STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A070	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYONLANDS CARE CENTER	390 WEST WILLIAMS WAY MOAB, UT 84532

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 4 of 18 sampled residents, that the facility assessment did not accurately reflect the resident's status. Specifically, a resident with a wanderguard elopement alarm was not coded accurately on the Minimum Data Set (MDS) assessment as having the alarm. Two residents with bed rails were not coded accurately on the MDS assessments as having the bed rails in place . In addition, a resident had not received [MEDICATION NAME] feedings was coded as receiving feedings on the MDS assessments. Resident identifiers: 10, 15, 23, and 28. Findings include: 1. Resident 10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/2/20 at 2:41 PM, observations were made of resident 10's bed. Resident 10's bed was observed to have bilateral bed rails extending from the head of the bed to the approximate middle of the bed. The bed rails were observed in the up position. Resident 10's medical record was reviewed on 3/3/20. A Significant Change in status MDS assessment dated [DATE], was reviewed and documented the following information: . Section P - Restraints and Alarms . A. Bed rail . 0. Not used . On 3/4/20 at 9:27 AM, observations were made of resident 10's bed. Resident 10's bed was observed to have bilateral bed rails extending from the head of the bed to the approximate middle of the bed. The bed rails were observed in the up position. On 3/4/20 at 10:49 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that all resident beds have bed rails or arm rest. RN 1 stated that the bed rails were not a restraint. RN 1 stated that the bed rails were to help residents with positioning. RN 1 stated that no attempts had been made to try other things. RN 1 stated that the bed rails were able to be lowered on the beds. On 3/4/20 at 11:06 AM, an interview was conducted with the Acting Administrator (AA). The AA stated that resident 10 would use the bed rails to assist the staff with changing her brief at night. The AA stated that resident 10 had [DIAGNOSES REDACTED] from a stroke on the right side. The AA stated that she did not have bed rail assessments for any of the residents using bed rails because the bed rails were not on her radar. The AA further stated that she was aware that the MDS assessments were not coded accurately for residents using bed rails. On 3/4/20 at 11:14 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that resident 10 would use the bed rails to reposition at night. 2. Resident 15 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 15's medical record was reviewed on 3/3/20. A care plan dated 9/30/19, and revised 11/27/19, documented that resident 15 was at risk for elopement and wandering. The care plan further documented that resident 15 required a wanderguard device to monitor her safety. A physician's orders [REDACTED]. Resident 15's MDS assessments were reviewed and documented the following information: a. A Significant Change MDS assessment dated [DATE], was reviewed and documented the following information: . Section P - Restraints and Alarms . E. Wander/elopement alarm . 0. Not used . b. A Quarterly MDS assessment dated [DATE], was reviewed and documented the following information: . Section P - Restraints and Alarms . E. Wander/elopement alarm . 0. Not used . On 3/4/20 at 8:33 AM, observations were made of resident 15. Resident 15 was observed sitting in her room with a wanderguard device around her right wrist. On 3/4/20 at 11:51 AM, an interview was conducted with the Acting Director of Nursing (ADON). The ADON stated she also served as the MDS Coordinator, and resident 15's MDS assessments should have documented that she utilized a wander guard. 3. Resident 23 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/3/20 at 11:22 AM, observations were made of resident 23's bed. Resident 23's bed was observed to have bilateral side rails extending from the head of the bed to the approximate middle of the bed. The bed rails were observed in the up position. Resident 23's medical record was reviewed on 3/3/20. Resident 23's Annual MDS assessment dated [DATE], was reviewed and documented the following information: . Section P - Restraints and Alarms . A. Bed rail . 0. Not used . On 3/4/20 at 8:37 AM, an interview was conducted with the ADON. The ADON stated she did not interpret the MDS question to apply to resident 23's side rails. 4. Resident 28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 28's medical record was reviewed on 3/3/20. Resident 28's Discharge Return Anticipated MDS assessment dated [DATE], was reviewed and documented the following information: . Section K - Swallowing / Nutritional Status . A. [MEDICATION NAME]/IV (intravenous) feeding . 1. Checked (Yes) . On 3/4/20 at 7:40 AM, an interview was conducted with the Lead CNA. The Lead CNA stated resident 28 did not and never had [MEDICATION NAME] nutrition. On 3/4/20 at 11:51 AM, an interview was conducted with the ADON. The ADON stated resident 28 never had a tube feeding or [MEDICATION NAME] nutrition, and it was an error on her MDS assessment.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 2 of 18 sampled residents, that the facility did not develop and implement a comprehensive person-centered care plan, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, a resident who had three recent urinary tract infections (UTIs), did not have current interventions listed on the care plan. Additionally, a resident whose annual Minimum Data Set (MDS) assessment triggered care areas for falls and nutrition, had no documented care plans for falls and nutrition. Resident identifiers: 12 and 28. Findings include: 1. Resident 12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/3/20 at approximately 8:30 AM, an interview was conducted with resident 12. Resident 12 stated that he frequently got UTIs. Resident 12 further stated that he had used a straight catheter for years and that he currently required a straight catheter three to four times a day. Resident 12's medical record was reviewed on 3/3/20. Resident 12 had three recent UTIs on 9/26/19, 12/5/19, and 2/10/20. Resident 12's care plan included a Focus initiated on 12/12/18 and revised on 1/3/19, I need Intermittent Catheter and is able to self cath (catheter), needs reminders of technique and hand. A Goal initiated on 12/13/18 and revised on 1/9/20, documented will show no s/sx (signs or symptoms) of Urinary infection through review date. The Interventions initiated were as follows: a. Antibiotics per MD (medical doctor) order if needed. b. Assess/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp. (temperature), Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. c. Offer frequent fluids. (Resident 12) likes tea, and sprite, root beer, lemon aide the best. On 3/4/20 at approximately 8:32 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that she checks on resident 12 every 2 hours to anticipate his needs. CNA 1 further stated that if resident 12 needs to urinate she would notify the nurse, who would assist resident 12 with a straight catheter. On 3/4/20 at approximately 8:36 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she would help resident 12 prevent UTIs by encouraging fluids, increasing the frequency she would straight

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) catheter resident 12, and she would use a new all-in-one sterile catheter kit that the facility had recently purchased. LPN 1 stated that in the past she had to gather all the catheter supplies separately when resident 12 needed a straight catheter. On 3/4/20 at approximately 8:41 AM, an interview was conducted with the Infection Control Registered Nurse (IC RN). The IC RN stated that following resident 12's recent UTIs, she developed and initiated some new interventions for staff to help prevent resident 12 from getting more UTIs. The IC RN stated that Resident 12 used to straight catheter himself and was not good at following sterile technique. The IC RN stated that she had convinced resident 12 to allow the nurses, who are trained to use sterile technique, to straight catheter every 6 hours. The IC RN stated that a new all-in-one catheter kit was purchased for resident 12, which helps nurses maintain sterility when they straight catheter resident 12. The IC RN stated that resident 12's family has insisted that the facility obtain a urinalysis test each time resident 12 has been confused. The IC RN stated she thinks resident 12's confusion was more related to his progressing dementia rather than resident 12 having an active UTI. The IC RN stated she had been educating resident 12, his family, and facility staff about antibiotic stewardship and not getting a urinalysis unless resident 12 was symptomatic. The IC RN stated she thought that resident 12 may have been colonized with bacteria rather than having an active UTI. On 3/4/20 at approximately 9:08 AM, an interview was conducted with LPN 1. LPN 1 stated that the Acting Director of Nursing (ADON) developed and updated resident care plans and would put them in a Care Plan binder at the nurse's desk. LPN 1 further stated that the care plan was there to communicate each residents' needs to facility staff. Resident 12's care plan was reviewed and it did not include the new interventions recently developed and initiated by the IC RN for staff to prevent UTIs. On 3/4/20 at approximately 12:46 PM, an interview was conducted with the IC RN. The IC RN stated she did not think the new interventions to prevent UTIs needed to be added to resident 12's care plan. On 3/4/20 at approximately 3:17 PM, an interview was conducted with the Acting Administrator (AA) and the ADON. The AA stated she would expect resident 12's care plan be updated with current interventions that the staff were using to prevent resident 12's UTIs. 2. Resident 28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 28's medical record was reviewed on 3/3/20. Resident 28's Annual MDS assessment dated [DATE], was reviewed and documented the following information: . Section V - Care Area Assessment (CAA) Summary . 11. Falls . 12. Nutritional Status . (Note: The Falls and Nutritional Status care areas were highlighted, which indicated that they were triggered care areas for care planning.) Resident 28's care plans were reviewed. There was not a documented care plan related to resident 28's risk of falling. Furthermore, there was not a documented care plan related to resident 28's nutritional status. On 3/4/20 at 11:51 AM, an interview was conducted with the ADON. The ADON stated she developed residents' care plans based on the triggered care areas within section V of residents' MDS assessments. The ADON further stated resident 28's MDS assessment triggered care plan development related to falls and nutrition, and she was not aware that there were not active care plans within resident 28's medical record related to these care areas. The ADON further stated resident 28 had experienced recent falls and was assessed as high-risk for falling. On 3/4/20 at 12:44 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated resident 28 had multiple swallowing issues and was recently admitted to the hospital with [REDACTED]. The RD further stated she was not aware that there was not an active nutrition-related care plan within resident 28's medical record. On 3/4/20 at 12:49 PM, a follow up interview was conducted with the ADON. The ADON stated resident 28's nutrition component of the care plans was taken out last May, and she should have created a replacement care plan at that time.
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, interview, and record review, it was determined the facility did not ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Specifically, for 1 out of 18 sampled residents, a resident was not provided with feeding assistance during snack meals in accordance with her plan of care. Resident identifier: 28. Findings include: Resident 28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/2/20 at approximately 2:30 PM, observations were made of resident 28. Resident 28 was observed in her room and taking bites of an unwrapped snack in her hand. (Note: There was no staff present throughout this observation.) Resident 28's medical record was reviewed on 3/3/20. Resident 28's Quarterly Minimum Data Set (MDS) assessment dated [DATE], was reviewed and documented that resident 28 required, at minimum, limited assistance with eating and, at maximum, one-person physical assistance with eating. (Note: The MDS assessment defined limited assistance as the resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance.) An emergency room Report dated 1/9/20, was reviewed and documented that resident 28 was transferred to the hospital with complaints of cough and shortness of breath for several days, and gradually decreasing oxygen saturations. The report further documented that resident 28 was admitted to the hospital with [REDACTED]. On 1/16/20, (Resident 28) was started on [MEDICATION NAME] on 1/12/20 for aspiration pneumonia . Patient continues to aspirate in spite of working with OT (occupational therapy) and consuming thickened liquids . Assessment and plan . Aspiration pneumonia . Her chest x-ray shows worsening opacities bilaterally. Patient actively aspirates everything that she eats . b. On 1/19/20, . admitted with aspiration pneumonia . ASSESSMENT AND PLAN . 1. Aspiration pneumonia. Continue on [MEDICATION NAME]([MEDICATION NAME]) . Anticipate that she can go back to the Care Center if we can get her off oxygen or with oxygen over the next 24 to 48 hours . Resident 28's Discharge Note from the hospital dated 1/20/20, was reviewed and documented that resident 28 was treated for [REDACTED]. On 3/4/20 at 7:40 AM, an interview was conducted with the Lead Certified Nursing Assistant (CNA). The Lead CNA stated resident 28 got pneumonia a couple months ago and was admitted to the hospital for a while, and was not able to swallow well upon her return to the facility. The Lead CNA further stated staff ensure that resident 28 was upright and supervised by a Restorative Aide (RA) during meals. On 3/4/20 at 9:06 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 28 was sat up all the way prior to eating and there was always someone with her in order to help her. RN 1 further stated resident 28 was supervised by either a caregiver or staff member any time she had food including meals and snacks. On 3/4/20 at 9:21 AM, an interview was conducted with the RA. The RA stated swallowing exercises were conducted with resident 28 before meals, which included mouth, tongue, and jaw exercises. The RA further stated between herself, the other RA, and resident 28's sitter, there was someone who monitored resident 28 for signs and symptoms of aspiration during meals. The RA further stated she believed resident 28's sitter was with her while eating snacks. Resident 28's Bedside Kardex Report dated 3/4/20, was reviewed and documented the following information: . Eating/Nutrition . (Resident 28) is on Aspiration precautions, and someone must be with her when she eats . Watch her for choking, drooling, difficulty breathing and being unable to speak. If she is choking, unable to speak, of cough, do the [MEDICATION NAME] maneuver, and call a nurse . On 3/4/20 at 11:51 AM, an interview was conducted with the Acting Director of Nursing (ADON). The ADON stated the hospital documentation did not say for sure whether or not resident 28 experienced aspiration pneumonia. The ADON further stated the RA conducted swallowing exercises with resident 28 during meals, which was written into her plan of care related to activities of daily living. On 3/4/20 at 12:44 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated resident 28 had multiple swallowing issues and was recently admitted to the hospital with [REDACTED]. The RD further stated resident 28 was diagnosed with [REDACTED]. The RD further stated upon resident 28's return to the facility, a CNA or nurse conducted swallowing exercises with resident 28 before she ate and she required monitoring while she is eating. (Note: An Illness Report Form dated [DATE], documented that resident 28 was transferred to the hospital on [DATE] and diagnosed with [REDACTED]. The RA stated swallowing exercises were conducted with resident 28 during mealtimes, but not when snacks were provided. On 3/5/20 at 8:30 AM, an interview was conducted with the Acting Administrator (AA). The AA stated resident 28's family brought snacks for her and she probably had food in her room.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **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 observation, interview, and record review, it was determined the facility did not ensure that the resident environment remained as free of accident hazards as was possible; and each resident received adequate supervision and

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) assistance devices to prevent accidents. Specifically, for 1 of 18 sampled residents, a resident was observed making a pot of coffee which subsequently overflowed onto the counter and floor without staff supervision. Resident identifier: 11. Findings include: Resident 11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/3/20 at 11:41 AM, observations were made of resident 11. Resident 11 was observed to remove a stack of coffee filters and a bag of coffee grounds from the cabinet below the coffee maker located at the nurses' station. Resident 11 was subsequently observed to place a coffee filter into the coffee machine, take a pair of scissors from the nurses' station, cut open the bag of coffee grounds, pour the coffee grounds into the coffee machine, and turn on the coffee machine. Approximately two cups of coffee were observed already in the coffee pot that resident 11 used to brew fresh coffee. The coffee pot was then observed to overflow onto the counter and floor, and resident 11 grabbed the overflowing coffee pot out from underneath the coffee machine and pour himself a cup of coffee. (Note: Staff members were not present throughout the duration of the observation.) Resident 11's medical record was reviewed on 3/3/20. Resident 11's Quarterly Minimum Data Set assessment dated [DATE], was reviewed and documented the following information related to resident 11's cognition: . Section C - Cognitive Patterns . C0500. Summary Score . 09 . (Note: A score of 9 indicated that resident 11 had moderately impaired cognition.) The facility's Safety of Hot Liquids policy was reviewed and documented the following information: Policy Statement . Appropriate precautions will be implemented to maximize choice of beverages while minimizing the potential for injury . Policy Interpretation and Implementation . 1. The potential [MEDICAL CONDITION] hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions . 2. Residents with these or other conditions may suffer from [MEDICAL CONDITION] related complications stemming from thinner, more fragile skin that may burn quickly and severely and take longer to heal . 4 . appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include . e. Staff supervision or assistance with hot beverages . On 3/4/20 at 7:21 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated residents were not able to make coffee by themselves, and staff tried to beat them to it in order to provide assistance. CNA 1 further stated there was a sign that told residents to wait for assistance but no other barrier was between residents and the coffee machine, and the supplies to make coffee were stored in an unlocked cabinet underneath the coffee machine. CNA 1 further stated the sign was not effective for resident 11, and she was not so sure that resident 11 was safe to make coffee or handle scissors. Immediately following the interview with CNA 1, the sign referenced by CNA 1 was observed. The sign was approximately 8 inches by 11 inches, and was located to the right-hand side of the coffee machine. The sign indicated the following information: These coffee pots should ONLY be handled by Nursing Staff. If you would like some coffee please talk to the nurse or Nursing Assistant. This is for your own SAFETY. Thank you On 3/4/20 at 7:33 AM, an observation was made of another resident pouring himself a cup of coffee from the coffee pot. The resident stated, Don't tell anyone because I know I'm not supposed to do this, then the resident was observed to pour himself a cup of coffee, and then place the coffee pot back onto the coffee machine. On 3/4/20 at 7:47 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated there were residents who were independent and reminded frequently that they need assistance to make coffee. LPN 1 further stated resident 11 was recently admitted and had a difficult time accepting his placement at the facility, and therefore became upset when staff provided assistance. LPN 1 further stated the sign located to the right-hand side of the coffee machine was not as effective as it could be, and she tried her best to get to the coffee machine before residents did. In addition, LPN 1 stated resident 11 was currently prescribed an anticoagulant medication and should not have had access to scissors. On 3/4/20 at 7:51 AM, additional observations were made of resident 11. Resident 11 was observed to walk over to the coffee machine and pour himself a cup of coffee without staff intervention. On 3/5/20 at 8:30 AM, an interview was conducted with the Acting Administrator (AA). The AA stated the sign to the right-hand side of the coffee machine was intended to deter residents from handling the coffee themselves, but had become less effective for resident 11 over time.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 2 of 18 sampled residents, that the facility did not attempt to use appropriate alternatives prior to installing a side or bed rail. Specifically, 2 residents with bed rails were not assessed for the use of the bed rails and consents were not obtained prior to the use of the bed rails. Resident identifiers: 10 and 23. Findings include: 1. Resident 10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/2/20 at 2:41 PM, observations were made of resident 10's bed. Resident 10's bed was observed to have bilateral bed rails extending from the head of the bed to the approximate middle of the bed. The bed rails were observed in the up position. Resident 10's medical record was reviewed on 3/3/20. A Significant Change in status Minimum Data Set (MDS) assessment dated [DATE], was reviewed and documented the following information: . Section P - Restraints and Alarms . A. Bed rail . 0. Not used . There was no documentation located in resident 10's medical record identifying that staff tried appropriate alternatives prior to the use of the bed rails. An assessment for entrapment risks and a risk versus benefits form were unable to be located in resident 10's medical record. An informed consent form from resident 10 or resident 10's representative prior to the use of the bed rails was unable to be located in resident 10's medical record. On 3/4/20 at 9:27 AM, an observation was conducted of resident 10's room. Resident 10's bed was observed to have bilateral bed rails extending from the head of the bed to the approximate middle of the bed. The bed rails were observed in the up position. On 3/4/20 at 10:49 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that all the resident beds have bed rails or arm rest. RN 1 stated that the bed rails were not a restraint. RN 1 stated that the bed rails help the resident with positioning. RN 1 stated that no attempts had been made to try other things. RN 1 stated that the bed rails were able to be lowered on the beds. On 3/4/20 at 11:06 AM, an interview was conducted with the Acting Administrator (AA). The AA stated that resident 10 would use the bed rails to assist the staff with changing her brief at night. The AA stated that resident 10 had [DIAGNOSES REDACTED] from a stroke on the right side. The AA stated that she did not have bed rail assessments for any of the residents because the bed rails were not on her radar. The AA further stated that she was aware that the MDS assessments were not coded accurately for residents using bed rails. On 3/4/20 at 11:14 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that resident 10 would use the bed rails to reposition at night. 2. Resident 23 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/3/20 at 7:50 AM, an observation was made of resident 23 at the nurses' station. Resident 23 approached Licensed Practical Nurse (LPN) 1 and stated that she hit her wrist on the bed rail in her bedroom. On 3/3/20 at 8:03 AM, an interview was conducted with LPN 1. LPN 1 stated resident 23 bonked her wrist on the bed rail, and winced when she attempted to touch her wrist. LPN 1 further stated resident 28 refused pain medication and did not want to have her wrist assessed by a doctor. On 3/3/20 at 11:22 AM, observations were made of resident 23's bed. Resident 23's bed was observed to have bilateral side rails extending from the head of the bed to the approximate middle of the bed. Resident 23's medical record was reviewed on 3/3/20. Resident 23's Annual MDS assessment dated [DATE], was reviewed and documented the following information: . Section P - Restraints and Alarms . A. Bed rail . 0. Not used . There was no documentation located in resident 23's medical record identifying that staff tried appropriate alternatives prior to the use of the bed rails. An assessment for entrapment risks and a risk versus benefits form were unable to be located in resident 23's medical record. An informed consent form from resident 23 or resident 23's representative prior to the use of the bed rails was unable to be located in resident 23's medical record. Resident 23's Incident Audit Reports were reviewed and documented the following incidents related to her bed rails: a. On 4/17/19, resident 28 was found to have bruising on the back of her left hand and stated she thought she hit her hand on the side rail of her bed. b. On 2/5/20, resident 28 was found to have bruising to the back of her left hand and stated, only thing (resident 28) can think of is (resident 28) got it stuck under the bedside bar . The facility's Proper Use of Side Rails policy was reviewed and documented the following information: Purpose . The purposes of these guidelines are to

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F 0700 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . General Guidelines . 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails . 4. The use of side rails as an assistive device will be addressed in the resident care plan . 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails . 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks . 11. The resident will be checked periodically for safety relative to side rail use . On 3/4/20 at 7:21 AM, an interview was conducted with CNA 1. CNA 1 stated resident 23's side rails had been in place since she admitted to the facility, and she used them for repositioning in bed. CNA 1 further stated the side rails were how (resident 23) has been getting bruises on the top of her hands. On 3/4/20 at 7:47 AM, a follow up interview was conducted with LPN 1. LPN 1 stated resident 23's repositioning bars had been in place since she admitted to the facility, and the bars extended from the top of bed to approximately resident 23's ribs or waist area when she was in bed. LPN 1 further stated resident 23 used the bars for security because she was afraid of falling out of bed, and there had been incidents related to resident 23 hitting her hands or wrist on the bars. LPN 1 further stated the bars were assessed and monitored by the maintenance department, which was overseen by the Environmental Director (ED). In addition, LPN 1 stated she was unaware whether or not other interventions were attempted prior to the installation of resident 23's side rails or if risks and benefits were discussed related to the use of resident 23's side rails. On 3/4/20 at 8:13 AM, an interview was conducted with the AA. The AA stated the beds were delivered to the facility with side rails installed on them, and the maintenance department conducted bed checks on a monthly basis. The AA further stated to her knowledge, all of the residents had side rails installed on their beds. In addition, the AA stated she was unsure whether or not an informed consent was obtained related to the use of side rails and it might be a component of the admission packet. On 3/4/20 at 8:37 AM, an interview was conducted with the Acting Director of Nursing (ADON). The ADON stated she was unaware that all shapes of side rails were considered bed rails, and an informed consent was not obtained related to the use of side rails. The ADON further stated there were not risk versus benefit discussions related to the use of side rails at the facility. On 3/4/20 at 8:43 AM, a follow up interview was conducted with the AA. The AA stated she was unaware that resident 23's side rails were considered bed rails. The AA further stated resident 23's bed was older and all older beds were being replaced throughout the upcoming year. On 3/4/20 at 10:26 AM, an interview was conducted with the ED. The ED stated the functionality of residents' beds and side rails were audited by the maintenance department, and CNAs notified the maintenance department if there were concerns related to functionality. The Long Term Bed Inspection Sheet was reviewed and documented that side rails were checked on a quarterly basis to ensure that they move, latch, and stow properly. The sheet further documented that side rail pendants were also checked to ensure they were working properly. On 3/5/20 at 8:30 AM, a follow up interview was conducted with the AA. The AA stated she planned to conduct one-on-one observations of each resident related to the use of side rails, and involve the residents and families in risk versus benefit discussions.
F 0728 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.** Based on interview and record review, it was determined the facility did not ensure that any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, was competent to provide nursing and nursing related services; and completed a training and competency program, or a competency evaluation program approved by the State. Specifically, a Nurse Aide was employed at the facility, on a full-time basis, for approximately 7 months without completion of a training and competency evaluation program. Findings include: On 3/4/20 at 11:08 AM, an interview was conducted with the Acting Administrator (AA). The AA stated the facility employed one Nurse Aide (NA) who was formerly a housekeeper at the facility. The AA further stated the employee transitioned from a housekeeper to a NA in July 2019. The AA further stated the NA failed her certification test the first time, and there was leeway on the certification time frame because there was only one local option for a certification class. The NA's employee file was reviewed and documented a start of 7/28/19. On 3/4/20 at 11:32 AM, an interview was conducted with the NA. The NA stated she worked at the facility on a full-time basis, and she had not scheduled her second certification exam yet. On 3/5/20 at 8:30 AM, a follow up interview was conducted with the AA. The AA stated several of the students failed the exam on the first try and the instructor was fired, and the NA was currently studying for her second exam.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 18 sampled residents, that the facility did not ensure that a resident who used [MEDICAL CONDITION] drugs was not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Specifically, a resident's [MEDICATION NAME] medication was increased without documented clinical rationale for administering the medication. Resident identifier: 82. Findings include: Resident 82 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 82's medical record was reviewed on 3/4/20. A physician's orders [REDACTED]. Order was discontinued on 3/4/20. A review of the February 2020 Medication Administration Record [REDACTED]. The administration was documented as effective. A Nursing Note dated 2/27/20 at 12:48 PM, documented (Resident 82) has been sitting quietly today. She has had her daughter at the bedside most of the day. Her daughter reports (Resident 82) has made a few paranoid statements with regards to believing staff do not have good intentions. She took her bath and the CNA (Certified Nursing Assistant) said (Resident 82) really enjoyed the bath. Her daughter wants the [MEDICATION NAME] scheduled for breakfast and dinner time. The physician is out of the office today but I informed her I will instruct the evening and night shift to use it prn and I will send the physician a note for him to address when he is in the office. A Communication with Physician Note dated 2/27/20, documented Situation: (Resident 82's) family would like the [MEDICATION NAME] scheduled for AM and PM because that is how she routinely took it at home. Background: (Resident 82) has an order for [REDACTED]. Assessment (RN) (Registered Nurse)/Appearance (LPN) (Licensed Practical Nurse): She was verbalizing paranoid thoughts last night which affected her sleep. She did not make paranoid statements to staff today but she did to her daughter. Reccomendations: (sic) [MEDICATION NAME] 0.5 mg BID (twice daily) and [MEDICATION NAME] (sic) 0.5 mg BID prn for paranoid thinking. A Behavior Note dated 2/28/20 at 4:27 PM, documented (Resident 82's) daughter is returning to her home in (city removed) this afternoon. (Resident 82) has a furrowed brow and has been verbalizing paranoid thoughts relating to the door to her room needing a lock and concerns about being left. A prn dose of her [MEDICATION NAME] was administered prior to her daughter's departure. (Resident 82) is in her room with her daughter at this time. A Nursing Note dated 3/4/20 at 10:26 PM, documented (Resident 82) has been pleasant and cooperative. Participates in group activities and eats meals in the dining room. A review of the active physician's orders [REDACTED]. On 3/4/20, [MEDICATION NAME] Tablet 1 MG Give 0.5 mg by mouth as needed for paranoid thinking, anxiety twice daily. b. On 3/4/20, [MEDICATION NAME] Tablet 1 MG Give 0.5 mg by mouth two times a day for paranoid thinking, anxiety. (Note: The first dose was administered on 3/4/20 at 5:00 PM.) A Behavior Note dated 3/5/20 at 3:53 AM, documented Resident has been calm and pleasant while being assisted with toileting, saying 'First give me a hug' before standing to ambulate. After using the restroom she requested to sit in the common area to have a snack and watch T.V. A Behavior Note dated 3/5/20 at 5:44 AM, documented As of 0545 (5:45 AM), resident has not wanted to return to bed and stated that she wanted to stay in the recliner in the common room. On 3/4/20 at 1:33 PM, an interview was conducted with the Lead Certified Nursing Assistant (CNA). The Lead CNA stated that resident 82 was deaf in one ear and could not hear well out the other ear either. The Lead CNA stated that resident 2 was very sweet and had no behaviors. The Lead CNA stated that resident 82 did not normally eat in her room but today for lunch resident 82 was eating in her room. The Lead CNA stated that resident 82

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) required coaching with eating. The Lead CNA stated that resident 82's son was visiting today. The Lead CNA further stated that resident 82 required the assistance of staff members for most cares. The Lead CNA stated that resident 82 required standby assistance with walking. The Lead CNA stated that resident 82 liked to get up early in the morning and resident 82 lived by herself prior to coming to the facility. On 3/5/20 at 8:19 AM, an interview was conducted with RN 1. RN 1 stated that the [MEDICATION NAME] order for resident 82 was a new order that came up yesterday. RN 1 stated that it was reported to her that resident 82 was up last night until one AM. RN 1 stated that [MEDICATION NAME] was not a typical medication for sleep. RN 1 stated that she had not seen the facility physician in the facility yesterday. RN 1 stated that resident 82 gets her days and nights mixed up as far as sleeping. RN 1 stated that resident 82 yesterday afternoon asked to put her pajamas on and go to bed at 12:30 PM. On 3/5/20 at 8:57 AM, an interview was conducted with the Acting Administrator (AA). The AA stated that the physician would initiate the [MEDICAL CONDITION] medication. The AA stated that when a resident was admitted the home medications were compared to the admitting medications. The AA stated that resident 82 was getting scheduled [MEDICATION NAME] at home and resident 82 was admitted to facility with a PRN order for the [MEDICATION NAME]. The AA stated that the physician recently changed resident 82's [MEDICATION NAME] to scheduled and PRN. The AA stated that most communication with the physician was written communication because the physicians do not want to be called unless it was an emergency. The AA stated that it was her understanding that resident 82's [MEDICATION NAME] was ordered PRN at home but caregivers were giving the [MEDICATION NAME] scheduled. The AA stated that the [MEDICATION NAME] helped with resident 82's paranoid thinking. The AA stated that the request to schedule the [MEDICATION NAME] was sent to the physician because staff was administering the [MEDICATION NAME] scheduled and the [MEDICATION NAME] was working for resident 82. The AA stated that it would depend on the physician if they came to the facility to do an evaluation on the resident. The AA stated that if the resident chose a physician other than the facility physician the staff would transport the resident to the physician's office. The AA stated that when a resident chose to see there physician it was hard to get the physician to understand the regulations. The AA stated that the pharmacist would complete an initial review of medications for newly admitted residents at the pharmacy level, an independent review. The AA stated if the pharmacist identified a concern he would fax the care center and physician.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined, for 1 of 18 sampled residents, that the facility did not maintain medical records on each resident that were complete and accurately documented. Specifically, a resident's updated Hospice care plan and physician's orders [REDACTED]. Resident identifier: 19. Findings include: Resident 19 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 19's medical record was reviewed on 3/3/20. 1. Resident 19 started receiving Hospice services on 4/10/18, following a change in condition. Resident 19 became lethargic and not responding, which prompted facility nursing staff and resident 19's physician to request a hospice consult. Resident 19's care plan in the electronic medical record (EMR) was reviewed. The care plan included a focus area, goal, and interventions for pressure injuries. On 3/4/20 at approximately 10:36 AM, resident 19's sacral pressure ulcer dressing changed was observed. The dressing changed was observed to be completed by the Acting Director of Nursing (ADON) with the assistance of resident 19's Hospice nurse. The ADON stated that resident 19 has had sacral pressure ulcers off and on since his admission to Hospice services. Resident 19's care plan in the Care Plan binder at the nurse's desk was reviewed. The care plan revealed a handwritten note in red ink documenting, See Hospice Care Plan. The Hospice care plan, which was behind the facility's care plan in the binder, was dated 4/19/18. There were no updates and the Hospice care plan did not include a focus/problem area, goal, or interventions for resident 19's current sacral pressure ulcers. On 3/4/20 at approximately 1:45 PM, the ADON provided a copy of an updated Hospice care plan. The ADON stated the Hospice nurse had just brought the care plan to the facility. The ADON stated she added the updated Hospice care plan to the Care Plan binder at the nurse's desk. The updated Hospice care plan was reviewed and included a problem, goal, and interventions for resident 19's pressure ulcers. The problem was dated 11/27/18, with revisions dated 12/11/18, 4/2019, 10/10/19, and 2/12/20. On 3/4/20 at approximately 3:17 PM, an interview was conducted with the Acting Administrator (AA) and the ADON. The AA and the ADON stated that the facility should have obtained an updated Hospice care plan and current Hospice medication information. 2. Resident 19 had the following [MEDICAL CONDITION] as needed (PRN) physician's orders [REDACTED]. Give 0.25 ml by mouth every 2 hours as needed for terminal agitation, anxiety, air hunger related to DELUSIONAL DISORDERS (F22); ALTERED MENTAL STATUS, UNSPECIFIED (R41.82); HYPOXEMIA (R09.02); ENCOUNTER FOR PALLIATIVE CARE (Z51.5). Give 0.25-1 ml PO (by mouth) every 2-4 hours PRN. The medication was listed on resident 19's (NAME)2020 Order Summary Report and Medication Administration Record [REDACTED]. a. Clarification of [MEDICATION NAME] purpose - 1. for Terminal agitation 2. Expected End Date: 2018 [DATE] Order Date: 7/12/2018. b. Clarification of [MEDICATION NAME] PRN purpose: For Terminal agitation. Order Date: 10/11/19 Expected End Date: 12/9/19. (Note: The purpose for the [MEDICAL CONDITION] PRN medication order was not updated in the facility's EMR.) The following medication order, written by resident 19's Hospice physician documented, [MEDICATION NAME] 2 mg/ml. 1/4 ml - 1 ml Q2 hrs (every 2 hours) PO/SL (by mouth or sublingually) PRN - Terminal agitation. Order Date: 12/9/19 Expected End Date: 5/9/20. The Hospice order was provided on 3/4/20 at approximately 7:25 AM, by the facility's ADON. The ADON stated that resident 19's Hospice nurse had brought a copy of this order into the facility the morning of 3/4/20. (Note: The time, route, and purpose for the [MEDICAL CONDITION] PRN medication order was not updated in the facility's EMR.) On 3/4/20 at approximately 10:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that when a Hospice physician wrote a new medication order, a copy of the new medication order was brought into the facility and given to the nurse. LPN 1 further stated that the nurse should enter the new medication order into the facility's EMR. On 3/4/20 at approximately 10:28 AM, an interview was conducted with the ADON. The ADON stated that when a Hospice physician wrote a new medication order, the Hospice nurse would bring a copy of the new medication order to the facility and give the order to the resident's nurse. The ADON further stated that the nurse should then enter the new medication order into the facility's EMR. On 3/4/20 at approximately 3:17 PM, an interview was conducted with the AA and the ADON. The AA and the ADON stated they would expect the nurses to enter Hospice medication orders into the facility's EMR.

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, 1 of 18 sampled residents was observed to blow on a pack of coffee filters and subsequently place the filters back into the supply cabinet. Resident identifier: 11. Findings include: Resident 11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/3/20 at 11:41 AM, observations were made of resident 11. Resident 11 was observed to remove a stack of coffee filters and a bag of coffee grounds from the cabinet below the coffee maker located at the nurses' station. Resident 11 was subsequently observed to blow on the stack of coffee filters in order to separate one from the stack, place a coffee filter into the coffee machine, and then returned the stack of coffee filters back into the cabinet. (Note: Staff members were not present throughout the duration of the observation.) On 3/4/20 at 7:21 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated residents were not able to make coffee by themselves, and staff tried to beat them to it in order to provide assistance. CNA 1 further stated there was a sign that told residents to wait for assistance but no other barrier between residents and the coffee machine, and the supplies to make coffee were stored in an unlocked cabinet underneath the coffee machine. CNA 1 further stated the sign was not effective for resident 11. Immediately following the interview with CNA 1, the sign referenced by CNA 1 was observed. The sign was approximately 8 inches by 11 inches, and was located to the right-hand side of the coffee machine. The sign indicated the following information: These coffee pots should ONLY be handled by Nursing Staff. If you would like some coffee please talk to the nurse or Nursing Assistant. This is for your own SAFETY. Thank you On 3/4/20 at 7:47 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated there were residents who were independent and reminded frequently that they need assistance to make coffee. LPN 1 further stated resident 11 was recently admitted and had a difficult time accepting his placement at the facility, and therefore became upset when staff provided assistance. LPN 1 further stated the sign located to the right-hand side of the coffee

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) machine was not as effective as it could be, and she tried her best to get to the coffee machine before residents did. On 3/4/20 at 7:51 AM, additional observations were made of resident 11. Resident 11 was observed to walk over to the coffee machine and pour himself a cup of coffee without staff intervention. On 3/4/20 at 10:32 AM, a follow up interview was conducted with LPN 1. LPN 1 stated only staff members were supposed to touch the coffee machine area and wash their hands prior to handling anything. LPN 1 further stated she was unaware that resident 11 touched and blew on the coffee filters, and those actions posed a risk related to infection control. (Note: LPN 1 was subsequently observed to remove the stack of coffee filters from the cabinet.) On 3/5/20 at 8:30 AM, an interview was conducted with the Acting Administrator (AA). The AA acknowledged that resident 11 touching and blowing on the coffee filters posed an infection control concern, and did not have any additional information to provide.