STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366417	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUR SEASONS OF WASHINGTON NURSING AND REHAB	201 COURTHOUSE PARKWAY WASHINGTN C H, OH 43160

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the Emergency Medical Squad (EMS) run report, review of hospital records, review of facility maintenance work orders, review of in-servicing and sign-in sheets, review of facility invoices for call light repairs, review of the Minimum Data Set Resident Assessment Instrument manual, review of facility policies for meal service in the resident rooms and call lights and staff interviews, the facility failed to provide adequate supervision with eating and maintain an assistive device in a fully operational manner to allow a resident to summon for assistance in the event of an emergency while eating alone in her room. This resulted in Immediate Jeopardy and serious life-threatening consequences when Resident #01 began choking while eating supper in her bed, unattended in her room. Upon receiving a phone call from the resident's Family Member #150, Registered Nurse (RN) #800 went to Resident #01's room and found her choking. RN #800 removed Resident #01's dentures, did a finger sweep, removed food, suctioned the resident and called 911. The resident was intubated by emergency medical personnel and admitted to the hospital with [REDACTED]. This affected one (#01) of three residents reviewed for supervision of diets and utilizing assistive devices. The facility census was 54. On 07/22/20 at 4:45 P.M., the facility Administrator was notified Immediate Jeopardy began on 07/10/20 at approximately 4:40 P.M., when Resident #01 experienced a choking incident while eating supper, in her bed, unattended in her room. Resident #01 pressed her call light which activated a flashing light outside of the resident's room. The audible signal for the call light, which was supposed to sound at the nurses ' station was not working. Resident #01's Family Member #150 had called Resident #01's cell phone on 07/10/20 at 4:46 P.M. when the resident was eating and learned the resident was gasping for air and no one was coming to help her. Family Member #150 called the facility telephone and requested staff check on the resident immediately because of the choking concerns. RN #800 entered Resident #01's room at approximately 4:46 P.M. on 07/10/20. The nurse verified the call light was flashing with a visual signal but there was no audible signal, because the call light was not functioning properly. The nurse did a finger sweep and removed a large piece of food from Resident #01's mouth and called 911. The resident was assessed by the nurse as being cyanotic, unresponsive, with irregular breathing and wet/gurgling breath sounds. The EMS personnel removed more food and intubated the resident in route to the hospital. Resident #01 was admitted to the hospital with [REDACTED]. Per interview with Family Member #150, the resident is now off the ventilator and is currently residing in another nursing facility, per the family request, and had been hospitalized at the larger hospital for a total of 15 days. The Immediate Jeopardy was removed on 07/22/20 when the facility implemented the following corrective actions: On 07/10/20, Resident #01 received assistance for choking by RN #800. Resident #01 was provided treatment at the facility and then was taken to the hospital by emergency medical personnel. On 07/18/20, between 9:00 P.M. and 10:00 P.M., Licensed Practical Nurse (LPN) #250 ensured the call light in Resident #01's room was functioning with light and sound properly. On 07/20/20, the facility's outside call light vendor was onsite and worked on repairs to the call light system from 7:15 A.M. to 3:30 P.M. The work order revealed the call light system was fully functional. On 07/20/20, between 10:30 A.M. and 12:30 P.M., the facility's outside call light vendor conducted a facility wide audit of the call lights and determined all the lights were fully functional. On 07/21/20, the Administrator purchased additional cow bells, in case needed in the future. On 07/22/20, beginning at 6:20 P.M. and completed by 9:00 P.M., RN #350 in-serviced all nursing staff on the call light system and notification policy if the system is not working. Review of in-service sign-in sheets confirmed all nursing staff were trained. On 07/22/20, beginning at 6:20 P.M. and completed by 9:00 P.M., RN #350 in-serviced all nursing staff on providing a resident with assistance while eating. Review of in-service sign-in sheets verified all nursing staff had been trained. On 07/22/20, at 7:00 P.M., Maintenance Director (MD) #700 completed a facility wide audit of the call lights and determined all the lights were fully functional. Beginning 07/22/20, nurses will audit every resident daily for any choking, chewing, or swallowing issues to ensure correct supervision is provided with meals. Beginning on 07/22/20, MD #700 or designee will conduct random audits of the call light system daily. The call light daily audits will continue and become permanent with the daily maintenance logs. The Quality Assurance and Performance Improvement committee will monitor the audits at their monthly meetings with the Medical Director for the next six months and then will monitor every other month thereafter. Although the Immediate Jeopardy was removed on 07/22/20, the facility remains out of compliance at Severity Level 2 (the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective actions and monitoring for effectiveness and on-going compliance. Findings include: Review of the medical record for Resident #01 revealed the resident was admitted to the facility's designated COVID-19 quarantine area for new admissions on 07/02/20 with a [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment for Resident #01, dated 07/09/20 revealed the resident was cognitively intact, required supervision and set up help for eating, was assessed as coughing or choking during meals or when swallowing medications and was totally dependent on the assistance of two staff with bed mobility and transfer. Review of the Care Area Assessments (CAA) regarding Nutritional Status revealed the resident was morbidly obese and had functional problems that affected the resident's ability to eat including functional limitation in range of motion and inability to perform activities of daily living without significant physical assistance. The CAA further revealed nutritional status would be addressed in the resident's care plan with an objective to avoid complications. Review of the CAA regarding Activities of Daily Living (ADL) functional rehabilitation potential revealed the resident needed assistance with most ADLs and would be care planned to maintain current level of ADL functioning and avoid complications. Review of the baseline care plan for Resident #01 dated 07/02/20 revealed the resident ate in her room, feeds self, wore upper dentures, was at risk for chewing and swallowing problems and was totally dependent on staff to transfer out of bed. Review of the July 2020 physician orders [REDACTED].#01 dated 07/02/20 at 2:40 P.M., revealed the resident was oriented to the use of the call light upon admission. Review of the nurse's progress note for Resident #01 dated 07/10/20, no time noted, revealed the nurse was notified at 4:46 P.M., the resident was in distress. Further review of the note revealed the resident was unable to respond, skin was bluish in color, and respirations were short, shallow, irregular and moist, and resident had a faint pulse. The note also documented the nurse removed the resident's teeth and attempted to suction her airway and called 911. The EMS arrived at 5:04 P.M., to transport resident to the hospital. Review of the EMS run report for Resident #01 dated 07/10/20, revealed the emergency personnel arrived at the facility at 5:06 P.M. The emergency personnel suctioned a small amount of food from resident's airway at 5:09 P.M. and inserted a breathing tube at 5:12 P.M. Further review of the EMS run report revealed Resident #01 was unconscious upon their arrival to the facility and the chief complaint was a foreign body obstructing the airway which caused acute respiratory distress. Review of the hospital admission record for Resident #01 dated 07/10/20, revealed the resident was admitted to the hospital with [REDACTED]. Further review of the record revealed the resident remained on a ventilator and was transferred to a larger

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) hospital. Review of a 15-minute log dated 07/10/20 revealed signatures of staff performing 15-minute checks with the last check being completed at 4:45 P.M. Review of a nurse progress note for Resident #01 dated 07/11/20, no time noted, revealed the resident had been admitted to the intensive care unit of the hospital in critical condition but stable condition. Review of the hospital discharge note for Resident #01 dated 07/17/20, revealed the resident was sent via squad to a local hospital on [DATE] but was then transferred to a larger hospital via life flight. Review of facility maintenance work orders for the month of July 2020 revealed no reports of call lights not working, including Resident #01's call light. Review of a service log from the call system vendor dated 06/16/20 revealed multiple call lights were repaired prior to Resident #01's admission to the facility. Resident #01's room was not listed as needing repair. The report documented the boards at the nurse's station needed repaired. Review of a service log from the call system vendor dated 07/20/20 revealed several call lights were repaired or replaced and the call light system board to the nurse's station where Resident #01's room would have alerted was replaced. The service work was for eight hours from 7:15 A.M. to 3:15 P.M. Random observations of call lights on 07/20/20 from 3:37 P.M. to 4:40 P.M., throughout the facility, revealed call lights were answered in less than two minutes and were functioning with visual and audible signals at the nurses ' stations. Interview with the Administrator on 07/20/20 at 4:02 P.M., verified all the call lights in the facility were currently functioning properly and there had been some problems with a few lights recently, but she did not recall which rooms were affected and she would e-mail the information later on 07/20/20. Interview on 07/21/20 at 10:08 A.M. with Family Member (FM) #150 verified she spoke to Resident #01 by phone on 07/10/20 at 4:46 P.M., and the resident complained she couldn't breathe. FM #150 further verified she called the facility and spoke to RN #800 and asked her to check on the resident immediately. FM #150 verified the resident remained in the hospital but was no longer on a ventilator. Interview on 07/21/20 at 4:29 P.M. with RN #800, verified Resident #01's call light was not fully functional all day on 07/10/20 and did not produce an audible signal. RN #800 further verified the facility staff checked on Resident #01 approximately every 15 minutes but did not have written or electronic documentation of the checks. RN #800 stated the facility did not provide the resident with a tap bell to summon staff in the event of an emergency. RN #800 verified she was alerted to go to Resident #01's room on 07/10/20, at approximately 4:46 P.M., when FM #150 called the facility and requested RN #800 check on the resident. RN #800 verified she enter Resident #01's room on 07/10/20, at approximately 4:46 P.M., and found the resident was in bed and appeared to be choking. RN #800 verified the resident's call light was in reach and the visual signal portion of the call light was functioning and flashing, but the call light did not emit an audible signal. RN #800 verified she removed Resident #01's dentures and performed a finger sweep which produced a bolus of undigested food and she attempted to suction for more food and called 911 for assistance. Interview on 07/22/20 at 8:03 A.M. with MD #700 verified he was not aware of any problems with Resident #01's call light. MD #700 further verified the facility has work order books at each nurses' station and no work orders had been filled out regarding the resident's call light nor had anyone told him the call light was not fully functional. Interview on 07/22/20 at 8:27 A.M. with Certified Nursing Assistant (CNA) # 400 verified Resident #01's call light had not been fully functional for approximately one week prior to 07/10/20. CNA #400 verified the light portion of the call light worked but the audible signal which was supposed to ring in the nurses' station was not working. CNA #400 further verified the resident did not have a tap bell to summon staff in the event of an emergency. CNA #400 stated the staff checked on the resident approximately every 15 minutes but did not have written or electronic documentation of the checks. CNA #400 verified she delivered a supper tray which included a pulled pork sandwich to Resident #01 who was eating supper in bed. CNA #400 further verified Resident #01 was able to feed herself with set up but could not get out of bed without the use of a mechanical lift and the assistance of two staff. CNA #400 verified on 07/10/20 at approximately 4:46 P.M., she had left Resident #01's room and was assisting another resident when RN #800 called her name and asked her to come and assist. CNA #400 verified the visual signal to Resident #01's light was flashing but no audible signal was emitted. CNA #400 verified she brought the crash cart to Resident #01's room and resident appeared to be unresponsive. CNA #400 verified she witnessed RN #800 perform a finger sweep of Resident #01's mouth and removed a piece of what appeared to be undigested pork. Interview 07/22/20 at 11:30 A.M. with Physical Therapy Assistant (PTA) #900, verified Resident #01's call light had not been working properly for about a week prior to 07/10/20. PTA #900 verified the lights were supposed to emit an audible signal at the nurses ' station to alert the staff, but Resident #01's light did not produce a sound. PTA #900 verified she had asked facility staff if staff were going to provide the resident with a bell or similar device since the call light was not working, but she did not think the resident had been provided with one. Interview on 07/22/20 at 4:40 P.M. with the Administrator, verified the facility had completed hand-written every 15-minute checks for Resident #01 on 07/10/20 and was not sure why staff had said they did not complete them. Review of the written statement by RN #800, provided by the facility dated 07/22/20, no time noted, revealed the nurse was aware Resident #01's call light was not sounding at the nurses' station to alert the staff. The written statement indicated that is why the resident was placed on 15-minute checks. Further review of the statement revealed the nurse went to check on Resident #01 on 07/10/20 at 4:46 P.M. after the resident's family member had called on the phone to say she thought the resident was choking. Interview on 07/27/20 at 10:13 A.M. with FM #150 verified on 07/10/20 at approximately 4:46 P.M., she called Resident #01 on her cell phone, and the resident was gasping for air and when asked if she was okay, Resident #01 replied, No, choking, they won't come. FM #150 verified the phone call to the resident's cell phone lasted approximately five seconds. FM #150 stated she then called the facility and told a female who answered the phone to get to Resident #01's room immediately because she was not okay. FM #150 verified the female told her they would check on her immediately and this phone call lasted only approximately five seconds. FM #150 stated Resident #01 was currently residing in another nursing facility and had been hospitalized at the larger hospital for a total of 15 days. Review of the undated facility policy titled Meal Service in the Resident Room revealed the facility will take measures to promote meal satisfaction for residents who eat in their rooms which included leaving the room for the resident to eat his/her meal after ensuring adequate assistance had been provided and ensuring the resident's call light was in reach. Review of facility document titled Open Discussion: Call Lights undated revealed call lights were to be placed within resident reach and should be maintained in working order. Further review revealed if a call light was not functioning properly the resident should be placed on every 15-minute checks or provided with a tap bell. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.17.1 dated 10/2019, chapter three, page G-1, defines supervision as requiring oversight, encouragement, or cuing during the activity of eating. Page G-10 revealed staff were to code supervision for residents who receive individual supervision with eating. Page K-1 revealed the ability to swallow safely can be affected by many disease processes and functional decline and alterations in the ability to swallow can result in choking and aspiration. The resident's care planning should include provisions for monitoring the resident during mealtimes and during functions/activities that include the consumption of food and liquids. The resident should be evaluated by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids. Staff should assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions and represents a functional problem for the resident. The care plan should be developed to assist the resident to maintain safe and effective swallowing using compensatory techniques, alteration in diet consistency, and positioning during and following meal. This deficiency substantiates Complaint Number OH 166.
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 upon medical record review, observation, staff interview, review of facility policy, and review of Center for Disease Control (CDC) online resources, Center for Medicare and Medicaid Services (CMS) memo, the facility failed to appropriately wear facemasks to prevent the spread of Coronavirus (COVID 19). This had the potential to affect two (#04 and #05) random residents observed receiving care. In addition, the facility failed to ensure social distancing was implemented in the common area and during meal service. This had the potential to affect the following seven (#05, #07, #08, #09, #10, #11, #12) of seven random residents observed. The census was 54. Findings include: 1. Review of the medical record for Resident #04 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].#04 dated 06/06/20 revealed resident was cognitively impaired and required extensive assistance with activities of daily living (ADLs). Observation of incontinence care for Resident #04 on 07/20/20 at 4:15 P.M., with State tested Nursing Assistant (STNA) #100 revealed STNA #100's facemask was positioned below her nose during care. Resident #04 was not wearing a facemask. Interview on 07/20/20 at 4:20 P.M., with STNA #100 verified her facemask was not covering her nose during the provision of care to Resident #04. Interview on 07/20/20 at 4:02 P.M., with the Administrator verified all staff are required to always wear facemasks while in the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) facility. The Administrator further verified residents were provided with facemasks and were encouraged to wear them but most declined to do so. Review of an educational sheet provided by the facility to the staff dated 04/01/20 titled Donning Personal Protective Equipment revealed facemasks should be fitted to the bridge of the nose, fit snugly to the face and be positioned below the chin. Review of the facility policy titled Optimization of Personal Protective Equipment, undated, revealed all staff should wear facemasks in the patient care area and should leave the area if necessary, to remove the facemask. Review of an online resource from the CDC (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wear-cloth-face-coverings.html) revealed the following guidance regarding proper wearing of face coverings: put it over your nose and mouth and secure it under your chin. 2. Review of the medical record for Resident #05 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the MDS for Resident #05 dated 06/21/20 revealed resident was cognitively impaired and required extensive assistance of one staff with eating. Observation on 07/20/20 at 4:30 P.M., revealed STNA #600 was feeding Resident #05. STNA #600 was wearing a facemask which was pulled below her chin. Interview on 07/20/20 at 4:31 P.M., with STNA #600 verified her facemask was pulled down below her chin while she was feeding Resident #05. Interview on 07/20/20 at 4:02 P.M., with the Administrator verified all staff always wear facemasks while in the facility. Administrator further verified residents were provided with facemasks and were encouraged to wear them but most declined to do so. Review of the facility policy titled Optimization of Personal Protective Equipment undated revealed all staff should wear facemasks in the patient care area and should leave the area if necessary, to remove the facemask. Review of an educational sheet provided by the facility to the staff dated 04/01/20 titled Donning Personal Protective Equipment revealed facemasks should be fitted to the bridge of the nose, fit snugly to the face and be positioned below the chin. Review of an online resource from the CDC (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wear-cloth-face-coverings.html) revealed the following guidance regarding proper wearing of face coverings: put it over your nose and mouth and secure it under your chin. 3. Observation on 07/20/20 at 4:00 P.M., revealed Residents #07, #08, #09, #10, and #11 were seated in chairs across from the nurses' station in the common area. The chairs were positioned right next to one another. Staff made no attempts to redirect residents to a socially distanced seating arrangement. Interview on 07/20/20 at 4:02 P.M., with Registered Nurse (RN) #300 verified the residents were seated directly next to one another and social distancing was not maintained. Review of the facility policy titled Infection Control COVID 19 dated 03/18/20, revealed staff would encourage social distancing between residents and close contact was defined as being within six feet of another person and could occur while sharing a health care waiting area. Review of the CMS memo titled QSO-20-28-NH revealed the following: nursing homes should adhere to social distancing, such as seating residents at separate tables at least six feet apart and social distancing should always be practiced. 4. Observation on 07/20/20 at 4:29 P.M., revealed Residents #10, #11, and #12 were eating dinner from trays at a small square table approximately 4 feet in diameter. Interview on 07/20/20 at 4:30 P.M., with STNA #500 verified she had served Residents #10, #11, and #12 their meal trays at a small square table and social distancing was not maintained. Review of the facility policy titled Infection Control COVID 19 dated 03/18/20 revealed staff would encourage social distancing between residents and communal dining would be discontinued and residents requiring monitoring during meals would be brought to their doorways for meals or would be fed in their rooms. Review of the CMS memo titled QSO-20-28-NH revealed the following: Residents are not forced to eat in their rooms. Residents may still eat in dining rooms, however, nursing homes should adhere to social distancing, such as being seated at separate tables at least six feet apart. We note that social distancing should be practiced at all times (not just while dining).