STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045354	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIANNA HILLS NURSING AND REHABILITATION CENTER	8411 SOUTH 28TH STREET FORT SMITH, AR 72908

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were not referred to as feeders or smokers, and meals for residents sitting at the same table were served together to promote dignity and respect for 3 (Residents 8, 67 and 54) of 11 (Residents #8, 16, 18, 30, 34, 40, 46, 54, 61, 67 and 288) final sample residents and one non sample resident. This failed practice had the potential to effect 17 residents who required assistance with meals and 12 residents who smoke according to a list provided by the Dietary Manager on 3/05/2020 at 9:40 AM. The facility failed to ensure signs identifying care needs were not posted where they were visible by others to promote dignity for 2 (Resident (R) 28 and 29) of 11 sampled residents. This failed practice had the potential to affect 22 residents who resided on the 300 and 400 hall as identified by a list provided by the Director of Nursing (DON) on 3/06/2020. The facility failed to ensure staff did not ignore and/or delay providing care for1 (Resident #40) who was dependent on staff for assistance with activities of daily living. The findings are: 1. On [DATE] at 12:31 PM, beverages were not being offered to some residents in assistive dining room. a. On 302/2020 at 12:34 PM, Resident 288 was trying to drink hot chocolate by sucking on two small stir straws. Resident 73 sitting at same table without a drink. b. On [DATE] at 12:40 PM, CNA 1 was asked, What is your responsibility during lunch with regard to the residents? CNA 1 stated, Get them up and bring them here. Serve them coffee or what they want unless they are thickened or they can't have a drink. (CNA 2) is the meal coordinator and will get the hall carts out, then assist or set up, go out first then the assist. CNA 1 was asked, Is there a reason these residents don't all have beverages? (Indicated residents at the short semi-circular corner table R 65, R 40, and R 75) CNA 1 stated, (Resident 65) is actually supposed to have a cup. I don't know if all of them well, they are feeders and cannot hold cups. CNA 1 was asked, 'Do you think it is fair for one to have a drink and the others not? CNA 1 stated, No. CNA 1 was asked, Who is responsible to get them drinks? CNA 1 stated, Whoever is in the dining room helping should be passing drinks. CNA 1 was asked, Are you assigned to specific residents or areas? CNA 1 stated, Yes. CNA 1 was asked, Who is responsible for this table? CNA 1 stated, I don't know. I am assigned to 2 feeders, (Resident 8) and (Resident 14). c. On 3/02/2020 at 1:55 PM, CNA 3 was asked, :Is there a reason everyone did not get a drink at the same time? CNA 3 stated, No, I don't see why they wouldn't. 2. Resident #54 had [DIAGNOSES REDACTED]. On [DATE] at 12:20 PM, Certified Nursing Assistant (CNA) #10 called across the dining room to C.NA #11 regarding Resident #54 stating she's a feeder right 3. On [DATE] at 12:52 PM, the first meal tray was served to the long table in the main dining room, the second tray was delivered at 12:57 PM. The trays were served sporadically to this table of 8 ladies and as the other tables were receiving their trays, while the 8 residents at the long table sat and watched their tablemates eat. The last tray served at this long table with 8 female residents was at 1:20 PM. This was the last tray served in the dining room. a. On 3/2/20 at 12:40 PM, CNA #1 was asked, Are you assigned to specific residents or areas? The CNA stated, Yes. The CNA was asked, Who is responsible for this table? The CNA stated, I don't know. I am assigned to 2 feeders (Resident #8 and R#14). b. On [DATE] at 12:53 PM, CNA #2 meal coordinator stated, They just made her a feeder this week. 4. On 3/4/2020 at 12:50 PM, the SSD (social services director) came from two hundred hall carrying a meal tray and called out to C.NA #10 who was standing in the dining room that was between three hundred hall and four hundred hall. SSD stated, .Grab her, she's a feeder now . pointing to Resident #1A sitting in the large dining area. C.NA #10 rolled the resident into the smaller dining area and placed her at a table. On 3/4/2020 at 12:55 p.m., the SSD was asked if calling a resident a feeder was a dignity issue? The SSD stated, .Oh my god, I am so sorry, I know better . The SSD was asked, Does that put a label on the resident? The SSD stated, .yes, I'm sorry . C.NA #10 stated, .she caught me the other day ., and I know better . 5. On 3/4/2020 at 1:23 PM, a resident asked C.NA #1 if they were taking the smokers out? CNA #1 stated, .I can't, I'm not on the smokers today . 6. On 3/4/2020 at 1:45 PM the DON was asked, does calling a resident a feeder or a smoker label them? She stated yes, it's a dignity issue ., they shouldn't do that . 7. Resident 29 had [DIAGNOSES REDACTED]. On [DATE] at 3:14 AM, there was a 8 x 11, white, plastic covered sign, taped on four corners, located to the right of the resident's bed and left of the exit door. The sign stated, At risk for Skin Breakdown Turning and Repositioning Schedule . 8. Resident 28 had [DIAGNOSES REDACTED]. On [DATE] at 3:27 AM, there was a 8 x 11, white, plastic covered sign, taped on four corners and a blue push pin was located at the center top of the paper, holding sign on the wall, centered above resident's bed. The sign stated, Power chair is for all doctor appointments & (and) Activity Outings!!! Please keep chair charged and make sure resident is in the chair for these events! Thank you. 9. Resident 40 had a [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 12/16/2019 documented the resident scored a 3 (indicates severely impaired, never/rarely made decisions) on a Staff Assessment for Mental Status (SAMS), was totally dependent, one-person assistance for eating; extensive two-person assistance for bed mobility, transfers, dressing, and toilet use; extensive one-person assistance for locomotion on and off the unit and personal hygiene; and was totally dependent upon staff for bathing. a. A care plan with a revision date of 10/11/2019, documented, . ADL self-care performance deficit . revision date of 07/08/2019, BED MOBILITY: The resident requires 2 person assist with repositioning, a revision date of 04/02/2018, requires extensive assist of 2 persons, for transfers . b. On 3/3/2020 at 2:00 PM, the resident was sitting in hallway across the hall from Resident room [ROOM NUMBER], in front of soiled utility door. The resident's head was drooping to the left with eyes closed, and hands in the lap. c. On 3/3/2020 at 2:09 PM, CNA 5 was attempting to enter the solid utility room and stated, Excuse me (Resident 40) you need to move. CNA #8 was entering the soiled utility door and stated, Excuse me (Resident 40), I have to get in here. CNA #8 pushed resident's wheelchair back from the door. The resident's eyes opened momentarily, the resident's head drooping back to right and the eyes were closed, and the resident mumbled (no specific words audible). (A photo of resident sitting in wheelchair, at soiled utility door, was taken at 2:13 PM) d. On 3/3/2020 at 02:24 PM, the resident was in a wheelchair in the hallway outside soiled utility door, snoring. e. On 3/3/2020 at 02:27 PM, CNA 5 stated, I'm gonna move you away from this door until I can get some help okay? CNA 5 proceeded to move the resident to the opposite side of the hallway to the left of Resident room [ROOM NUMBER]. The resident self-propelled the wheelchair to the center of the hallway. The resident's head was drooping to right and the resident's eyes were closed. f. On 3/3/2020 at 2:33 PM, CNA 5 walked passed the resident into the dining room, came back out into hallway and walked down the 300 hall away from resident. The resident remained sitting in the wheelchair to the right of Resident room [ROOM NUMBER]. g. On 3/3/2020 at 2:37 PM, the resident self-propelled down the 300 hall along the odd numbered side of the wall. h. On 3/3/2020 at 3:00 PM, CNA 8 stated, Come on (R40) let's get you laid down. i. On 3/4/2020 at 1:56 PM, the Director of Nursing (DON) was asked, When you tell a resident you will get assistance to perform a task and return, should you return? The DON stated, Yes you should return. It establishes trust. The DON was asked, What is an acceptable timeframe?

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

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) The DON stated, No more than 5 minutes. At least check in. The DON was asked, If you observe a resident sitting in a wheelchair with eyes closed, head to the side, do you attempt to place the resident in the bed for comfort? The DON stated, They should. The DON was asked, Does (R 40) require assistance with transfers and positioning? The DON stated, I do not know. The DON was asked, Is 33 minutes an acceptable time for the resident to wait? The DON stated, No. The DON was asked, Is one hour an acceptable time for the resident to wait? The DON stated, No. j. On 3/4/2020 at 2:40 PM, CNA 1 was asked, When you tell a resident you will get assistance to perform a task and return, should you return? CNA 1 stated, Yes CNA 1 was asked, What is an acceptable timeframe? CNA 1 stated, 5 minutes. CNA 1 was asked, If you observe a resident sitting in a wheelchair, with eyes closed, head to the side, do you attempt to place the resident in the bed for comfort? CNA 1 stated, I will ask them if they want to lay down and if they do I get them down. If no, resident has rights. CNA 1 was asked, Does (Resident 40) require assistance with transfers and positioning? CNA 1 stated, Yes. CNA 1 was asked, What are your responsibilities for positioning based on the current care plan? CNA 1 stated, Do what is on the care plan. If they are able to do stuff they do. We chart what we do. CNA 1 was asked, Does the resident have any complaints of pain/discomfort in neck, arms, or back? CNA 1 stated, No complaint of pain, just fusses and reacts. We calm her, talk to her and if it is too much we get someone else to do it. CNA 1 was asked, Is 33 minutes an acceptable time for the resident to wait? CNA 1 stated, No. CNA 1 was asked, Is one hour an acceptable time for the resident to wait? CNA 1 stated, Definitely not. 10. On 3/5/2020 at 3:46 PM the DON provided a document titled .Quality of Life-Dignity . with a revised date of .(NAME)2009 . It Documented .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Residents shall be treated with dignity and respect at all times . Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, [DIAGNOSES REDACTED]. Demeaning practices ad standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed . 9. b. Signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room .
F 0567 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Honor the resident's right to manage his or her financial affairs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents had access to their personal funds on weekends and after hours for 1 (Resident (R) #79) of 30 (Residents #65, #64, #18, #192, #84, #7, #73, #42, #37, #288, #77, #30, #52, #68, #57 ,#6, #71, #4, #45, #33, #11, #8, #16, #79, #80, #19, #43, #46, #28, and #40) sampled residents who had a personal trust fund account managed by the facility. The failed practice had the potential to affect 93 residents who had a personal trust fund account managed by the facility, as documented on a list provided by the Business Office Manager (BOM) on 3/4/2020 at 8:16 AM. The findings are: 1. Resident #79 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two people with bed mobility, transfers, dressing, toileting, bathing, and personal hygiene; required set-up help for meals. On [DATE] at 11:32 AM, Resident #79 was asked, Does the facility hold your money for you? She stated, Yes. She was asked, Can you get your money when you need it, including weekends? She stated, No. On weekends there is no one here to get it. If I think I will need money I have to get it on Friday. 2. On 3/4/2020 at 8:23 AM, the Business Office Manager was asked, Can you explain the facility's process for providing money from trust fund to residents after business hours and on weekends? She stated, I don't leave the money open after hours or on weekends.
F 0568 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure quarterly statements were provided for 1 (Resident #79) of 30 (Resident #65#64,#18,#192, #84 ,#7,#73,#42,#37,#288, #77, #30, 52, #68, #57, #6, #71, #4, #45, #33, #11, #8, #16, #79, #80, #19, #43, #46, #28, and #40) sampled residents whose funds were managed by the facility. The failed practice had the potential to affect 93 residents who had a personal trust fund accounts managed by the facility, as documented on a list provided by the Business Office Manager (BOM) on 3/4/2020 at 8:16 AM. The findings are: 1. Resident #79 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two people with bed mobility, transfers, dressing, toileting, bathing, and personal hygiene; required set-up help for meals. On [DATE] at 11:32 AM, Resident #79 was asked, Do you get a quarterly statement from the facility telling you the balance in your account? She stated, I ask what my balance is, but no. She does not give me anything that says how much money I have. 2. On 3/4/2020 at 9:52 AM, the Business Office Manager was asked, Does Resident #79 receive trust fund statements quarterly? She stated, No. She has never wanted it. The Business Office Manager was asked, Have you asked the resident to sign the statement showing she doesn't want quarterly statements? She stated, No. I was always told that as long as it was available when requested then that was enough. The Business Office Manager provided a list of residents that do not receive quarterly statements. The Residents were R's #44, #46, #68, #75 and #79.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility failed to ensure complete privacy was provide during incontinent care for 1 (Resident (R) #34) of 33 (R #4, R #7, R #8, R #10, R #16, R #18, R #18, R #19, R #21, R #25, R #28, R #30, R #33, R #34, R #36, R #37, R #38, R #40, R #42, R #43, R #45, R #46, R #52, R #54, R #58, R #61, R #64, R #67, R #68, R #73, R #78, R #79, R #193, and R #288) sample residents who required staff assistance with peri-care. This failed practice had the potential to affect 74 residents who receive peri-care care, according to a list provided by the Administrator on 3/4/2020 at 4:15 PM. The findings are: Resident 34 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2019 documented the resident scored 3 (indicates severely impaired, never/rarely made decisions) a Staff Assessment for Mental Status (SAMS); and was totally dependent upon staff, two-person assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene; required of one-person assistance for locomotion on and off the unit; and was totally dependent upon staff for bathing. a. A physician's orders [REDACTED].Apply [MEDICATION NAME] SPP to areas of redness on groin and coccyx Q (every) shift for 14 days. every shift every 14 day(s) for Rash for 14 Days Redness . b. On 3/3/2020 at 8:45 AM, Certified Nursing Assistant (CNA) #8 and CNA #9 entered the resident's room. After knocking, they gathered supplies that were needed to perform peri-care. CNA #8 explained care to the resident. The resident's room door was not closed. The privacy curtain, to the left of the resident's bed, was pulled around the lower half and bottom of resident's bed area by the wall and remained open approximately 12 inches, with a view to the hallway. CNA #8 pulled the privacy curtain between the beds. CNA #8 made no attempt to close the door or curtain. CNA #9 began peri-care for the resident. CNA #8 removed their gloves and left the room to obtain additional supplies. CNA #8 returned to the resident's room with supplies and did not close the door. CNA #8 did not completely pull the privacy curtain. The resident remained uncovered and exposed during CNA 8's absence. c. On 3/3/2020 at 1:48 PM, CNA #6 provided a copy of the Incontinent & (and) Catheter Care Observation Checklist, dated 5/8/7, which documented, . 8. Close door, privacy curtains and widow (sic) blinds or curtains; Even in a private room and lower bed to a working level? . d. On 3/5/2020 at 3:46 PM, the Director of Nursing (DON) provided a policy titled, Quality of Life - Dignity which documented, . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . 1. Resident shall be treated with dignity and respect at all times . 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care . Demeaning practices and standards of care that compromise dignity are prohibited .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure effective housekeeping and maintenance services were provided to ensure the interior environment was sanitary, orderly, and comfortable for residents who reside on the 200 and 300 halls. This failed practice had the potential to affect 90 residents who currently reside in the facility, according to the Resident Census and Condition of Residents form provided by the Administrator on [DATE]. The findings are: 1. On [DATE] at 11:33 AM, located in Resident room [ROOM NUMBER]'s bathroom, there was a shower chair with brown debris smeared horizontally at the rear of the seat. Three brown, half circle areas in various sizes on the lower edge of the shower curtain that were approximately 10 inches from the bottom right side. The electrical outlet located to the left of the sink, under the towel dispenser was pulled away from the wall. A photograph of the and the electrical outlet was taken at this time. The Maintenance Supervisor was asked, Should an electrical outlet cover be flush with the wall for resident safety? He stated, Yes. The Maintenance Supervisor was asked, What could happen if a resident was to touch the wiring under the faceplate? He stated, Electrocution. The Maintenance Supervisor was asked, Have you been notified of a faceplate and outlet pulled from the wall? He stated, No. The Maintenance Supervisor was asked, Have you been notified of a faceplate and outlet pulled from the wall? He stated, No. 2. On [DATE] at 11:38 AM, Resident room [ROOM NUMBER]'s ceiling over bed B to the right of the light had tan and brown, dimensional, circular areas in a splatter pattern in a diameter of approximately 12 inches. A photograph of the ceiling over bed B was taken at this time. The Maintenance Supervisor was asked, Can you tell me what that is on the ceiling? He stated, I'm not sure. It looks like stuff from a feeding tube. 3. On [DATE] at 11:45 AM, located in Resident room [ROOM NUMBER] in the bathroom, the toilet had stool smeared on the seat and on the side. The shower and the shower curtain were soiled. A black baseboard was partially detached from the wall to the left of the closet door. A photograph of the bathroom and baseboard was taken at this time. The Maintenance Supervisor was asked, Should this baseboard look like that? He stated, No. 4. On [DATE] at 2:18 PM, located in Resident room [ROOM NUMBER], at the entry to the bathroom, the threshold was loose and black, had sticky dirty area, and the shower curtain had black and brown spots at the lower edge in a scatter pattern. The Maintenance Supervisor was asked, Should the threshhold be loose there? He stated, No. The Maintenance Supervisor was asked, What could happen to ambulatory residents? He stated, They could trip. 5. On [DATE] at 2:41 PM, Resident room [ROOM NUMBER] there was a chunk of brown debris on the bathroom floor, approximately 12 inches from the shower area. The interior bathroom door, on the lower area was missing paint, and had horizontal scrape marks and 4 holes of various sizes horizontally across lower of the door. A photograph of the bathroom floor and door was taken at this time. 6. On 3/3/2020 at 10:18 AM, in Resident room [ROOM NUMBER]A, the privacy curtain had various sizes of round and oval, various shades of brown stains, on the interior portion of the curtain near the seam approximately 24 inches from the bottom hem. An dirty black area, that measured approximately 16 inches wide was on the exterior area of the curtain midway between top and bottom, toward the right side. A photograph of the privacy curtain was taken at this time. 7. On 3/3/2020 at 1:41 PM, in Resident room [ROOM NUMBER] there was a piece of baseboard missing from around the wall that measured approximately 2 feet. 8. On 3/3/2020 at 2:35 PM, in Resident room [ROOM NUMBER] bathroom frame that measured approximately 12 inches long was missing from the bathroom door frame. 9. On 3/4/2020 at 10:39 AM, the Environmental Housekeeping Supervisor was asked, When you enter a resident room, what tasks do you perform? The Supervisor stated, Straight to the bathroom to clean toilets and get all the trash out of there, then take the trash out of the room, then I sweep all of it. The Environmental Housekeeping Supervisor was asked, Who is responsible for changing soiled privacy curtains? The Supervisor stated, We are to get the Maintenance Supervisor Assistant and remove it, he takes it to laundry, and then he brings a clean one and replaces it. The Environmental Housekeeping Supervisor was asked, Were any curtains replaced today? The Supervisor stated, No. The Environmental Housekeeping Supervisor was asked, Were any curtains replaced yesterday? The Supervisor stated, I was in laundry and he brought one in, but I don't know where it was from. The Environmental Housekeeping Supervisor was asked, When is deep cleaning done? The Supervisor stated, If it is a deep clean we all gang up on it and remove everything out away from the walls and clean the beds good and the rails good and around the wall clean mop and dust everything and make sure there is no rips on walls we write it down and give it to maintenance and they take care of it. The Environmental Housekeeping Supervisor was asked, When you find something in a room and you write it down, how long does it take to get fixed? The Supervisor stated, Usually by the end of the day it is fixed. 10. On 3/4/2020 at 10:58 AM, the Human Resources/Environmental employee was asked, When you enter a resident room, what tasks do you perform? She stated, Check trash at the bedside and bathroom clean bathroom bedside tables sweep, mop is regular duties and inspect really quick and do a little more sometimes. She was asked, Who is responsible for changing soiled privacy curtains? She stated, Usually the housekeepers are, but sometimes they can't reach them, so we have the maintenance guy to do it. She was asked, When is deep cleaning done? She stated, Like spring cleaning they have to dust and clean out dresser drawers, bedframe, behind doors, windowsills, and disinfect. She was asked, When is it scheduled? She stated, If a resident has left or passes then those are done at that time but they have another one they generally do daily, they just have the CNAs take them out of the room. If a resident refuses they move to a different room. 11. On 3/4/2020 at 10:59 AM, the Maintenance Supervisor was asked, What are you responsible for within resident rooms? He stated, I am supposed to check equipment and beds and things like that. He was asked, Were you notified of damage in resident's room? He stated, I have a log outside of my office and they put it in there. He was asked, When you are notified of damage in a resident's room, what is your timeframe for repairs? He stated, I try to have it fixed within 24 hours. 12. On 3/4/2020 at 1:30 PM, CNA #6 was asked, When you see a privacy curtain that is soiled, what do you do? CNA#6 stated, Let maintenance know so they can come take it down and it can be changed immediately. CNA #6 was asked, If there is damage in a room who do you notify? CNA#6 stated, We put it in the maintenance log-book and report it to maintenance immediately. 13. On 3/4/2020 at 1:49 PM, the Director of Nursing (DON) was asked, When you see a privacy curtain that is soiled, what do you do? The DON stated, I notify our maintenance supervisor that the privacy curtain needed to be changed out. The DON was asked, If there is damage in a room who do you notify? The DON stated, Maintenance. He has a book outside of his book that we write down the room number and the issue and he takes care of it. 14. A document titled, Housekeeping Protocol, provided by Human Resources Director on 3/5/2020 documented, . 21. Check your work and make certain there is nothing you have not done. 15. A document titled Environmental Services Deep Cleaning provided by Human Resources Director on 3/5/2020 documented, . 28. Make list of maintenance for room and put in log . 16. A untitled document was provided by the Administrator on 3/4/2020 at 1:00 PM, in response to a request from surveyor for a cleaning schedule for rooms on 300 hall, did not provide specific dates that cleaning was to be performed in specific rooms.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on record review and interview, the facility failed to ensure an allegation of abuse was reported within 2 hours to the Office of Long Term and other state officials agencies in accordance with state law for 1 (Resident #19) of 1 resident who had an allegation of abuse. The failed practices had the potential to affect all 90 residents who resided in the facility, according to the Census provided by the Administrator on [DATE]. The findings are: 1. The Arkansas Department of Health and Human Services: Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property & (and) Exploitation of Residents in Long Term Care Facilities documented ., On [DATE]20, A vendor in the facility reported witnessing verbal and physical abuse of a resident at 7:50 AM On [DATE]20, the Administrator was notified of the incident 7:50 AM . On [DATE]20, the Office of Long Term Care was notified of the incident at 6:00 PM . On [DATE]20, the physician was notified of the incident at 6:20 PM . On [DATE]20, the Police Department was notified of the incident at 6:30 PM . On [DATE]20 the family was notified of the incident at 8:11 PM . 2. On 3/5/2020 at 1:57 PM, the Administrator was asked, What is your time frame for reporting an incident of alleged abuse? The Administrator stated, 2 hours if there is injury and twenty fours if not.
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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	045354	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIANNA HILLS NURSING AND REHABILITATION CENTER	**8411 SOUTH 28TH STREET FORT SMITH, AR 72908**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 3) Based on record review and interview, the facility failed to ensure legible, written notification of transfer/discharge to the hospital was provided to the resident and / or resident's representative to protect resident rights for 2 (Resident (R) #79 and R #78) of 21 (Resident #19, #65, #46, #25, #189, #84, #33, #16, #64, #57, #67, #78, #70, #77, #79, #38, #68, #21, #34, #18, and #6) sampled residents who were sent to the hospital in the last 120 days, according to a list provided by the Business Office Manager (BOM) on 3/5/2020 at 1:53 P.M. This failed practice had the potential to affect 74 residents who were transferred or discharged from the facility in the last 120 days, according to a list provided by The Business Office Manager on 3/5/2020 at 1:53 PM. The findings are: 1. Resident # 78 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/2020 documented the resident scored 10 (8-12 indicates moderate impairment); and required extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. a. A nurse's note dated 12/30/19 at 8:35 PM, documented the resident was sent to the hospital after a fall and returned on 12/30/19. b. A nurse's note dated 1/6/2020 at 3:40 PM, documented the resident was sent to the hospital after becoming lethargic and confused. c. A nurse's note dated 1/13/2020 at 8:47 PM documented the resident was sent to the hospital with shortness of breath (SOB). d. The Business Office Momager (BOM) provided a typed letter that was addressed to the responsible party that was faded and not legible for the surveyor to review. 2. Resident # 79 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 1/27/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two people with bed mobility, transfers, dressing, toileting, bathing, and personal hygiene; and needed set-up help for meals. a. A Nurse's note dated 1/17/2020 at 11:07 p.m., documented, .Order received from (Doctor's Name) to send out via (by way of) EMS (Emergency Medical Service) to hospital for evaluation and treatment Sent to (Hospital Name). b. On 3/4/2020 at 10:40 AM the BOM was asked, Did the facility notify the resident/responsible party with a transfer/discharge letter when the resident was sent to the hospital? The Business Office Manager stated, Yes. We sent out this letter (copy shown to surveyor) and it shows the date here where I mailed it. The BOM was asked, Is this exactly like the letter you sent out to the resident/responsible party? This one is faded out? The BOM stated, Yes. I just made a copy of the letter and put it in this book, but this is the letter. The BOM gave the surveyor a notebook titled, Transfer/Discharge Notices. The BOM stated, All the copies of the letters that I send out are in this notebook. c. The transfer/discharge notebook contained 21 letters from September 2019, 25 letters from October 2019, 21 letters from November 2019, 21 letters from December 2019, 24 letters of January 2020, 25 letters from February 2020. The forms were faded and became worse as the months passed. d. On 3/4/2020 at 11:00 AM, the Social Services Designee was shown a copy of the discharge letter for Resident #78 dated as mailed on 1/14/2020. She was asked, Can you read this document? She stated, No. It kind of fades out. It is darker on one side. e. On 3/4/2020 at 11:15 AM, the Administrator was shown a copy of the discharge letter for Resident #78 dated as mailed on 1/14/2020. She was asked, Can you read this document? She stated, No. I can't read that. Surely, we did not send this out like that. I am going to print a new one off right now to give to (BOM's Name).
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure legible, written notification of bed hold policy to the resident and/or resident's representative to protect resident rights for 2 (Resident (R) #79 and R #78) of 21 (Resident #19, #65, #46, #25, #189, #84, #33, #16, #64, #57, #67, #78, #70, #77, #79, #38, #68, #21, #34, #18, and #6) sampled residents who were sent to the hospital in the last 120 days, according to a list provided by The Business Office Manager (BOM) on 3/5/2020 at 1:53 P.M. This failed practice had the potential to affect 74 residents who were transferred or discharged from the facility in the last 120 days, according to a list provided by The Business Office Manager on 3/5/2020 at 1:53 PM. The findings are: 1. Resident # 78 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/2020 documented the resident scored 10 (8-12 indicates moderate impairment); and required extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. a. A nurse's note dated 12/30/19 at 8:35 PM, documented the resident was sent to the hospital after a fall and returned 12/30/19. b. A nurse's note dated 1/6/2020 at 3:40 PM, documented the resident was sent to the hospital after becoming lethargic and confused. c. A nurse's note dated 1/13/2020 at 8:47 PM documented the resident was sent to the hospital with shortness of breath (SOB). d. The facility provided a typed letter that was faded and not legible for the surveyor to review. 2. Resident # 79 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 1/27/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two people with bed mobility, transfers, dressing, toileting, bathing, and personal hygiene; and needed set-up help for meals. a. A Nurse's note dated 1/17/2020 at 11:07 p.m., documented, .Order received from (Doctor's Name) to send out via (by way of) EMS (Emergency Medical Service) to hospital for evaluation and treatment Sent to (Hospital Name). b. On 3/4/2020 at 10:40 AM the BOM was asked, Did the facility notify the resident/responsible party with a transfer/discharge letter when the resident was sent to the hospital? The Business Office Manager stated, Yes. We sent out this letter (copy shown to surveyor) and it shows the date here where I mailed it. We do not send out a separate bed hold letter I was under the impression they were all included in this letter. The BOM was asked, Is this exactly like the letter you sent out to the resident/responsible party? This one is faded out? The BOM stated, Yes. I just made a copy of the letter and put it in this book, but this is the letter. The BOM gave the surveyor a notebook titled, Transfer/Discharge Notices. The BOM stated, All the copies of the letters that I send out are in this notebook. c. The transfer/discharge notebook contained 21 letter from September 2019, 25 letters from October 2019, 21 letters from November 2019, 21 letters from December 2019, 24 letters of January 2020, 25 letters from February 2020. The notices were not legible and became worse as the months passed. The print was not legible. d. On 3/4/2020 at 11:00 AM, the Social Services Designee was shown a copy of the discharge letter for Resident #78 dated as mailed on 1/14/2020. She was asked, Can you read this document? She stated, No. It kind of fades out. It is darker on one side. e. On 3/4/2020 at 11:15 AM, the Administrator was shown a copy of the discharge letter for Resident #78 dated as mailed on 1/14/2020. She was asked, Can you read this document? She stated, No. I can't read that. Surely, we did not send this out like that. I am going to print a new one off right now to give to (BOM's Name).
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS Care Plan Coordinator was accurately transmitting the MDS and updating the Care Plan for 1 (Resident (R) #8) of 19 sample residents, in order to provide accurate and up to date information to enhance or improve each resident's quality of life. This failed practice had the potential to effect 90 residents who resided in the facility according to the Resident Censes and Condition of Residents form 4:07 PM on [DATE]. Resident #8 had [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment Reference Date (ARD) of 11/11/2019 documented the resident scored a 2 (0-7 indicates severe impairment) on a Brief Interview for mental Status (BIMS). a. The resident had a Quarterly MDS with an ARD of 11/11/2019. The residents next assessment would have been a quarterly due by 2/11/2020. A Quarterly MDS was in progress and dated .2/10/2020 . b. On 3/3/2020 at 10:15 AM, the MDS/Care Plan Coordinator was asked what In Progress meant on residents Quarterly MDS. She Stated, .It's in progress because the Registered Nurse (RN) hasn't signed it yet. But I'll get right on that . RN Was asked, Does in progress mean that the MDS isn't completed? She stated .Yes . But it's not my fault she hasn't signed it . RN Was asked, Who's responsibility is it to ensure the MDS's are completed in the time allotted by the regulations? She stated, .Mine . c. On 3/4/2020 at 12:25 PM, the MDS/Care Plan Coordinator surveyor was asked, .Most of your resident assessments MDS's state in progress, can you tell me why your MDS's are not completed? The MDS Coordinator stated, Life. The surveyor asked for a clarification of Life. The MDS Coordinator stated, I have been the only one here for about one month, and I have had to try to do these all myself. We run a large skilled census and they keep me busy. The MDS Coordinator was asked, Does the words, in progress regarding the MDS mean they are not completed? The MDS Coordinator stated, Yes.
F 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.**

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F 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data sets (MDS) Discharge assessments were encoded and transmitted upon discharge of a resident for 2 (Residents (R) #2 and #3) of 22 (Resident #54, #61, #6, #8, #16, #80, #67, #78, #192, #189, #79, #196, #193, #34, #288, #77, #30, #52, #68, #18, #2, and #3) sample residents whose MDS assessments were reviewed. This failed practices had the potential to affect 131 residents who were discharged in the last 120 days and required assessments, according to a list provided by the Administrator on 3/6/2020 at 8:45 AM. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. The Admission MDS with an Assessment Reference Date (ARD) of 1/18/2020 documented the resident scored 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of 2 people for bed mobility, transfers, dressing, toileting, bathing, and was able to feed herself with minimal assistance. As of 3/5/2020 at 10:38 PM, the electronic medical record documented the last MDS assessment completed and transmitted was End of PPS Part A Stay dated 2/10/2020. The Discharge return anticipated assessment dated [DATE] was in progress . 2. Resident #3 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 10/22/19 documented the resident scored 7 (0-7 indicates severe impairment) on a BIMS and required limited assistance of 1 person for bed mobility, transfers, dressing, toileting, bathing, and set-up for eating. On 3/4/2020 after this surveyor made the facility aware, a Discharge return not anticipated dated 11/12/19 was documented in the electronic health record (EHR) as completed and transmitted on 3/4/2020. 3. On 3/4/2020 at 12:25 PM, the MDS Coordinator was asked, In the electronic health record, (Resident #2's Name) has a Discharge Return Anticipated that is dated and shows in Progress. Can you tell me why the resident's information is triggering that it is over 120 days old? The MDS Coordinator stated, It is not. I don't know where you are getting that. But she was just sent to the hospital. On 3/4/2020, nurse's notes dated 2/19/2020 document the resident was sent to the hospital and nurse's notes dated 2/21/2020 document the resident was admitted to in patient hospice. 4. In the electronic health record (Resident's Name) #3, has a Discharge Return not Anticipated that is dated 11/12/19 and shows in Progress. The MDS Coordinator was asked, Can you tell me why the resident's information is triggering that it is over 120 days old? The MDS Coordinator stated, The Discharge was done but was never sent. The MDS Coordinator was asked, Can you tell me why it was not sent? The MDS Coordinator stated, No. It got marked to not send it to the state, by mistake, because she was private insurance. I will get it transmitted today. Most of your resident assessments MDS's state in progress. The MDS Coordinator was asked, Can you tell me why your MDS's are not completed? The MDS Coordinator stated, Life. The MDS Coordinator was asked for a clarification of Life. The MDS Coordinator stated, I have been the only one here for about one month, and I have had to try to do these all myself. We run a large skilled census and they keep me busy. The MDS Coordinator was asked, Does the words, In progress regarding the MDS mean they are not completed? The MDS Coordinator stated, Yes.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) was completed after a [DIAGNOSES REDACTED].#77) of 1 sample residents. This failed practice had the potential to affect 2 residents who received [MEDICATION NAME] per a physician's orders [REDACTED]. The findings are: Resident 77 had [DIAGNOSES REDACTED]. The Significant Change MDS with an Assessment Reference Date (ARD) of 2/9/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a BIMS; and. was a limited to extensive assist of one to two staff members for activities of daily living and received an antipsychotic 7 of 7 days look back period. a. A physician order [REDACTED].[MEDICATION NAME] Sprinkles Capsule Delayed Release Sprinkle 125 MG ([MEDICATION NAME] Sodium) Give 1 capsule by mouth every 12 hours related to [MEDICAL CONDITION], urinary tract infection, and [MEDICATION NAME] tablet 25 mg (quetiapine [MEDICATION NAME]) give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION], urinary tract infection . Directions under the orders indicated the medication was originally ordered for [MEDICAL CONDITION] Disorder, current episode manic severe with psychotic features. A photograph of the physician's orders [REDACTED]. b. A Care Plan dated 1/14/2020 documented, .BEHAVIORS- (Resident #77) has recently started have reoccurring delusions/hallucinations regarding bugs, things coming up out of floor, people looking into her window, fearful, paranoia . Administer medications as ordered. Monitor/document for side effects and effectiveness . c. A Care Plan dated 1/20/2020 documented, .BEHAVIORS-has recently started have reoccurring elusions/hallucinations . d. The pharmacist review dated 1/23/2020 documented, . 37 [MEDICATION NAME]/[MEDICATION NAME] ADDED DX (diagnosis) [MEDICAL CONDITION] - DOC (documented) - OK BUT ON ANTIBIOTIC FOR UTI (Urinary Tract Infection) 5.5/1.7 LFTS (Liver function test) OK . e. A physician's orders [REDACTED]. f. On 3/4/2020, the Director of Nursing (DON) was asked, Do you have a PASSAR for (Resident #77)? The DON stated, I will have to check. g. On 3/4/2020 at 3:36 PM, the DON provided a fax that documented .Re: (Resident #77) . DOB 8/28/1936 ., I have reviewed the recent hospital records again in regards to a [DIAGNOSES REDACTED]. This [DIAGNOSES REDACTED]. I am continuing these medications in relation to (name) Resident #77 issues with recurrent UTI's (urinary tract infections) that result in metabolic [MEDICAL CONDITION] with nightmares, and hallucinations. I feel these medications are helping with these issues and with her sleep hygiene. I will review these medications monthly and as needed in regard to future reductions. (Resident #77) has [MEDICAL CONDITION], a [MEDICAL CONDITION] bladder and multiple drug allergies [REDACTED]. signed by a stamp . MD (Medical Doctor) .
F 0646 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the state mental health authority was immediately notified after a significant change in condition resulting in a mental health [DIAGNOSES REDACTED].#77) of 1 sample residents who was diagnosed with [REDACTED]. The Significant Change MDS with an Assessment Reference Date (ARD) of 2/9/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a BIMS; and was a limited to extensive assist of one to two staff members for activities of daily living and received an antipsychotic 7 of 7 days look back period. a. A physician order [REDACTED].[MEDICATION NAME] Sprinkles Capsule Delayed Release Sprinkle 125 MG ([MEDICATION NAME] Sodium) Give 1 capsule by mouth every 12 hours related to [MEDICAL CONDITION], urinary tract infection, and [MEDICATION NAME] tablet 25 mg (quetiapine [MEDICATION NAME]) give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION], urinary tract infection . Directions under the orders indicated the medication was originally ordered for [MEDICAL CONDITION] Disorder, current episode manic severe with psychotic features. A photograph of the physician's orders [REDACTED]. b. A Care Plan dated 1/14/2020 documented, .BEHAVIORS- (Resident #77) has recently started have reoccurring delusions/hallucinations regarding bugs, things coming up out of floor, people looking into her window, fearful, paranoia . Administer medications as ordered. Monitor/document for side effects and effectiveness . A Care Plan dated 1/20/2020 documented, .BEHAVIORS-has recently started have reoccurring elusions/hallucinations . c. The pharmacist review dated 1/23/2020 documented, . 37 [MEDICATION NAME]/[MEDICATION NAME] ADDED DX (diagnosis) [MEDICAL CONDITION] - DOC (documented) - OK BUT ON ANTIBIOTIC FOR UTI 5.5/1.7 LFTS (Liver Function teat) -OK . d. A physician's orders [REDACTED]. e. On 3/4/2020, the Director of Nursing (DON) was asked, Do you have a PASSAR for (Resident #77)? The DON stated, I will have to check. f. On 3/4/2020 at 3:36 PM, the DON provided a fax that documented .Re: (Resident #77) . DOB 8/28/1936 ., I have reviewed the recent hospital records again in regards to a [DIAGNOSES REDACTED]. This [DIAGNOSES REDACTED]. I am continuing these medications in relation to (name) Resident #77 issues with recurrent UTI's (urinary tract infections) that result in metabolic [MEDICAL CONDITION] with nightmares, and hallucinations. I feel these medications are helping with these issues and with her sleep hygiene. I will review these medications monthly and as needed in regard to future reductions. (Resident #77) has [MEDICAL CONDITION], a [MEDICAL CONDITION] bladder and multiple drug allergies [REDACTED]. signed by a stamp . MD (Medical Doctor) .

F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted**

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a Baseline Care Plan was established upon entry to the facility to direct resident care for 1 (Resident (R) #288) of 10 (R #38, R #64, R #84, R #189, R #196, R #193, R #192, and R #288) sampled residents who were admitted in the last 30 days. This failed practice has the potential to affect 32 residents who were admitted to the facility in last 30 days, as identified by a list provided by the Administrator on 3/6/2020. The findings are: Resident #288 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/2020 documented the resident scored 12 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS): and required extensive two-person assist with bed mobility, transfer, dressing, toilet use and personal hygiene; required extensive one-person assist with locomotion on and off the unit; and required limited one-person assistance with eating. a. The Care Plan dated 2/26/2020, did not address the resident's assistance needs for personal hygiene, transfer, bed mobility, dressing, toilet use or eating. b. A physician's orders [REDACTED]. PT (Physical Therapy) Clarification: PT/PTA to treat 5x (times)/week x (times) 8 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, gait training and PRN (as needed) group therapy as indicated OT (Occupational Therapy) clarification: OT to tx (treatment) 5 x wk (week) x 8 wks to include therapeutic exercises, therapeutic activities, self care, neuromuscular reeducation, and pt (patient)/caregiver ed . c. A record review on 3/5/2020 did not reveal a baseline care plan was established upon the resident's entry into the facility. d. On 3/5/2020 at approximately 4:22 PM, the Director of Nursing (DON) was asked to provide a copy of resident's baseline care plan. e. On 3/5/2020 at approximately 5:12 PM, the Social Services Director advised, We do not have a baseline care plan for that resident.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the facility failed to ensure the plan of care was revised to include the enteral tube feed per physician's order in order to accurately reflect the current needs of the resident and ensure appropriate care was provided for 1 (Resident (R) #34) of 1 sample resident who required enteral tube feeding. The findings are: Resident 34 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2019 documented the resident scored 3, (indicates severely impaired, never/rarely made decisions), on a Staff Assessment for Mental Status (SAMS); and was totally dependent upon staff, two-person assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene; required of one-person assistance for locomotion on and off the unit; was totally dependent upon staff for bathing, and had a feeding tube. a. A physician order dated 1/17/2020 documented, . Enteral Feed Order every shift glucerna 1.5 at 75 cc (cubic centimeters)/hour via (by way of) pump for 23 hours a day . b. The Care Plan dated 10/9/2019 documented, .The resident has the potential unplanned/unexpected weight loss . Serve diet as ordered-REGULAR DIET, PUREE TEXTURE, NECTAR LIQUIDS . The care plan did not document the resident was receiving tube feeding per physician order.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure nail care was performed to maintain good grooming for 1 (Resident #288) of 20 (Residents (R) R #4, R #16, R #18, R #19, R #30, R #33, R #36, R #38, R #40, R #42, R #45, R #46, R #58, R #65, R #68, R #73, R #78, R #80, R #189, and R #288) sampled residents who were dependent on staff for nail care. This failed practice had the potential to affect 47 residents who were dependent on staff for nail care, according to a list provided by the Admissions Licensed Practical Nurse (LPN) on 3/4/2020 at 4:15 PM. The findings are: Resident #288 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/2020 documented the resident scored 12 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive two-person assist with bed mobility, transfer, dressing, toilet use and personal hygiene; required extensive one-person assist with locomotion on and off the unit; and required limited one-person assistance with eating. a. The Care Plan dated 2/26/2020, did not address resident's assistance needs for personal hygiene. c. On [DATE] at 12:22 PM, the resident was unshaven, his nails were long with debris under nails both hands. The resident was asked, Does the staff shave you? He stated, They shaved me once and it hurt, the razor pulled my hair. I would shave myself everyday if I could use my right hand. The resident was asked, Do you ask the staff to shave you every day? He stated, No. (A photograph of the resident's hands with long nails and black debris under nails bilateral hands was taken at this time. d. On 3/5/2020 at 11:02 AM, the Director of Nursing (DON) was asked, How much assistance does the resident need with personal hygiene, nail care, bathing? The DON stated, Off the top of my head I do not know. The DON was asked, Does the resident participate in ADLs (activities of daily living)? The DON stated, I know he is impulsive. As far as participation I would need to refer to closet care plan. The DON was asked, Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the care plan? The DON stated, I could not guarantee without me monitoring. The DON was asked, Is the goal to maintain or improve the resident's current level of functioning? The DON stated, Absolutely. The DON was asked, Are all procedures explained and the resident given time to respond to changes in care? The DON stated, That should be provided to every resident and should explain what they are going to do before they do it and make sure resident is accepting of the care. The DON was asked, Has the resident had a decline in ability to independently perform any of his/her ADLs? The DON stated, Not that I have been made aware of. I would have to check his functionality on admission and compare to what it is now. The DON was asked, If the resident refuses care, do you know why? The DON stated, I am not sure. The DON was asked, If the resident resists care on a repeated basis, how does staff respond? The DON stated, The nurse should notify the family, first of all we try different approaches and get someone with a different personality it may just be that persons approach and get someone to agree to allow us to provide the care and then call the family and let them know the e resident is refusing and provide some assistance there. If we still cannot get it, we get with family and see what options are and at some point, the become a danger to themselves and others based on a level of care they are refusing and get with physician and get admit to Geri-psych. At that point we are not providing the care we need to keep them safe. e. On 3/5/2020 at 11:12 AM, Certified Nursing Assistant (CNA) #2 was asked, What do you provide for ADLs, when and how do you determine what must be provided? CNA #2 stated, He can provide some with his left arm. We help him transfer and we help get his arm in the shirt on the right arm and we help him pull pants and brief up, socks and shoes. CNA #2 was asked, Does the resident receive assistance with ADLs? How much assistance does the resident need? CNA #2 stated, He can provide some with his left arm. we help him transfer and we help get his arm in the shirt on the right arm and we help him pull pants and brief up, socks and shoes. CNA #2 was asked, Who is responsible for trimming and cleaning the resident's nails? CNA #2 stated, When they do the showers. CNA #2 was asked, What is resident's hygiene and shower schedule? CNA #2 stated, Evenings and I believe there is Monday, Wednesday, and Friday evenings. CNA #2 was asked, If they are not able to do it on evenings what happens? CNA #2 stated, We try to pick it up the next day. CNA #2 was asked, Is resident a diabetic? CNA #2 stated, No he is not. CNA #2 was asked, Does resident refuse care? CNA #2 stated, No. CNA #2 was asked, Do you document when a resident refuses? CNA #2 stated, We let the nurse know and we document on our side that he refused. CNA #2 was asked, If the resident refuses care, do you know why? CNA #2 stated, He hasn't refused. CNA #2 was asked, What is the procedure if a resident refuses care? What do you do? CNA 2 stated, We let the nurse know and give them a few minutes 10 minutes or so and go back and try again. CNA #2 was asked, Do you know why R #288 nails were not trimmed or cleaned? CNA #2 stated, I am not even sure. f. On 3/5/2020 at 11:17 AM, CNA #12 was asked, What do you provide for ADLs, when and how do you determine what must be provided? CNA #12 stated, They got their deal on the closet door. CNA #12 was asked, Does the resident receive assistance with ADLs? How much assistance does the resident need? CNA 12 stated, Yes. He needs assistance getting out of bed. When I helped get him up there was two of us in there. CNA #12 was asked, Who is responsible for trimming and cleaning the resident's nails? CNA 12 stated, The aide on the hall. CNA #12 was asked, What is residents hygiene and shower schedule? CNA 12 stated, I have no idea. We have a certain amount on 7-3 (morning shift) and they have a

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) certain amount on 3-11 (evening shift). I don't know if he is on the 7-3. CNA #12 was asked, If they are not able to do it on evenings what happens? CNA #12 stated, They notify day and I have picked it up I don't know if anyone else has but I have. CNA #12 was asked, Is resident a diabetic? CNA 12 stated, I don't know. CNA #12 was asked, Does resident refuse care? CNA 12 stated, No. CNA #12 was asked, Do you document when a resident refuses? CNA 12 stated, I tell the nurse and let her document it. I go back a little bit later and try again because I have found if I go back, they let you later. CNA #12 was asked, If the resident refuses care, do you know why? CNA 12 stated, I don't know if he has refused. CNA #12 was asked, What is the procedure if a resident refuses care? What do you do? CNA 12 stated, I tell the nurse and let her document it. I go back a little bit later and try again because I have found if I go back, they let you later. CNA #12 was asked, Do you know why (R #288) nails were not trimmed or cleaned? CNA 12 stated, No. If he is diabetic the nurse has to do it. One of mine that is diabetic I have to tell the nurse because I am not allowed to do it. g. On 3/5/2020 at 11:25 AM, LPN #1 was asked, How much assistance does the resident need with personal hygiene, nail care, bathing? LPN #1 stated, Initially when he came in it was assist of 2 because he was unsteady. Now he is one assist. When he initially came in, we assessed him and asked a bunch of questions. LPN #1 was asked, Does the resident participate in ADLs? LPN 1 stated, He will still need supervision. We should encourage. LPN #1 was asked, Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the care plan? LPN #1 stated, I think to the best of their ability. LPN #1 was asked, Is the goal to maintain or improve the resident's current level of functioning? The LPN stated, Yes. LPN #1 was asked, Are all procedures explained and the resident given time to respond to changes in care? LPN 1 stated, Prior to providing yes they should be. LPN #1 was asked, Has the resident had a decline in ability to independently perform any of his/her ADLs? LPN 1 stated, He has had a slight improvement. LPN #1 was asked, If the resident refuses care, do you know why? LPN #1 stated, I will say no because I have not been notified that he has refused any type of care. 2. The policy and procedure titled, Nails, Care of (Finger and Toe), provided by the Administrator on 3/4/2020 at 1:00 PM, documented, . nursing assistants may perform the procedure if the resident is not at risk for complications of infection .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure physical therapy recommendations were followed for 1 (Resident (R) #8) of 23 (Resident #8, #18, #19, #21, #25, #28, #33, #37, #38, #40, #45, #61, #64, #65, #68, #77, #78, #80, #189, #192, #193, #196 and #288) sample residents had physical therapy recommendations. This failed practice had the potential to affect 43 residents who therapy according to a list provided by the Social Service Director on 3/5/2020 at 5:12 PM The findings are: Resident #8 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 11/11/2019 documented the resident scored 2 (0-7 indicates severe impairment) on a BIMS BIMS. a. On [DATE] at 1:57 PM, the resident was leaning extremely sideways in her Broda chair with her arm hanging off and laying on the floor. b. On 3/3/20 at 9:59 AM, the resident was leaning to the right side in her Broda chair. The staff repositioned the resident, but resident had swinging motion to her legs and moves herself back to the leaning position. The Director of Nursing (DON) stated resident had been assessed previously by therapy for positioning. But couldn't remember the outcome. c. On 3/4/2020 at 11:36 AM, Speech Language Pathologist (SLP) therapy Coordinator stated the current company that provides therapy services has only been in the facility since (NAME)2019, any therapy notes prior to that would have come from (Company name) and this company had no access to their records. d. On 3/4/2020 at 12:49 PM, the DON was asked for prior therapy documentation. She stated she would have to contact the prior therapy provider in order to locate resident's records if she had any. e. On 3/4/2020 at 1:11 PM, the DON provided, .PT (Physical Therapist)-Therapist Progress & (and) Discharge Summary . that documented .Skilled services provided since last report seating system ordered, .Discharge plans & instructions to staff/awaiting seating system . this was signed by PT#1. The DON was asked for documentation where the positioning device was purchased and used. f. On 3/4/2020 at 1:27 PM, the DON stated therapy was unaware of the positioning device mentioned in the resident's discharge summary, and was going to try and contact PT #1, that made the recommendation because she was no longer with the company. The DON stated, .I don't recall ordering any seating device around the specified time (10/2/2019). I can check the ordering log to see if anything was ordered at that time . g. The resident's medical record was reviewed, and no documentation could be found regarding the positioning device. h. On 3/5/2020 at 1:22 PM, the DON provided a handwritten statement that stated .This nurse is unable to locate a receipt of ordering or receiving a seating device recommended for (Resident #8) in October 2019 . A policy was requested on following therapy recommendations at this time. i. On 3/5/2020 at 3:46 PM, the DON stated, .We don't have a policy for following therapy recommendations . The DON was asked, What is the usual process for therapy notifying the facility of their recommendations? She stated, .they just give them to one of us . The DON was asked who us was. She stated, .one of the nurses, but obviously it doesn't work very well, because this one fell through the cracks .
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure weekly skin audits were completed as scheduled in order to identify skin breakdown for 1 (Resident #52) of 23 (Residents #4, #6, #10, #11, #16, #21, #30, #33, #34, #36, #42, #45, #46, #52, #54, #64, #67, #68, #77, #78, #79, #80 and #193) sample residents who had physician orders [REDACTED].#4 on 3/5/2020 at 4:15 PM. The findings are: Resident #52 had [DIAGNOSES REDACTED]. a. The .Care Plan . dated 12/30/2019 documented, .The resident has Diabetes Mellitus, . Check all of body for breaks in skin and treat promptly as ordered by doctor ., Follow facility policies/protocols for the prevention/treatment of [REDACTED]. On 3/5/2020 at 1:33 PM, Licensed Practical Nurse) # LPN #1 was asked, How often are skin audits completed? LPN #1 stated, .weekly skin audits are standard, when they're first admitted we do skin audits daily for several days . LPN #1 was asked, Who is responsible for assessing the resident? LPN #1 stated, . All nurses are responsible . Where are they documented? LPN #1 stated, .they are in (electronic heath record) and that's the only place they are, unless the resident had a readmit. Then the nurse would put it in the admit reassessment . c. On 3/5/2020 at 1:39 PM, a body audit of this resident was performed with LPN #1 and LPN #4. The coccyx area was visualized and had two teardrop shaped dry scaly areas that was similar to [MEDICAL CONDITION]. The left buttock measured 4 x (by) 3 cm (centimeters). There was a reddened scratched area on the inner aspect of the left dry scaly area that measured 1x1 cm. The right buttock was had a matching dry scaly area that measured 3x2 cm. LPN #1 was asked if she usually works this hall and LPN #1 stated, .I work different halls and shifts . The LPN was asked, Did you work last week? LPN #1 stated, .I don't know if I had him last week or not, but not to my knowledge . d. On 3/5/2020 at 1:50 PM, LPN #4 was asked when the skin audits were scheduled and LPN #4 stated .skin audits are on a weekly schedule. Each nurse has a set of residents that they are supposed to complete weekly . LPN #4 was asked, What nurse is assigned to complete these skin audits? LPN #4 stated .the shift nurse, each shift nurse has certain resident room numbers to complete on their shift . e. On 3/5/2020 at 1:54 PM, the DON was asked, How often are the nurses supposed to do skin audits? She stated, .weekly . The Don was asked, Are the nurses supposed to follow the schedule? She stated, .Yes, it's posted . The DON was asked, Do you expect your staff to follow the policies and procedures of the facility? She stated, .Yes. Of course . f. On 3/5/2020 at 2:50 PM, a copy of .skin audit and weekly summaries are to be done as follows . documented, Residents room [ROOM NUMBER]B was listed under .7-3 (morning) . shift .Thursday . The last skin audit documented in his electronic record was dated .[DATE] . by LPN #4. Another skin audit reported by LPN #4 on 2/10/20 documented dry skin issues on the resident's feet.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure supra pubic catheter care was provided in accordance with physician orders [REDACTED].#77) of 3 (Resident (R) #46, R #68, and R #77) sampled residents who received catheter care. This failed practice had the potential to affect 5 residents who receive catheter care on the 300 hall according to a list provided by the Minimum Data Set (MDS) Coordinator on 3/6/2020. The findings are: Resident #77 had a [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) (assessment

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) reference date) of 2/9/2020 documented the resident scored 14 (13 - 15 indicates cognitively intact) on a Brief Interview for mental Status (BIMS), was a limited to extensive assist of one to two staff members for activities of daily living and had an indwelling catheter. a. A physician's orders [REDACTED]. Foley cath (catheter) care q (every) shift every shift for SUPRA-PUBIC CATHETER . b. A Care Plan dated [DATE] documented, . ADL (Activities of Daily Living) self-care performance deficit TOILET USE: The resident is usually independent with toileting but for safety reasons may need assist at times, is able to use call light and exhibits good safety awareness . Revision date of 8/7/2015 . SUPRAPUBIC CATHETER-risk for complications. d. On 3/3/2020 at 10:11 AM, Resident #77 stated, I wear a catheter and sometimes they don't empty it and leave it for the next person. I have had it for 7 years. It gets stinky e. On 3/3/2020 at 11:41 AM, Certified Nursing Assistant (CNA) 1 was asked, How often do you provide care for Resident #77? CNA #1 stated, She takes care of her own peri and catheter care. CNA #1 was asked, So you do not clean her, perform any peri-care? CNA #1 stated, No. CNA #1 was asked, Does she have a suprapubic catheter or urethral catheter? CNA #1 stated, I think it is up here. (Indicates above the pubis) CNA #1 was asked, Does she have a dressing that is changed? CNA #1 stated, I think the nurse takes care of that. CNA #1 was asked, Do you have to empty her catheter bag? CNA #1 stated, She empties it herself. At approximately 1:10 PM CNA #1 advised I can do catheter care if you need me to. I was told we do clean the tubing so I can show you that.) f. On 03/4/2020 at 2:00 PM, Licensed Practical Nurse (LPN) 1 was asked, How often is catheter care provided for (R77)? LPN 1 stated, Every shift, she does it on her own. LPN #1 stated, Who is responsible to provide catheter care for (R #77)? LPN 1 stated, Well staff on the floor for catheter care. So wound care nurse does that daily, cleans around the catheter site. LPN #1 was asked, Do you know how many UTI's she has had since December (2019)? LPN #1 stated, I think 2. Twice on our end since December. LPN #1 was asked, Is there a doctor order for her to self-care? LPN 1 stated, No. I think she is a limited with assist of one. If self-care self-administered it would need to be ordered.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a physician-ordered narcotic pain medication was available for administration as ordered to provide pain management, promote comfort, and wellbeing for 1 (Resident (R) #189) of 28 (Resident #18, #78, #84, #189, #7, #73, #37, #61, #21, #77, #30, #52, #68, #57, #6, #4, #36, #45, #33, #8, #16, #79, #25, #46, #58, #28, #38, and #67) sampled residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 53 residents who had a physician's orders [REDACTED]. The findings are: Resident #189 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required limited assistance of 1 person for bed mobility, transfers, dressing, toileting, personal hygiene and required tray set-up only for eating. a. A physician's orders [REDACTED]. Pain scale Q (every) shift, all pain must be addressed: 0-10. b. A physician's orders [REDACTED]. c. The Care Plan dated [DATE]20 documented, . PAIN-potential for pain r/t (related to) spinal/vertebra issues, chronic back pain . Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain . d. A February 2020 Medication Administration Record [REDACTED]. e. A nurse's note dated 2/29/2020 at 1:53 PM documented, . Med (Medication) unavailable. MD (Medical Doctor) notified. There was no documentation the physician was notified of the other doses not being given. f. A (NAME)2020 MAR indicated [REDACTED]. There was no documentation the physician was notified of the missed medications. g. On [DATE] at 10:45 AM the resident was asked, Do you have any pain or discomfort? The resident stated, The facility ran out of my pain medication on Saturday evening and it was not until Sunday evening that they found a lighter dose of meds (medication) to give me .I have pain in my back . Is this lighter dose of medication helping with your pain? The resident stated, Yes. h. On 3/4/2020 at 2:43 PM, Licensed Practical Nurse (LPN) #2 was asked, Does the resident have Doctor ordered pain medication? LPN #2 stated, Yes. It is routine scheduled pain medication. LPN #2 was asked, Has the resident ever not received the scheduled, Doctor ordered pain medication? LPN #2 stated, Yes. Over the weekend on Saturday, February 29th (2020), the medication was unavailable. LPN #2 was asked, What does unavailable mean? LPN #2 stated, 'The resident had run out of the medication. LPN #2 was asked, What would you do if the medication was not available? LPN#2 stated, On Sunday I called the doctor and got the order changed to [MEDICATION NAME] 5-325mg because we have that here in the ER (Emergency Drug) box. The doctor said to monitor him for pain. I called the doctor back later that day and the resident stated the [MEDICATION NAME] 5-325mg was helping him so since the medication was helping, the doctor left it at the lower dose. LPN #2 was asked, When are medications ordered from the pharmacy? LPN #2 stated, The nurses try to keep track of that, I am not sure when they are ordered. i. On 3/4/2020 at 2:56 PM, the Director of Nursing (DON) was asked, Does the resident have a Doctor's order for pain medication? The DON stated, Yes. [MEDICATION NAME] 5-325mg 1 tablet every 4 hours, scheduled, this is not PRN (as needed). LPN #2 was asked, Has the resident ever not received the Doctor ordered pain medication? The DON stated, Okay, looking at the February (2020) MAR, February 29th (2020) Saturday, at 1:53pm the med was unavailable and the doctor was notified. On 3/1/20 at 00:03 (12:03 a.m.) (3 minutes after midnight), awaiting arrival, and at waiting arrival, and at 7:38 (a.m.) will give upon arrival from pharmacy. LPN #2 was asked, What would you do if the medication was not available to give? The DON stated, Contact the physician, and get an order to pull the medication from the EKit (emergency Kit) and if that medication was not available, I would tell the physician what medication I had available, the resident's allergies [REDACTED]. LPN #2 was asked, When are medication ordered from the pharmacy? The DON stated, I don't want to tell you wrong I will check with the Administrator. j. On 3/4/2020 at 3:38 PM, the Director of Nursing provided a policy titled, Ordering and Delivery of Medication which documented, .Refills: All drugs are to be monitored daily during administration. Sufficient supply should be available for at least five days . k. On 3/4/2020 at 3:55 PM, LPN #3 was asked, If a resident needs medications on Saturday or Sunday, where do they get medication from? LPN #3 stated, The pharmacy is just around the corner and they will deliver on Saturday and Sunday. If we need them, they are available 24 hours a day, 7 days a week.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, record review, and interview, the facility failed to ensure medications in 2 of 3 medication carts were labeled and stored in accordance with State law and accepted standards of pharmacy practice; failed to ensure discontinued or expired medications were removed and placed into an area for destruction to prevent potential administration to residents; and failed to ensure controlled medications which have a potential for abuse, contained the correct count of medications. These failed practices had the potential to affect all 90 residents who resided in the facility and would receive any physician-ordered medications from the medications room, or the medication carts. The findings are: 1. On 3/5/2020 at 4:05 PM, Licensed Practical Nurse (LPN) #5, unlocked the 500/600 Hall medication cart. Inside of the cart, sitting inside the top drawer were two clear plastic medication cups. One medication cup contained a yellow pudding like substance with white pieces in it. LPN #5 stated, I am going to waste this with her, (LPN #6) but she is sending someone to the hospital. She said this was (Resident's Name)'s [MEDICATION NAME] that she crushed and mixed with pudding, then the resident refused to take it. The other clear medication cup contained a small pill, which LPN #6 stated was (Resident's Name) Klonopin 0.5mg (milligrams). The LPN was asked, What does this page (Resident #56's [MEDICATION NAME] 5/325mg) of the narcotic book say? LPN #6 stated, Fourteen. LPN #6 was asked, What does the medication card say? LPN #6 stated, Thirteen. LPN #6 was asked, Should they match? LPN #6 stated, Yes. LPN # 5 stated, I would have caught it. 2. On 3/5/2020 at 4:22 PM, the 500/600 medication cart was checked with LPN # 5. The Medication Cart contained the following: a. There was a bottle of [MED] ([MEDICATION NAME]) [MED] for Resident # 64, dated as opened on 1/29/2020. The manufacturer's package insert documented, Throw away all [MED] [MEDICATION NAME] in use after 28 days, even if there is [MED] left. b. A bottle of [MEDICATION NAME] for Resident #64, dated as opened on 1/29/2020. The manufacturer's package insert documented, Discard containers in use after 28 days, even if there is [MED] left. 3. The Narcotic check for the Medication cart contained the following results: a. 38 [MEDICATION NAME]/[MEDICATION NAME] 5/325 --resident expired b. 5 [MEDICATION NAME] 1mg--resident expired c. 5 [MEDICATION NAME]/[MEDICATION NAME] 7.5/325---resident expired d. 36 [MEDICATION NAME]/[MEDICATION NAME] 10/325---resident expired e. 51 [MEDICATION NAME]/[MEDICATION NAME] 7.5/325---resident expired f. 26 [MEDICATION NAME]

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) 0.5mg --Resident # 38--Discontinued g. 6 [MEDICATION NAME] 0.5mg---Resident # 38---Discontinued 4. The PRN (as needed) medications check for the Medication cart contained the following results: a. 3 [MEDICATION NAME] 25mg ---Resident # 6--expired 2/28/2020 b. Twenty 1/2 tablets [MEDICATION NAME] 25 mg---Resident # 43--expired 2/12/2020 c. 6 [MEDICATION NAME] 100mg ----Resident # 77--expired [DATE] 5. 100/200 medication cart checked with LPN # 7. There were 6 Sodium Chloride 0.9% (percent) syringes, unlabeled laying loosely in the bottom drawer of the medication cart. LPN #7 was asked, Is there a resident who currently uses these syringes? LPN #7 stated, Yes. 6. A policy titled, Labeling of Medication Containers received from the Director of Nursing (DON on 3/5/2020 at 4:37 PM, documented, .Labels for each single unit dose package shall include all necessary information, .The names of the resident and physician do not have to be on each unit dose package, but they must be identified with the package in such a manner as to ensure that the drug is administered to the right resident . 7. On 3/5/2020 at 4:37 PM, the Director of Nursing provided a policy titled, Storage of Medications. This policy documented, .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals .
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review, and interview the facility failed to follow the menu to meet the nutritional needs of the residents. The failed practice has the potential to affect 99 residents who receive meals from the facility's kitchen, (Total Census 91). The findings are: 1. On [DATE], at the lunch meal called for residents on regular and mechanical altered diets to receive 1 cup of tossed salad. The portions of salad at the meal were small. The mechanical altered salad had chunky diced tomatoes appropriately 1 half of an inch each. At 1:29 PM, the Dietary Manager was asked, How much salad was called for on the menu? She said, One cup. She was asked, How much was served? The Dietary Manager said, I don't know. We can measure it. When measured, the salad was a 1/2 cup.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview the facility failed to provid palatable food to encourage residents to increase the amount they eat. This failed practice had the potential to effect 8 residents who had physician's orders [REDACTED]. Based of observation, record review, and interview the facility failed to ensure meals were served at temperatures that were acceptable to the resident, to maintain palatability, encourage adequate nutritional intake, and enhance the dining experience for residents who received meals in their rooms on 4 Halls (#100, #200, #500, and #600) of 6 halls. The failed practice had the potential to affect 34 residents who eat meals in their rooms (Total Census: 90), according to lists provided by the Dietary Manager on 3/5/2020 at 11:49 AM. The findings are: 1. Resident #54 had [DIAGNOSES REDACTED]. a. A physician's orders [REDACTED].No added sugar/ no added salt diet, Pureed texture, Pudding consistency . The Care Plan 11/11/2019 documented, .Nutrition-potential for unplanned weight loss r/t (related to) Diabetes, Dementia. At risk for weight fluctuations r/t [MEDICAL CONDITIONS] and diuretic drug therapy . a. On [DATE] at 2:08 PM, the resident received puree Chili (identified by the Dietary Manager) with a spoon full of red sauce on top of 2 spoon fulls of chili. CNA #12 stated the resident won't eat the chili, the last time she had it, it made her sick . CNA #12 was asked, Why won't she eat it? CNA #12 stated, I guess because it tastes bad. I don't know. The resident's tray card was provided by the CNA and it documented .Gravy on everything . The Dietary Manager was asked if there was any more to taste. She stated Yes. I'll get some. The Dietary manager was asked to get the menu for me. The cook was asked to provide a portion of the chili with the same tomato sauce to taste. The Cook scooped a portion of chili and tomato sauce into a bowl. The Cook was asked for a spoon and when provided was instructed to taste the puree chili with tomato sauce. This surveyor and the Cook tasted the product with the Certified Dietary Manager (CDM) observing. The Cook stated, .it tastes like crap, it has no taste at all . The Cook was asked, If it doesn't add flavor or nutrition, why did you use it? The Cook stated, .Because it called for gravy, and I didn't think brown or white gravy was appropriate. When tasted the puree chili tasted like chili, but the tomato sauce had no other seasoning and tasted like tomato sauce fresh out of the can. The Cook was asked, Did you put any seasoning in the tomato sauce? The Cook stated, .No. I didn't. I didn't know I was supposed to . 2. Resident #79's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2020 documented the resident scored 15 (13-15 indicates cognitively intact). a. On [DATE] at 11:35 AM, The resident was asked if the facility served food at acceptable temperatures. The Resident stated, The food is usually cold because it comes on those carts, and they have so many to hand out, that by the time you get it, it is cold . The resident was asked, Do you always eat your meals in your room? The resident stated, Yes. I don't get out of bed. So, I eat all my meals in my room. 3. Resident # 192's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. a. On 3/3/2020 at 9:28 AM, the resident was asked if the facility served food at acceptable temperatures. The resident stated, Food is always cold when you eat in your room. I always eat breakfast in my room, today I had lunch in my room. We did not even get our lunch trays until after 1:30pm today. 4. The Resident Council Minutes dated [DATE] documented, Three residents shared a concern: Food is always cold. Ask staff to warm it up and resident will have to go warm food themselves. 5. On 3/3/2020 at 3:00 PM, a Facility Resident Council meeting was held. The residents were asked, Does anyone receive meals in their room and is the food cold when you receive it? Resident #67 stated, Yes. The food is cold. Resident #71 stated, Yes. My food is cold, even the coffee. 6. On 3/4/2020 at 1:15 PM., an insulated tray cart that contained 4 lunch trays for 100 hall, 7 lunch trays for 200 halls and two test trays, one Regular and one Pureed, for residents on 100 and 200 halls arrived on 200 hall. At 1:35 PM., immediately after the last resident received a tray on 200 hall, the temperatures of the food items on the test trays were checked and read by the Dietary manager with the following results: b. Regular carrots-113 degrees Fahrenheit (F) d. Pureed corn casserole-106 degrees Fahrenheit g. Pureed bread-76.6 degrees Fahrenheit 7. Resident # 193's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/21/20 documented the resident scored 12 (8-12 indicates moderately cognitively impaired) on a Brief Interview for Mental Status. On 3/4/2020, Resident #193 was asked if the facility served food at acceptable temperatures. Resident #193 stated, The food is cold. I eat breakfast in my room and sometimes lunch. I get to cold when I go to the dining room, so I eat in my room. My sausage is always cold .The other day we did have oatmeal, it was warm, not hot, but it was good.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based on observation, record review, and interview the facility failed to prepare food in a form to meet individual needs of the residents. The failed practice has the potential to affect 32 residents on a mechanical altered or puree diet, (Total Census 91). 1. On [DATE] at 1:45 PM, The Dietary Manager was asked what was the difference with the mechanical soft salad and the regular salad? She stated, The mechanical has shredded lettuce. The Dietary Manager was asked what the recipe said for mechanical soft salad? The Dietary Manager stated, For the entire salad to be finely chopped. The Dietary Manager was asked if the tomatoes were finely chopped on the mechanical soft salad? She stated, No. A photograph of the mechanical and regular salads was taken at this time.
F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure resident received physician ordered nutritional shake was provided for 1 (Resident (R) #63) resident of 7 (R #7, R #16, R #5, R #46, R #54, R #63, and R #84) sampled residents who were to receive nutritional supplements. This failed practice had the potential to affect 16 residents, who required health shakes with all meals, as identified by a list provided by the Certified Dietary Manager on

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F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) 3/5/2020 at 9:40 AM. The findings are: Resident #63 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 3 (indicates severely impaired, never/rarely made decisions) on a Staff Assessment for Mental Status (SAMS), and required extensive two-person assistance with bed mobility and dressing; was totally dependent on two-person assistance for transfers, toilet use and personal hygiene; totally dependent on one-person assistance for locomotion on and off the unit and eating; did not have a swallowing disorder. a. A physician's orders [REDACTED].No added sugar/ no added salt diet Mechanical soft texture, Nectar consistency, *** NO STRAWS *** . b. A Care Plan dated of 11/27/2019 documented, .EATING: The resident is dependent on one staff member . Dietary consult for nutritional regimen and ongoing monitoring . The resident has (POTENTIAL) unplanned/unexpected weight loss r/t new stroke, communication deficits, Dysphagia . Give the resident supplements as ordered. Alert nurse/ dietitian if not consuming on a routine basis. Date Initiated: 07/30/2018 . c. A Nutrition/Dietary progress note date 1/28/2020, documented, . Diet is NAS, NA SUGAR, Mechanical Soft, Nectar Liquids. Current weight is 213#, Eating 50% (percent) average, BMI (body mass index) is 31, Gets . health shake TID (3 times a day) . potato soup, vegetables . Weight is stable at this time. Continue . honor preferences as they are known . d. A Nutrition/Dietary progress note dated 2/10/2020, documented, .Diet is a Regular NAS/NASugar (No added salt/No added sugar) mechanical soft nectar liquids . chocolate health shake each meal . e. On [DATE] at 2:03 PM, Resident #63 was sitting in assist dining room. The resident's dining card documented, . NAS/NA Sugar, Mech (mechanical) soft, Nectar THK (thick) . potato soup, vegetables, chocolate health shake 4 oz (ounce) Nectar Choc Milk 8 oz, Nectar Tea 8 oz, Nectar Water . This Surveyor noted thickened water, thickened iced tea, a scant amount of thickened Chocolate milk in a clear cup, fiesta corn, Frito pie, four-layer cake, no vegetables and no potato soup. CNA #13 was asked, What is in the clear cup? CNA #13 responded, I think that is a chocolate health shake. CNA #13 was asked, Did resident receive potato soup or vegetables? CNA #13 stated, I was not here when the tray was served but it does not appear so. f. On [DATE] at 2:07 PM, CNA #2 was asked, Did resident receive any of these items on his tray? (Indicated to the meal card for potato soup, vegetables and health shake) CNA #2 stated, I don't think so. CNA #2 was asked, Should resident receive a chocolate health shake, potato soup and vegetables? CNA #2 stated, Yes. I missed that. I will get that for resident. CNA #2 was asked, What was your function during meal service? CNA #2 stated, I am the Meal Coordinator. A photograph of the meal card was taken at this time.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review, and interview the facility failed to ensure a food tray was served to a resident without being touched by a Certified Nursing Assistant (CNA), who had not performed hand hygiene, for 1 Residents (Resident (R) #28) of 22 (R #4, R #7, R #8, R #11, R #18, R #19, R #25, R #28, R #30, R #33, R #40, R #42, R #45, R #54, R #58, R #61, R #65, R #68, R #71, R #73, R #80, and R #288) sampled residents who were served meal trays in the dining room. This failed practice had the potential to affect 53 residents who receive their meals in the dining room, according to a list provided by the Certified Dietary Manager (CDM) on 3/5/2020 at 9:40 PM. The facility failed to ensure dietary equipment, supplies, and one of two ice machines were maintained in a sanitary manner, food was store and facial hair was properly covered to prevent the potential of food borne illness for eighty-nine residents who receive meals and ice from the facility's kitchen, (Total Census: 99). The findings are: 1. Resident #28 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/9/2019 documented the resident scored 10, (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS); was totally dependent upon staff, with two-person assistance, for transfers; required two-person, extensive assistance for bed mobility, dressing, and toilet use; required one-person extensive assistance for locomotion on and off the unit and with personal hygiene; and required supervision and set-up assistance with meals. a. The Care Plan, with a revision date of 7/31/2019, documented, .The resident is able to eat independently after tray setup, but needs checked on often . b. A physician's orders [REDACTED].No added sugar diet, regular texture, regular consistency . PT (patient) clarification effective 1/23/2020 . balance-trunk control for positioning . c. On [DATE] at 1:15 PM, Certified Nursing Assistant (CNA) #5 entered serving line in assisted dining room, through the left side door, from the main dining room and did not sanitize hands. d. On [DATE] at 1:18 PM, CNA #5 served and set up Resident #28's meal at the dining table located in the assisted dining room. 2. On [DATE] at 10:43 AM, there was a white handled 8-ounce scoop found in the clean utensil drawer with a dried green substance on the inside of it. When asked what does it look like? Employee #1 stated, Looks like puree greens. 3. On [DATE] at 10:55 AM, there was a small black speck the size of a pen point on the white shield covering in the kitchen's ice machine. The Dietary Manager was asked, Can you wipe the area with a white napkin? The black substance was seen on the napkin. The Dietary Manager was asked, What do you see? She stated, It's something black. 4. On [DATE] at 11:42 AM, there was a box of 12 individual sleeves containing 18 pancakes in each sleeve with a receive date of 2/25/2020 on the shelf in the walk-in refrigerator. On the side of the box was printed keep frozen. The Dietary Manager was asked, Are the pancakes supposed to be frozen? She stated, It says so on the box. But we thaw them if we are going to use them the next day. On 3/3/2020 at 10:33 AM, the menu was reviewed for the week. Pancakes were not on the menu for the week of Monday through Friday. The dietary manager was asked, Why it was necessary to thaw the entire box of pancakes when one sleeve at a time could be removed as needed? She stated, They should have only removed what they needed and left the rest in the freezer. 5. On 3/3/2020 at 9:15 AM, the Maintenance man who had facial hair was seen in the kitchen with no facial hair restraint. 6. On 3/3/2020 at 9:55 AM, the milk delivery man had facial hair and was seen in the kitchen with no hair or facial restraint. 7. On 3/3/2020 at 10:00 AM, there was a carton of cream with a received of 2-22-2020 with no open date. There was also a carton of heavy whipping cream with a receive date 2-11-2020 with no open date. The Dietary Manager was asked, Are the cartons securely closed? She stated, Well, no. Not securely. 8. On 3/3/2020 at 11:28 AM, the side of the steamer and the table it sits on had an excessive build-up of sticky, crumby, gooey substance on it. There was also the same type of build-up on the side of the deep fryer. The Dietary Manager was asked, How often is the steamer, table, and deeper fryer cleaned? She stated, Weekly. A photograph of the steamer, table, and deep fryer was taken at this time.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview the facility failed to ensure catheter bag and tubing were not left on the floor to prevent contamination for 1 (Resident #196) of 6 (Residents' #77, #68, #6, #79, #196, and #46) sample residents who had a foley catheter. The findings are: The facility failed to ensure hand washing was completed during incontinent care for 1 (Resident (R) #34) of 33 sampled residents (R 4, R 7, R 8, R 10, R 16, R 18, R 18, R 19, R 21, R 25, R 28, R 30, R 33, R 34, R 36, R 37, R 38, R 40, R 42, R 43, R 45, R 46, R 52, R 54, R 58, R 61, R 64, R 67, R 68, R 73, R 78, R 79, R 193, and R 288) who required staff assistance with peri-care. This failed practice had the potential to affect 74 residents who received peri-care care, according to a list provided by the Administrator on 3/4/2020 at 4:15 PM. The findings are: 1. Resident #196 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 9 (8-12 indicates moderately cognitively impaired) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two persons for bed mobility, transfers, bathing, and toileting, required limited assistance of two persons for dressing and personal hygiene. a. A Compressive Care Plan dated 2/27/2020 did not address that Resident #196 had a Foley catheter, or the potential for complications to occur due to the resident's [DIAGNOSES REDACTED]. b. On [DATE] at 11:56 AM, the resident was sitting in a straight back chair. A wheelchair with a Foley catheter attached was sitting in front of the resident. There was approximately 2 inches of catheter tubing that was laying on the floor under the wheelchair. A photograph of the catheter on the floor was taken at this time). c. On [DATE] at 4:30 PM, the resident was sitting in a wheelchair in the front lobby. The resident's Foley catheter bag was not covered in a privacy bag, the bag was attached to the side of the wheelchair at the level of the resident's bladder, with the catheter tubing touching the floor. d. On 3/5/2020 at 9:45 AM, Certified Nursing Assistant (CNA) #6 was asked, What type of training did you receive on how to handle catheters, tubing, drainage bags, and other devices during the provision of care? CNA #6 stated, We have had in-services, had on the job training, and I went to CNA classes. CNA #6 was asked, Should the catheter tubing be dragging on the floor? CNA # 6 stated, No. CNA #6 was asked, What could happen if the catheter tubing drags on the floor? CNA # 6 stated, It could cause an infection. CNA #6 was asked, Should a catheter bag be

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) covered or in a privacy bag when the resident is not in their room? CNA # 6 stated, Yes. e. On 3/5/2020 at 10:17 AM, Licensed Practical Nurse (LPN) #1 was asked, Should urinary catheter tubing be touching the floor? LPN #1 stated, No. LPN #1 was asked, What negative outcomes could occur if the tubing is on the floor? LPN #1 stated, It could rupture the tubing, lead to an infection, and could cause trauma to the resident. LPN #1 was asked, Should a catheter bag be covered or in a privacy bag when the resident is not in their room? LPN #1 stated, Yes. f. On 3/5/2020 at 10:19 AM, the Director of Nursing (DON) was asked, Should urinary catheter tubing be touching or dragging on the floor? The DON stated, No. The Don was asked, What could be the negative outcomes of the tubing touching or dragging on the floor? The DON stated, Germs from the floor can get on the tubing and that can migrate into the bladder causing infections. The DON was asked, Should the catheter bag be covered or in a privacy bag when the resident in not in their room? The DON stated, Always. 2. Resident #34 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2019 documented the resident scored 3, (indicates severely impaired, never/rarely made decisions), on a Staff Assessment for Mental Status (SAMS); and was totally dependent upon staff, two-person assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene; required of one-person assistance for locomotion on and off the unit; and was totally dependent upon staff for bathing. a. A physician's orders [REDACTED].Apply [MEDICATION NAME] SPP to areas of redness on groin and coccyx Q (every) shift for 14 days. every shift every 14 day(s) for Rash for 14 Days Redness . b. The Care Plan dated of 10/9/2019 documented, .Resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) cognitive and mobility deficits . has the potential for pressure ulcer development r/t mobility deficits and incontinence . Interventions/Tasks . Report . maceration . c. On 3/3/2020 at 08:45 AM, CNA #8 and CNA #9 entered room [ROOM NUMBER], after knocking, gathered needed supplies and placed on bedside table, a clean brief, Fitright Aloe wipes, and a box of large gloves. Both CNAs' performed hand hygiene in bathroom. d. On 3/3/2020 at 8:50 AM, CNA #8 explained care to the resident. CNA #8 performed peri-care while the resident was positioned on right side. CNA #9 changed gloves 4 times while cleaning thick black, unformed, loose stool from the resident's buttocks and scrotum. CNA #9 did not perform any hand sanitation between glove changes. f. On 3/3/2020 at 8:56 AM, CNA #9 placed a clean brief under the resident. Both CNAs' changed their gloves. No hand hygiene was performed during the glove change. g. On 3/3/2020 at 9:00 AM, Resident #34 rolled to the left side. CNA #8 began to roll the resident onto the back and was stopped by the surveyor. CNA #8 was asked to wipe resident's anus again. CNA #8 wiped resident anus and the wipe returned with dark stool. CNA #8 was asked, What is that? CNA #8 stated, BM (bowel movement). We are going to need more wipes; the call light is on. h. On 3/3/2020 at 9:02 AM, CNA #8 removed their gloves and left the room without performing hand hygiene. i. On 3/3/2020 at 9:04 AM, CNA #8 returned to the resident's room with wipes. No hand hygiene was performed after entering the room and prior to donning gloves. j. On 3/3/2020 at 9:10 AM, the CNAs completed cleaning of the stool from Resident #34, after 3 glove changes. Hand hygiene was not performed between glove changes. 3. On 3/4/2020 at 1:30 PM, CNA #6 was asked, Can you explain the process for hand hygiene during peri-care? CNA #6 stated, Incontinent and Catheter Care Observation Checklist. We get checked off on this every six months. CNA #6 was asked, It is kept in a book at the nurse's station. Have in-services been provided for proper peri-care? CNA 6 stated, Yes. CNA #6 was asked, When was the last one? CNA 6 stated, I don't remember the exact date, I think it was the one before. CNA #6 was asked, Should your hands be sanitized between glove changes? CNA #6 stated, Yes. CNA #6 was asked, What could a negative outcome be if you fail to sanitize between glove changes? CNA #6 stated, They could get infections. CNA #6 was asked, Prior to a clean brief being placed on resident, should the peri area be free of stool? CNA #6 stated, Yes. It should be completely clean. CNA #6 was asked, If it is not free of stool, what actions should be taken? CNA #6 stated, Repeat the steps of incontinent care. CNA #6 was asked, If peri area is not properly cleaned and free of urine and/or stool, how would that negatively affect the resident? CNA #6 stated, Infectious. It can cause skin breakdown also. 4. On 3/4/2020 at 1:30 PM, the Director of Nursing (DON) was asked, Can you explain the process for hand hygiene during peri-care? The DON stated, Hand hygiene is anytime you come in contact with anything that comes in you can use hand sanitizer three times unless hands are visibly soiled. You wash hands between providing any type of care. The DON was asked, Have in-services been provided for proper peri-care? The DON stated, I have not done a big overall in-service with everyone together. I have had them do check offs. I've had another gentleman that was a lead CNA do check offs. The DON was asked, When was the last one? The DON stated, It should be done on hire. The DON was asked, Should your hands be sanitized between glove changes? DON stated, Absolutely. The DON was asked, What could a negative outcome be if you fail to sanitize between glove changes? The DON stated, I mean UTI (urinary tract infection), severe. If you get a UTI bad enough you get septic. The DON was asked, Prior to a clean brief being placed on resident, should the peri area be free of stool? The DON stated, Yes. The DON was asked, If it is not free of stool, what actions should be taken? The DON stated, Start over. The DON was asked, If peri area is not properly cleaned and free of urine and/or stool, how would that negatively affect the resident? The DON stated, Again risk for infection, yeast, urinary, macerations and wounds. The DON was asked, How do you monitor staff for proper procedure during peri-care to ensure residents are receiving the highest practical care? The DON stated, Check offs. 5. On 3/4/2020 at 1:48 PM, CNA #6 provided a copy of the Incontinent & (and) Catheter Care Observation Checklist, dated 5/8/07, which documented, . 1. Wash hands . 5. Wash hands . 9. Change gloves . 14. Change gloves . 17. Change gloves . 20. Change gloves . 24. Wash hands . 6. On 3/4/2020 at 1:00 PM, the Administrator provided a document titled, Policies and Procedures - Infection Control which provided no additional information. On 3/4/2020 at 1:00 PM, the Administrator provided a document titled, Handwashing/Hand Hygiene which documented, .This facility considers hand hygiene the primary means to prevent the spread of infections . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections . 7. Use . j. After contact with blood or bodily fluids; . m. after removing gloves . 9. The use of gloves does not replace handwashing/hand hygiene. Integration along with routine hand hygiene is recognized as the best practice .