and review of other facility documentation, it was determined, for one (R19) out of four residents sampled for accidents, that the facility failed to ensure the resident received adequate supervision and fall prevention measures appropriate for a resident with severe cognitive impairment. R19's fall on 9/18/21 resulted in harm when R19 broke his neck, resulting in pain and limited use of his right arm affecting the ability to feed himself. Findings include: The facility policy entitled Falls Management (revised 8/10/21) identified that "interventions are to be re-evaluated after each fall. When changes are added to the care plan involving new interventions these new interventions need to be dated. Any occurrence of falls along with interventions will be documented in the nursing notes. The assessment process will include an investigation using the Fall Investigation analysis sheet. This is to help identify the root cause and whether or not the fall was avoidable or unavoidable." Review of R19's clinical record revealed: 12/28/20 - R19 was admitted to the facility with diabetes and dementia (brain disorder with memory loss, poor judgement, personality changes, disorientation, loss of mental functions such as memory and reasoning that interferes with a person's daily functioning). 1/21/21 - A care plan for falls was initiated (last updated 8/5/21) and included fall prevention interventions: answer calls, anticipate needs, keep call bell within reach, provide [verbal] safety reminders, keep room well lit and clutter free, therapy to evaluate and treat, non-slip	F 689	community. R19's care plan was reviewed and updated with appropriate fall interventions that reflect his current needs. Current residents that are cognitively impaired and assessed as a high risk for falls have the potential to be affected by this practice. An audit of fall prevention care plan interventions for residents who are severely cognitively impaired will be conducted for implementation of appropriate interventions. A root cause analysis revealed the need for re-education on reviewing the fall care plan after each fall to ensure that interventions implemented are individualized and effective. Licensed staff will be re-educated by Staff Development Director/designee on the Fall Management Policy and the importance of implementing appropriate and effective interventions for severely cognitively impaired residents and updating care plans with appropriate intervention(s). The DON/designee will conduct Post Fall Care Plan audits of 5 random resident incidents who are severely cognitively impaired to ensure appropriate interventions are individualized and effective. Audits will be conducted daily x5 days until 100% compliance is verified, then, weekly x4 weeks until 100% compliance is verified, then, monthly x2 months until 100% compliance is verified. Results from the audit will be presented to	

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F 689	Continued From page 27 socks/shoes at all times, per meter mattress (mattress with raised sides to help reduce rolling out of bed), soft touch call bell, visual sign to remind him to call for assistance before transfer, vital signs as needed for dizziness or lightheadedness due to medications. Encourage / remind [verbally] to use rolling walker (3/20/21 after fall). Therapy evaluate for balance, intermittent [verbal] reminders to use walker and call for assistance with transfers, medication review, restorative ambulation program (4/28/21 after fall). Offer toileting / bedpan around 11:30 PM, Physical Therapy to evaluate (5/17/21 after fall). Interventions of providing verbal reminders to call for help as well as physical therapy evaluations were repeated in response to falls in April and May 2021. 1/21/21 - A care plan for ADLs (Activities of Daily Living) included that R19 needed limited assist with one staff person for transfers, used a rolling wheeled walker with limited assistance from one staff member and was independent for eating. 6/24/21 - A fall risk assessment documented that R19 was a moderate risk for falls with a score of nine (ten or more indicated a high risk for falls). 6/27/21 - A Quarterly MDS assessment was completed and revealed R19 had severe cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 4 (0-7 equals severe impairment). July - August 2021 - Review of facility fall investigations revealed that R19 experienced multiple falls:	F 689	the Quality Assurance Process Improvement team for review and recommendations.	

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F 689	Continued From page 28 7/12/21 (8:40 PM): R19 stated he fell, skin tear sustained. The care plan was updated on 7/13/21 to include "recent room move, staff will continue to offer verbal reminders and cue resident to use call bell." R19 had dementia with severe cognitive impairment which affected his short term memory, reasoning and judgement. The facility added verbal reminders for R19 to call for help, which had already been included several times in the care plan. A person with severe cognitive impairment cannot remember verbal reminders. 7/17/21 (4:00 PM): Seated on the floor with his back against the bed, no injury, room door closed, not wearing non-slip footwear as in care plan. Care plan updated 7/18/21 to offer toileting around 3:30 PM. Interventions included signs to call for help before getting up which was previously in the care plan. The facility added written reminders (signs) to call for help. A person with dementia and severe cognitive impairment cannot understand the written reminders. There was no evidence that the facility verified that R19 could read the written reminders where they were posted or understand the meaning of the wording. 7/18/21 (6:45 PM): Seated on the floor with his back against the wall, skin tear. Interventions included to offer [verbal] reminders to call for help. The facility added verbal reminders to call for help, which had already been included several times in the care plan. It was clear that this	F 689		

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F 689	Continued From page 29 severely cognitive impaired resident with dementia could not remember the verbal reminders as he had fallen three times within one week. 8/4/21 (12:15 PM): Laying on the floor on his back, re-opened previous skin injury. Care plan updated 8/5/21 with PT/OT evaluation for balance strengthening and gait training, orthostatic blood pressure checks (checking BP and heart rate when sitting and standing to see if the BP drops which can cause dizziness). Elastic compression stockings to legs to help keep the BP from dropping when standing) was added on 8/11/21. There was a lack of thorough fall investigation to determine the root cause of the falls as evidenced by incomplete and naccurate information related to the medications R19 received that could have contributed to his falls: - 7/12/21: blood pressure medication, insulin and anticoagulant. - 7/18/21: antidepressant, insulin and anticoagulant medications. - 8/4/21: insulin. Review of fall risk assessments found that after the 7/12/21 fall, R19 was at high risk for falling. 8/10/21 - A Physician Progress Note documented falls with a reduction of BP (blood pressure) when standing leading to dizziness ... recommended trial of elastic stockings to legs. August 2021 - The pharmacy consultant's medication regimen review recommended to check glucose (blood sugar) with falls. The physician response was to defer the recommendation until the following month.	F 689		

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F 689	Continued From page 30 9/17/21 10:42 PM - A nursing progress note documented [R19] "found lying near bathroom door as if he was trying to go there, lying on left side at approx (approximately) 2140 (9:40 PM), minimal injury noted with skin tear to right arm, resident able to move all extremities and had complaint of minimal pain, PRN (as needed) tylenol given with good effect. VS (vital signs) stable and neuro checks WNL (within normal limits). [R19] unable to specify what he was trying to do ... stated he didn't (sic) hit his head ... assessed by 2 nurses and superv sor, able to move all extremities ... assisted back to bed with education to use call bell if needing assistance. MD made aware via teamhealth book (book where notes are written for the medical team), POA will need to be updated in the morning." 9/17/21 - Review of the facility fall investigation and written statements obtained during the investigation included: R19 was in the middle of treatment for low glucose when he fell at 9:40 PM. E13 (CNA) assisted [R19] back to bed at 9:15 PM after taking the resident to the toilet and that E13 helped R19 get into bed 3 times in around 30 minutes. After the fall R19 was verbally educated to use the call bell if needing assistance. R19 had severe cognitive impairment which affected his memory, reasoning and judgement. There was no evidence that the facility implemented additional interventions or increased supervision after the 9/17/21 fall. This severely cognitive impaired resident with dementia could not remember the verbal reminders to call for help before getting up.	F 689		

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F 689	Continued From page 31 9/18/21 - Review of a facility fall investigation revealed that around "4:45 AM during rounds, found [R19] on his left side on the floor. He was alert, verbally responsive and able to make needs known. Assisted up from floor, able to move all extremities and new neuro check initiated and brought to the dining room for close observation. Able to ambulate on his own with assist of his walker. Sustained skin tear on his left hand and dressing applied. No acute d stress. [R19] was [verbally] encouraged to call for help at all times. 9/18/21 - Review of E16's (CNA) written statement about the fall included that the CNA last toileted R19 at 2:30 AM when he walked to bathroom using his walker with staff assistance. E16 last saw R19 at 4:10 AM. "When I returned back from my lunch break nurse told me [R19] was on the floor." 9/18/21 7:36 AM - A nursing progress note documented POA was "updated on falls and skin tears, no questions at this time, reassured POA that staff is monitoring resident and will keep POA updated on any changes. resident sitting comfortably in dining area at this time." 9/18/21 9:57 AM - A nursing progress note documented "This nurse was called ... resident had 2 fall (sic) one on 3-11 last evening on one on 11-7 last night. Resident now stating neck and back are hurting and ... resicent not able to ambulate as usual d/t (due to) pain. Team Health called and notified of the same that stated to give tylenol 325 mg (2 tabs) 3 times a day and if there is no improvement then call back." R19's eMAR revealed he received tylenol at 8:30 AM. 9/18/21 12:49 PM - A nursing progress note	F 689		

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F 689	Continued From page 32	F 689		

documented [R19] was "medicated for pain but stated that he was still having pain, resident noted to not being able to stand freely, needed two staff members to assist with standing, after standing, resident could not self ambulate with his rolling walker as usual, resident cont (continued) to c/o(complaint of) neck and back pain, resident also noted with raspy voice and difficulty swallowing and difficulty in holding his head up, this nurse called his daughter and a message was left. On call MD was called and new order received to send resident to the ER for evaluation."

9/18/21 6:51 PM - A nursing progress note documented that R19 "was being admitted due to a fracture to his C7 and pneumonia, residents daughter is aware, nursing supervisor and [physician] made aware."

12/8/21 9:03 AM - During a random breakfast observation, staff was feeding R19 his breakfast.

12/9/21 9:00 AM - During a random observation two signs were visible hanging in R19's room to remind him to use the call bell and wait for help to get up. One sign was on the wall across from the foot of the bed and the other to the right of the closet across from R19's lounge chair.

12/9/21 9:10 AM - During an observation staff was encouraging R19 to feed himself, but the resident just sat, stared and did not attempt to self feed.

12/17/21 at approximately 10:55 AM - During an interview E29 (OT) stated that she had been working with R19 to improve his right arm movement and strength since he had impairment

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F 689	Continued From page 33 after he broke his neck. 12/20/21 10:05 AM - During an interview, E15 (LPN) stated that before the fall R19 could take himself to the toilet using his walker and use the call bell. Now, he was more confused. 12/20/21 10:59 AM - During an interview with E1 (NHA in Training) and E2 (DON), the Surveyor to reviewed R19's falls and the incomplete fall investigations. The Surveyor pointed out that many interventions added in response to a fall, were previously in the care plan, including non-skid footwear and reminders to use the call bell E2 stated that she understood that "interventions to be added should not already be included in the care plan." The Surveyor explained that when current interventions were not effective then additional measures would be warranted. E2 offered no further information. The facility continued to remind R19 verbally and with signs to call for assistance prior to getting up. R19 had severe cognitive impairment which affected his memory, reasoning and judgement. A person with dementia who was severely cognitive impaired cannot understand written reminders or remember the verbal reminders to call for help before getting up. There was no evidence that the facility identified the reasons for R19's falls or implemented additional interventions or increased supervision when the current fall prevention measures were ineffective. After the 9/18/21 fall, R19 was diagnosed with a broken neck, experienced pain and developed the limited ability to use his right arm. R19's residual right arm impairment affected his ability self feed and to ambulate due to not being able to use his wheeled walker.	F 689		

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F 689	Continued From page 34 Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director), and E5 (ADON), E9 (Regional Nurse), and E30 (Ombudsman) participated by telephone.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §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 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	F 690		2/8/22

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F 690	Continued From page 35 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that, for two (R19 and R48) out of four residents sampled for bowel and bladder incontinence, the facility failed to assess and provide services to monitor and/or restore bladder continence. Findings include: In the Presbyterian Senior Living (PSL) Policy dated 2/18/19, the steps involved in bladder retraining do not specifically address residents who would not meet the criteria for retraining based on bladder evaluations but may benefit from a toileting plan. 1. Review of R48's clinical record revealed: 12/6/18 - R48 was admitted to the facility. 12/919 - A review of R48's continence care plan revealed an intervention to "offer and assist with a urinal around every 3 hours when awake". 5/28/20 - A quarterly MDS assessment documented R48 was frequently incontinent of urine and on a toileting program. A review of MDS assessments 8/25/20 through 11/13/21 documented R48 was not on a toileting program. 2/17/21 - A bladder and bowel elimination	F 690	R48 and R19 continue to reside at the community and have been reassessed with a 3-day toileting assessment. Current residents with incontinence have the potential to be affected by this practice. Current incontinent resident records will be reviewed to ensure a Bowel and Bladder Assessment are completed in order to determine if voiding diaries are initiated, followed by the initiation of toileting plans as appropriate. A root cause analysis revealed the need for re-education on incontinence assessment, incontinence interventions, and timely reassessments. Resident Nurse Assessment Coordinator will be re-educated by the Staff Development Director/designee to initiate a Bowel and Bladder Assessment upon admission, quarterly, annually and with each resident significant change in order to determine if a voiding diary is appropriate which would then be followed by the initiation of appropriate toileting programs. Certified staff will be re-educated on the importance of toileting plans and to offer toileting per resident's individualized plan of care.	

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	085032	A. BUILDING _____ B. WING _____	C 12/20/2021

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F 690	Continued From page 36 evaluation were provided by the facility that stated the resident can communicate needs and was always incontinent. There was no indication the facility conducted a three-day toileting assessment or that a toileting program was initiated. 8/14/21 - A bladder evaluation stated that the resident was always incontinent but can communicate needs for toileting, ask for assistance, and participate in training. There was evidence R48 was restarted on a toileting program. 8/16/21 - An annual MDS assessment documented that the resident was always incontinent of bladder, and no toileting plan in place. 11/11/21 - A bladder elimination evaluation incorrectly stated the resident was unable to communicate his needs. 11/13/21 - An annual MDS evaluation documented that a toileting program had not been attempted and that R48 was always incontinent of bladder. R48 was cognitively intact. 12/1/21 - A physician progress note documented that the resident was alert to self and answers questions with 2-3 words at time. 12/9/21 9:50 AM - During an interview R48 indicated he could use a urinal to manage his bladder incontinence. 12/14/21 10:30 AM - During an observation, E8 (CNA) bathed, dressed, and assisted R48 to his wheelchair with a mechanical lift with another	F 690	The DCN/designee will complete a random audit of 7 incontinent residents using the Incontinent Care Audit to ensure residents have been assessed upon admission and reassessed for bowel and bladder incontinence and that toileting plans are initiated as appropriate. Audits will also be conducted to ensure certified staffs' documentation reflects the residents' individualized toileting plan of care. Audits will be conducted daily x5 days until 100% compliance is verified, then, weekly x4 until 100% compliance is verified then monthly x2 until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendations.	

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F 690	Continued From page 37 unidentified CNA. E8 did not offer R48 a urinal to void. 12/14/21 2:36 PM - During an interview E8 (CNA) stated that a urinal was not offered to R48 because he is incontinent. 12/17/21 9:11 AM - During an interview E23 (CNA) stated that in her experience no CNA's offer R48 a urinal because R48 is incontinent. 12/17/21 11:00 AM - A review of CNA documentation revealed that a urinal was not offered to R48 on any shift from 12/1/21 through 12/13/21. 12/17/21 11:43 AM - During an interview E22 (MDS) stated R48 should be re-evaluated with a new toileting program to assess if the resident was able to use a urinal to reduce incontinence. If the program was unsuccessful then the plan to use a urinal to maintain continence should be discontinued. 12/18/21 - Documentation provided by the facility showed the facility added an order for a three-day voiding diary to R48's plan. 12/20/21- A review of CNA voiding documentation from 12/18/21 through 12/20/21 revealed R48 was always incontinent. The facility failed to maintain a toileting program for R48 to maintain or reduce urinary incontinence. CNA documentation and interviews support evidence that toileting with a urinal was not being done despite a care plan with that intervention and the resident stated he could use a urinal. No documentation was provided by the	F 690		

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F 690	Continued From page 38	F 690		

facility with the results of the toileting program or why it was no longer being conducted.

2. Review of R19's clinical record revealed:

12/28/20 - R19 was admitted to the facility.

1/21/21 - A care plan for alteration in bowel and bladder elimination was developed and included R19 ambulated with limited assistance of one staff person with rolling walker, a toileting schedule: Offer and encourage toilet/urinal around 6:30 AM, around 9:30 AM, around 11:30 AM, around 2:00 PM, around 3:0 PM, around 6:00 PM, at bedtime and around 11:30 PM. Provide incontinence care as needed. Ask/encourage resident to use call light or request assistance for toileting. Complete a Bladder and Bowel (B&B) Assessment quarterly and as needed for change in condition.

6/27/21 - A Quarterly MDS assessment documented that R19 was frequently incontinent of urine and bowel.

9/28/21 - The Significant Change MDS assessment identified that R19 was now always incontinent of bowel and was on a toileting program.

10/8/21 - A care plan was developed for alteration in bowel and bladder elimination was created and included to encourage R19 to use the call light or request assistance for toileting / urinal and incontinence care as needed.

12/17/21 2:17 PM - During an interview, E22 (MDS Nurse) confirmed a Bladder and Bowel Assessment was not performed after the decline

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F 690	Continued From page 39 in bowel continence. E22 confirmed offering the urinal was in the care plan. The Surveyor informed E22 that offering the urinal was not seen during the survey and that R19 was extremely wet with urine and bowel movement after being up in the wheelchair from before breakfast until after lunch. 12/20/21 9:35 AM - During a follow-up interview, E22 stated they did a B & B Assessment, and started a voiding diary over the weekend. The facility failed to reassess R19's bladder and bowel functioning after he became always incontinent of bowel on the 9/28/21 Significant Change MDS assessment until after Surveyor inquiry. Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director), and E5 (ADON), E9 (Regional Nurse), and E30 (Ombudsman) participated by telephone.	F 690		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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.	F 842		2/8/22

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F 842	Continued From page 40 §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; (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	F 842		

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F 842	Continued From page 41 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for one (R19) out of four residents sampled for accidents, the facility failed to ensure records were accurate, complete and recorded timely. Findings include: Cross Refer F686, Example 1 and F689. The facility Falls Management Policy (revised 8/10/21) included, "Any fall that involves a potential/actual head injury will include follow-up neurological checks .. unwitnessed falls will need to have neurological checks implemented. Review of R19's clinical record revealed: 7/12/21 - 12/9/21 - R19 had nine unwitnessed falls, all requiring neurological checks. a. 12/17/21 2:46 PM - During an interview to request neurological checks for all nine falls, E1 (NHA in Training) stated they were paper forms that should have been scanned into the	F 842	R19 still resides at the community and had no negative affect from the incomplete resident record for neurological checks, incomplete progress note missing the details of fall(s) incident(s) (time and location), or late entry of wound assessment. Current residents' records following a fall that requires a Nursing Progress Note and neurological assessments have the potential to be affected. Current residents' records with a wound assessment have the potential to be affected. An audit of all current residents' medical records who had a fall and required a Nursing Progress Notes and/or neurological assessments in the last 30 days will be conducted to ensure that the Nursing Progress Note includes the time and location of the fall and neurological assessments are completed timely and accurately, and that the wound	

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F 842	Continued From page 42 computerized record. E1 added that they would need to locate the forms and provide them on Monday (12/20/21). 12/20/21 - Review of the neurological check documents provided by the facility revealed seven neurological checks were found, but two neuro check forms were not able to be located: - 10/20/21 (8:45 AM) - 11/17/21 (2:55 PM) b. Review of the Nursing Progress Notes corresponding with each of R19's nine falls revealed it was unclear as to the actual time of the fall and / or the specific location in the room where R19 was found. 12/20/21 10:59 AM - During an interview with E1 (NHA in Training) and E2 (DON) to review R19's nine falls and the facility fall investigations, the Surveyor explained that the Nursing Progress Notes often did not provide the time of the actual fall and / or the specific location in the room where R19 was found on the floor. No additional information was offered. c. 11/14/21 - Wound Assessment note described findings from the 11/9/21 assessment, five days after the assessment was completed. 12/20/21 10:46 AM - During an interview to determine why a 11/9/21 wound assessment note was not entered into the computerized chart until 11/14/21, E6 (ADON) explained that, "I try to get to them the next day, but it depends on what is going on here." Findings were reviewed during the exit conference on 12/20/21 at 4:05 PM with E1 (NHA	F 842	assessments are accurate and documented timely. A root cause analysis revealed the need for licensed staff to be re-educated. The Staff Development Director/designee will provide re-education to the licensed staff on the Nursing Progress Note regarding details of a fall (location and time), completion of timely documentation of neurological checks (Neurological Assessment Policy) and re-education on timely documentation of wound assessments. The DON/designee will complete a Post-Fall Nursing Progress Note Audit, a Neurological Assessment Audit, and a Wound Assessment Audit on 3 residents to ensure documentation is completed accurately and timely. Audits will be completed daily x5 days until 100% compliance is verified, then, weekly x4 weekly until 100% compliance is verified, then, monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendations.	

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F 842	Continued From page 43 in Training), E2 (DON), E3 (Executive Director), E4 (Medical Director), and E5 (ADON), E9 (Regional Nurse), and E30 (Ombudsman) participated by telephone.	F 842		