STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025024	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE SEWARD MED & CARE CENTER LTC	2203 OAK STREET (P.O. BOX 430) SEWARD, AK 99664

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, record review, resident interviews, and staff interview, the facility failed to ensure the dignity of Resident #15, and failed to encourage Resident #'s 2, 4, 16, 17, 19, 21, 23, 26, and 29 of 15 total sample residents to exercise their rights. This failure had the potential to lead to feelings of frustration placing the residents at risk of changes in their mood state. Findings: 1. Review of Resident #15's Face Sheet revealed s/he was admitted to the facility on [DATE]. Review of his/her [DIAGNOSES REDACTED]. Review of Resident #15's significant change of condition Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/7/12, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision making abilities and had experienced unplanned weight loss. Review of Resident #15's care plan revealed an approach of, I eat but I need to be fed . I use plastic spoons to eat . dated 2/19/20. Observations of Resident #15 at meals on 3/2/20 at 12:03 pm, 3/3/20 at 10:11 am, 3/3/20 at 4:47 pm, and 3/4/20 at 11:22 am, revealed she was provided with a plastic spoon for each of those meals. An interview with Certified Nursing Aide (CNA) #1 and CNA #3 on 3/4/20 at 4:26 pm revealed they had asked the MDS nurse to update Resident #15's care plan to include the use of a plastic spoon because Resident #15 had started tapping her spoon on the edge of her bowl, which sometimes startled the other residents at the table. The CNAs stated they were not sure why Resident #15 did that and had not considered the new behavior as an indicator that the resident might be hungry and needed help to eat. An interview with the MDS nurse on 3/5/20 at 10:35 am revealed she had updated Resident #15's care plan per request of the CNAs to include the use of plastic silverware because Resident #15 pounds silverware on the table and the noise is bothersome to others. The MDS nurse stated the facility had not attempted any other interventions and was not sure if Resident #15's behaviors changed if staff assisted the resident to eat. When asked how the facility had factored Resident #15's dignity into the care plan decision, the MDS nurse stated, I didn't know we had to do that. I'm aware of the big regulations but don't know too much about the little ones like this. An interview with the Director of Quality on 3/6/20 at 10:00 am revealed the facility did not have a policy on resident dignity. 2. On 3/3/20 at 1:17 pm, all nine of the residents in the Resident Council meeting (Resident #s 2, 4, 16, 17, 19, 21, 23, 26, and 29) reported the facility did not encourage them to exercise their rights. The residents cited the facility's response to their request to shop at a local grocery store as an example. The residents stated the facility had previously had an organized outing where residents would be taken on the facility van to the grocery store weekly, and they could use their own money to purchase soda, ice cream, or other snacks of their own choosing. The residents stated the facility informed them approximately two months ago that the outing to the grocery store had been permanently canceled, and they were told they would no longer be able to purchase those items on their own. The residents reported, we were told they would be the ones to supply the snacks, so they could control how much soda and ice cream we each got. They say we are no longer a 'Greenhouse' facility, so they don't have to let us choose our own snacks and they don't have to give us room to store the things we buy. Nobody talked to us about how we felt about that; they just stopped doing it. Several of the residents reported they had asked family members or friends to take them out to the store when the facility stopped the outing but, they don't even want us doing that. They said they will be the ones to go to the store for us and buy what we need. We like to choose our own stuff. Resident #17 said he/she liked Pepsi from a bottle, but Resident #26 liked Coke from a can. Resident #17 stated, they will only buy one or the other, so they tell us we all have to agree, and they won't let us drink out of the cans anyway. They say we will get cut or something. And I like to smell all of the different lotions and bath powders before I choose one. I don't want them choosing for me. An interview with the facility's Director of Quality (DOQ) on 3/4/20 at 1:48 pm revealed the facility had previously been a Greenhouse model, which was very focused on resident preferences and resident rights. The DOQ stated a couple of months ago, I'm not sure exactly when the decision was made to move away from the Greenhouse model, in part because the residents were making poor choices, in terms of their diet and safety. The DOQ stated that as part of the transition away from the Greenhouse model, the Director of Life Engagement (DOLE), who was also the Director of Rehab and the Director of Nutrition, made the decision not to take residents to the grocery store and to limit the amount of soda, ice cream, and other snacks each could have on hand. The DOQ stated the facility did not have anything in writing regarding the date or process by which they transitioned away from the Greenhouse model. The DOQ stated the facility was in the process of developing a policy regarding soda and snacks for the residents but did not have one at this time. The DOQ stated the DOLE had made arrangements for the facility to try to purchase items for the residents consistent with their preferences, but clearly we have a ways to go. An interview with the DOLE on 3/4/20 at 3:14 pm revealed, the whole shopping thing was just an activity in the beginning. Pretty soon we realized it was just a disaster. We offered it to everyone, no matter how cognitively impaired or handicapped they were. Some of the residents didn't understand they couldn't buy things like Fritos if they were on a puree diet, or cigarette lighters because they simply aren't safe, and when we tried to explain that they became agitated. Some of them had behaviors right there in the store, and one gentleman tried to shoplift when we wouldn't let him buy the desired product. We don't always have enough staff to have someone right with every resident. We've tried to come up with other solutions, maybe having someone do the shopping for the residents, but the ones you met with are just not satisfied with that. They want to go themselves. Then they purchase things that simply aren't good for them, or that we simply can't store. One resident bought a half gallon of ice cream, then had staff bring it right to her in the carton with a spoon. Another bought an eight-pack of the big Pepsi bottles, then wanted to drink about five of them in one day. No behavior management programs were attempted prior to prohibiting the residents from making the purchases of their choice. An interview with the DOQ on 3/6/20 at 10:00 am revealed the facility did not have a specific policy on resident dignity or resident rights. The DOQ provided an undated typed list she stated was provided to each resident. The list included, As a Resident, you have the Right . to be treated with dignity, respect and consideration at all times . to receive services that meet your individual needs and preferences and choose health care, activities and schedules that is consistent with these .
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** Based on resident interview, staff interview, and document review, the facility failed to promote resident self-determination for Resident #'s 2, 4, 16, 17, 19, 21, 23, 26, and 29 of 15 total sample residents. This failure had the potential to lead to feelings of frustration placing the residents at risk of changes in their mood state. Findings: On

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 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 3/3/20 at 1:17 pm, during the Resident Group meeting, all nine residents in attendance (Resident #s 2, 4, 16, 17, 19, 21, 23. 26, and 29) reported the facility did not allow them to go on outings to the grocery store. The group reported the facility used to schedule the van to take them to the store, which they enjoyed, but stopped taking them without notice or explanation. The residents stated that when they complained the facility told them they were no longer allowed to go to the grocery store, but the facility would designate someone to do their shopping for them. One of the residents stated, They treat us like children. They won't let us go, even on our own, and if we go and buy things on our own, they say there is no room to store them. You might put a soda in the refrigerator, and someone comes along and throws it out. Another stated, They won't even let us spend our own money on things. They want to call our guardians and families to ask them before we buy anything for ourselves. Sometimes it's none of their business. Another stated, At first they didn't want me to buy soda in a can, because I might choke on the pull tab. Then they told me I couldn't get it in a bottle because it was too big. Then they told me I couldn't have more than one bottle because I'm diabetic. I know I'm diabetic. I like Pepsi. I've had it for years. That's probably one of the reasons I'm here. But I'm going to keep drinking Pepsi. One resident stated the discontinuation of the activity had caused him to feel anxious and depressed and another stated, This is a free country and we are adults. These people won't even let us go to the store. On 3/4/20 at 11:54 AM, and interview with the facility's Director of Quality (DOQ) revealed she was aware the residents had been requesting the outing be re-instated, but no plans would be made to do so based on the recommendations of the Director of Life Engagement (DOLE) and the Registered Dietician (RD). The DOQ stated some of the residents who regularly went on the outing tried to buy items that were inconsistent with their dietary requirements in terms of diabetic management or texture requirements; one had tried to buy a cigarette lighter which he can't have and when staff put it back he tried to shoplift it; and other residents were buying unhealthy food and beverage items, such as ice cream or soda, in large quantities. The DOQ stated that the facility decided the residents could no longer go on the outing until they had completed a risk versus benefit analysis regarding the activity. The DOQ stated the facility had discontinued the program a couple of months ago but had not yet completed the analysis. Review of facility documentation revealed an undated document from the Director of Life Engagement (DOLE) which read, Taking Elders shopping at the local grocery store was suspended by the Life Engagement team . in September, 2019 . Reasons for stopping the activities and include substantial risks . Elders repeatedly did not recognize the inherent dangers of being in a very busy public place with increased noise levels and increased foot traffic . Several times the elders were observed to run into patrons when not paying attention . Several times certain Elders would yell out profanities . Several times Elders were caught shoplifting items . Certain Elders would refuse to return to the bus for departure because of their anger at not being able to purchase items they wanted . Numerous times Elders demanded to purchase foods that they could not tolerate in terms of chewing and swallowing . it was determined the . staff . would purchase food and non-consumable items for the Elders . with shopping lists that were generated by lodge staff . Immediately after the initiation of this shopping plan, challenges began to present themselves with Elders requesting a full months' worth of soda, ice cream bars, cookies, etc. . During further investigations of the shopping lists, Elders, with the assistance of staff, were requesting items that were more appropriate for families and guardians to purchase that in turn created an accounting nightmare for the persons responsible for the Elders' (Resident Trust Accounts) . An interview with the DOLE on 3/4/20 at 3:14 pm revealed it was her decision to stop the outing for the residents. The DOLE stated at first the decision was made because of some of the resident reactions in the grocery store, and it was her understanding that the outing had to be offered to all residents. The DOLE reported when the outing was canceled and staff started getting shopping lists from the residents, it quickly became apparent that many of the residents who were diabetic were asking for cookies, donuts, and ice cream; and when the facility told them they didn't have space to store a months' worth of these items the residents would sit and consume the entire amount in one sitting. The DOLE reported that once it came to the attention of the facility that residents were purchasing items that were inconsistent with their diets, it became a health care and safety issue and the decision was made that the activity could not resume. The DOLE stated, We don't know how to manage it by letting the residents be in total control of it. If you look at resident rights, we have the extreme responsibility to ensure they are not making decisions that will put them at risk of endangering themselves. The DOLE stated she had not reviewed Resident Rights regulatory requirements recently but had a copy of the regulations from 2016 and would review them again. On 3/5/20 at 2:14 pm, an interview with the RD revealed, They asked me for my opinion from a strictly clinical perspective, and I agreed that limiting soda and ice cream for a diabetic is a good idea. But the resident has the right to choose what they want to do, and I understand that. They never asked me about what I thought of the residents having soda from a resident rights perspective. On 3/5/20 at 4:54 pm, an interview with the Interim Director of Nursing (IDON) revealed, I don't know anything about them limiting what the residents can have. They should be honoring resident rights. On 3/6/20 at 10:00 am, the DOQ stated the facility did not have a specific policy on Resident Rights, but provided an undated list entitled, As a Resident, you have the Right: which the DOQ stated was provided to all residents. Review of the document revealed, . To receive services that meet your individual needs and preferences and choose health care, activities, and schedules that are consistent with these .
F 0565 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on resident and staff interview, review of the facility's Resident Group Meeting minutes, and review of individual resident grievances, the facility failed to respond to individual and group grievances for Resident #'s 2, 4, 16, 17, 19, 21, 23, 26, and 29 of 15 total sample residents. This failure had the potential to lead to feelings of frustration placing the residents at risk of changes in their mood state. Findings: On 3/3/20 at 1:17 pm, during the Resident Group meeting, all nine residents in attendance (Resident #s 2, 4, 16, 17, 19, 21, 23. 26, and 29) reported the facility did not respond to individual and group grievances. Specifically, the group reported the facility had recently stopped providing a popular weekly outing to a nearby grocery store without first consulting residents, and when the residents complained the facility did not respond. The residents in attendance reported they had complained as part of their monthly group meetings, and several residents had complained individually as well. One resident stated the discontinuation of the activity had caused him to feel anxious and depressed and another stated, This is a free country and we are adults. These people won't even let us go to the store. Review of the facility's Resident Council Meeting minutes for December 2019 and January and February 2020 revealed no documentation of resident concerns regarding the termination of the outing. The minutes for the Resident Council Meeting minutes was typed by staff and not available for interview to determine why the resident complaints was not included in the minutes. Review of the facility's grievances revealed a resident complained of feeling angry with the cancellation of the outings, and unhappy with the current process when the facility did not reinstate the outing on 1/13/20; and on 1/21/20 another resident complained that the change in the process wasn't fair. The area of the grievance forms to document the resolution of those grievances was blank. On 3/4/20 at 11:54 AM, and interview with the facility's Director of Quality (DOQ) revealed she was the facility's designated grievance officer. The DOQ stated she was aware the residents had been complaining about the lack of the popular outing in Resident Council meetings and was not sure why those complaints were not included in the Resident Council meeting minutes. The DOQ stated that the facility was well aware the residents wanted to go on the outing, but some of the residents who regularly went on the outing tried to buy items that were inconsistent with their dietary requirements in terms of diabetic management or texture requirements; one had tried to buy a cigarette lighter which he can't have and when staff put it back he tried to shoplift it; and other residents were buying unhealthy food and beverage items, such as ice cream or soda, in large quantities. The DOQ stated that the facility decided the residents could no longer go on the outing until they had completed a risk versus benefit analysis regarding the activity. The DOQ stated the facility had discontinued the program a couple of months ago but had not yet completed the analysis. The DOQ stated though the Resident Council and several individual residents had complained about the discontinuation of the outing, the facility had no plans to reinstate the outing, so she considered the grievances to be still open and unsolved. Review of the facility's Resident Complaints/concerns and grievances policy, dated 12/2018, revealed, . staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative . Complaints received at the Resident Council Meetings shall be recorded in the meeting minutes. Interventions shall be documented in the following month's meeting minutes after being reviewed at that meeting . Complaints expressed by individual elders/residents . will be handled on a one-to-one basis .

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F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to respond to notify a Family Member (FM) of bruising and a fracture for Resident #15 of 15 total sample residents. This failure had the potential for treatment decisions to be made for the resident without family input. Findings: Review of Resident #15's Face Sheet revealed he/she was admitted to the facility on [DATE]. Review of his/her [DIAGNOSES REDACTED]. Further review of the resident's face sheet revealed a family member designated as the Responsible Party to be contacted in the event of a change in Resident #15's condition. Review of Resident #15's significant change of Condition Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/7/12, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision-making abilities. Review of Resident #15's Nurse's Notes (NN) revealed bruising was noted to his/her right ankle on 9/10/19 at 4:05 pm. Continued review revealed the bruising was still present on 9/24/19 at 7:34 pm 14 days later, and an x-ray was ordered. Review of Resident #15's physician's progress notes for 10/8/19 revealed, . 9/09/19: Elder had right foot caught under wheelchair . 9/24/19: x-ray (right) ankle for pain, swelling, ecchymosis after fall (with) foot caught under wheelchair (with) result consistent (with) non-displaced ankle fracture . Further review of Resident #15's medical record did not reveal documentation to indicate Resident #15's FM was notified of the bruising or the ankle fracture. On 3/3/20 at 11:19 am an interview with Resident #15's FM revealed the FM was not aware of Resident #15's bruising or fracture. An interview with the Interim Director of Nursing (IDON) on 3/5/20 at 4:24 pm revealed he/she was not certain Resident #15's FM had been made aware of the bruising or the ankle fracture. The IDON said it would be his/her expectation that the FM would have been notified of both events. An interview with the Director of Quality (DOQ) on 3/6/20 at 10:00 am revealed the facility did not find documentation Resident #15's FM had been made aware of the bruising or the ankle fracture. The DOQ stated the facility had contacted the FM on the morning of 3/6/20 to make that notification, and the FM confirmed he/she had not been made aware of those events. The DOQ looked in the facility's computer system for a policy on family notification but was unable to locate one.
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**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** Based on record review and interview, the facility failed to ensure Residents and Resident Representatives (RR)/Power of Attorney (POA) received written notice of emergent transfer that advised the reason for and place of transfer; also the facility also failed to notify the State Ombudsman's office of transfers for two of two Resident's (#16 and #19) reviewed for hospitalization and all other residents that have been transferred from the facility to a hospital or other facility. This had the potential to allow a transfer of a resident against their wishes. Findings: 1. Review of Resident #16's undated Patient Information sheet showed an admitted to the facility of 8/17/17. Review of Resident #16's [DIAGNOSES REDACTED]. Review of Resident #16's Nurses Notes tab in the electronic medical record (EMR) showed: 01/02/2020 2:36 pm Subjective: I'm short of breath . Assessment: Elder with crackles in right lower lobe, wheezing, cough with some thick, yellow sputum. Elder coughing with thin liquids, on solid foods. Diet changed to nectar thick liquids and ground foods to assist with swallowing, per speech therapy. Completed last does of IV (intravenous) antibiotics this AM. Plan: Spoke with Dr. (name). Transferred elder to ER (emergency room) for evaluation. The next nurses note was: 01/06/2020 5:38 pm Returned from: Acute care hospital. (Hospital name) Return Time: 15:15 (3:15 pm) via ambulance. Further review of the nurse's notes (NN) did not show evidence of written notice to resident or responsible party of transfer in the NN. This was verified by interview of the QAC on 3/6/20 at 12:11 pm. 2. In an interview on 3/3/20 at 12:49 pm responding to a query regarding going to the hospital or ER recently, Resident #19 stated, Yes, about 2 weeks ago, my right side wouldn't move. Resident #19 stated he/she was admitted to the hospital. Review of Resident #19's undated Patient Information sheet showed an admittance date of 4/18/17. Review of the undated [DIAGNOSES REDACTED]. Review of Resident #19's Nurse's Notes in the EMR showed: 02/22/2020 2:05 PM Entered resident's room to give ordered mid-day medications. Resident appeared fatigued more pale than usual. Nursing asked resident what was wrong. I'm tired, I just want to go to bed. I have been waiting here for an hour and I just want to go to bed. Resident then became more lethargic. VS (vital signs) obtained at 0135 (1:35 pm) BP (blood pressure) 111/71, O2 sat (oxygen saturation) 91% - 93% on RA (room air), HR (heart rate) 76, 98.3 temporal temperature, RR18 (respiration rate). Lungs sounds auscultated to be clear bilat (bilaterally), dim bases, no SOB (shortness of breath) noted but ashy color noted to skin. 2L O2 (2 liters oxygen) placed and res (resident) helped into bed via lift, RN (Registered Nurse) and CNA (Certified Nurse Aide). CNA reports res to be more lethargic than usual, decreased strength to R (right) side than usual, resident lethargic and barely following commands, did not participate in quick stroke exam attempted by staff. Elevated HOB (head of bed) and VS rechecked to be stable and cont. (continuous) pulse ox and HR monitoring initiated. 1:37 pm (Name) Clinical support OC (on call) informed who informed MD Dr. (name). 1:40 pm. Orders rec'd (received) to transport pt. (patient) to ER for further evaluation. EMS (emergency medical services) called. Report called to ER to RN (name) per (name) RN, questions answered. 1:45 pm VS rechecked 96% on 2 L O2 on via n/c (nasal cannula), HR 66, BP 130/76, RR12, somnolent, strong peripheral pulses, eyes open to command, informed resident she would be transported to ER. Did deny pain by shaking head. 2:02 pm EMS arrive at Raven lodge for transport, rept. (report) and transfer documents given Transferred to ER/Acute care hospital. Resident #19 returned to the facility on [DATE]. No documentation the written notice of transfer was provided to the Resident and/or RR/POA upon transfer in the nurse's notes. This was verified by interview of the QAC on 3/6/20 at 12:11 pm. 3. On 3/5/20 at 10:30 am, evidence was requested from the Nurse Manager that the Ombudsman was notified of emergent transfers for January and February 2020. In an interview on 3/05/20 at 4:05 pm regarding a policy for notification of Ombudsman, Physician, and Family, the Quality Assurance Coordinator (QAC) stated, We don't have a policy on it. In an interview on 3/6/20 at 12:11 pm regarding written notice of transfer and Ombudsman notification, the QAC stated, We were verbally notifying family and physician, but we didn't know we needed to do it in writing. There is no policy regarding transfer notice, but our practice is to notify by phone.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**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 Residents or Resident Representatives (RR)/Power of Attorney (POA) received a bed hold policy upon emergent transfer for two of two Resident's (#16 and #19) reviewed for hospitalization and all other resident transferred from the facility. The failure to provide written notice of the facility bed hold policy puts the resident at risk for losing rights to make the decision to hold a bed and be aware of the facilities bed hold policy. Findings: 1. Review of Resident #16's undated Patient Information sheet showed an admitted to the facility of 8/17/17. Review of R#16's [DIAGNOSES REDACTED]. Review of Resident #16's Nurses Notes tab in the electronic medical record (EMR) showed: 01/02/2020 02:36 PM Subjective: I'm short of breath . Assessment: Elder with crackles in right lower lobe, wheezing, cough with some thick, yellow sputum. Elder coughing with thin liquids, on solid foods. Diet changed to nectar thick liquids and ground foods to assist with swallowing, per speech therapy. Completed last does of IV (intravenous) antibiotics this AM. Plan: Spoke with Dr. (name). Transferred elder to ER (emergency room) for evaluation. The next nurses note was: 01/06/2020 5:38 PM Returned from: Acute care hospital. (Hospital name) Return Time: 15:15 (3:15 pm) via ambulance Further review of the nurse's notes did not show evidence a bed hold notice was provided to Resident #16 or the RR/POA upon transfer or in a reasonable time. 2. In an interview on 3/3/20 at 12:49 pm responding to a query regarding going to the hospital or ER recently, Resident #19 stated, Yes, about 2 weeks ago, my right side wouldn't move. Resident #19 stated he/she was admitted to the hospital. Review of Resident #19's undated Patient Information sheet showed an admittance date of 4/18/17. Review of the undated [DIAGNOSES REDACTED]. Review of Resident #19's Nurse's Notes in the EMR dated 2/22/2020 2:05 pm showed the nurse entered resident room at 1:30 PM. Entered resident's room to give ordered mid-day medications. Resident appeared fatigued more pale than usual. Nursing asked resident what was wrong. I'm tired, I

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F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 3) just want to go to bed. I have been waiting her for an hour and I just want to go to bed. Resident then became more lethargic. VS (vital signs) obtained at 0135 (1:35 PM) BP (blood pressure) 111/71A O2 sat (oxygen saturation) 91% - 93% on RA (room air), HR (heart rate) 76, 98.3 temporal temperature, RR18 (respiration rate). . 1402 EMS arrive at Raven lodge for transport, rept. (report) and transfer documents given. An order received from: Dr. (name) Resident #19 transferred to ER/Acute care hospital. Resident #19 returned to the facility on [DATE] at 2:15 PM. No documentation that a bed hold notice was provided to the Resident or Responsible Party/POA upon transfer, or in a reasonable time, in the nurse's notes. The facility provided documentation on 3/04/20 at 3:23 pm. The slip returned to the surveyor that requested evidence the bed hold notice was provided upon transfer. A note written on the paper, 0 (no) bed hold, (he/she) was not dc'd (discharged). In an interview on 3/05/20 at 1:45 pm, the RN (Registered Nurse Team Advisor) stated, The resident wasn't discharged - only in observation status at the hospital, so (he/she) didn't need a bed hold. In an interview on 3/5/20 at 12:15 pm, the Quality Assurance Coordinator stated, No bed hold policy - just what is given in the admit packet no notice on transfer. Review of the facility admission packet revealed a sheet, revised 12/2017: Dear Elder, family member(s), and/or guardian: It is a Federal Requirement (483.12(b) (1)) that we notify you in writing of our Bed Hold Policy upon admission and when you leave the facility for hospitalization or a therapeutic leave. This letter serves as that notification. Providence Seward Mountain Haven recognizes there may be times when a person has to leave the facility due to a hospitalization or therapeutic leave. This letter is to let you know that the maximum time we can hold your bed open is ten days. In the even your hospitalization or therapeutic leave exceeds 10 days, we will readmit you to the facility immediately upon the first availability of a bed if: 1. The elder requires services provided by the facility and; 2. Is eligible for Medicaid nursing facility services. Then there are signature lines for the Resident, Representative, and Witness.
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, the facility failed to provide dining assistance to Resident #15 of 15 total sample residents. This failure had the potential to contribute to unplanned weight loss. Findings: Review of Resident #15's Face Sheet revealed he/she was admitted to the facility on [DATE]. Review of his/her [DIAGNOSES REDACTED]. Review of Resident #15's significant change of condition Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/7/12, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision making abilities, did not reject care, required supervision and set-up to eat, and had experienced unplanned weight loss. Review of Resident #15's Care Plan documented a new approach on 2/19/20 of, . I need to be fed. During a dining observation on 3/2/20 at 12:03 pm, Resident #15 was sitting at the dining table in his/her wheelchair. Certified Nursing Assistant (CNA) #1 placed a bowl of pureed food, a glass of water and a glass of juice, and a plastic spoon in front of Resident #15, then sat between Resident #15 and another resident. CNA #1 began to assist the other resident with his/her meal but did not assist Resident #15. At 12:09 PM, Resident #15 picked up his/her plastic spoon and laid it upside down on top of his/her water glass but did not attempt to eat. At 12:10 pm, CNA #1 placed a metal spoon into Resident #15's bowl and instructed him/her to eat but provided no assistance. Resident #15 picked up the spoon without scooping any food into the bowl of the spoon, placed the empty spoon in his/her mouth, removed the spoon, scowled at it, and dropped it on the floor. CNA #1 picked up the spoon, left the table, then returned with a new spoon. Resident #15 picked up the spoon but did not attempt to eat. CNA #1 instructed Resident #1 to eat and gestured towards her own mouth. Resident #1 laid the spoon on the table next to his/her bowl and mimicked CNA #1's pointing gesture, then dropped his/her chin to his/her chest. At 12:13 pm CNA #1 instructed Resident #15 to eat. Resident #15 picked up the spoon and tapped it on the side of the bowl but did not attempt to feed him/herself. Resident #15 laid the spoon on the table again. At 12:17 pm, Resident #15 picked up the spoon, dipped the back of the spoon into his/her food, then placed the spoon in his/her mouth and licked the food off the back of the spoon. At 12:23 pm, Resident #15 again placed her spoon in the bowl of food, though the spoon was upside down. Resident #15 placed the spoon, still upside down, into her mouth then removed it and dropped it on the floor. At 12:36 pm, CNA #1 removed Resident #15's bowl from the table and told Resident #15 he/she did not have to eat lunch if he/she didn't want to. On 3/3/20, from 4:47 to 5:00 pm, Resident #15 was observed at the evening meal. He/she was sitting at the dining room table with a bowl of pureed soup in front of him/her. His/her head was down, and his/her eyes were closed. CNA #1 and CNA #3 were at the table, each assisting another resident but neither helping Resident #15. CNA #1 and CNA #3 were interviewed on 3/4/20 at 4:26 pm. CNA #1 stated she had informed the MDS nurse about a month ago that Resident #15 was no longer feeding him/herself and needed staff to feed them. CNA #1 and CNA #3 stated they both knew Resident #1 needed to be fed but had also been told they could each only feed one resident at a time for infection control issues. The CNAs said since there were two other residents who required assistance at meals as well, so they each fed one of those residents. The CNAs stated on the occasions when the Licensed Nurse (LN) was passing medications or otherwise caring for other residents, no one was available to feed Resident #15. The CNAs stated this was a frequent occurrence. On 3/5/20 at 1:50 PM, an interview with the Registered Dietician (RD) revealed she was aware Resident #15 now required total assistance to consume his/her meals. The RD stated she observed Resident #15 at a meal during her visits to the facility every other week, and it was common for the resident to be sitting at the table with his/her head down without assistance. The RD stated she had notified the Interim Director of Nursing (IDON) several times via email that the resident was not receiving the required assistance. The IDON stated that if the resident required assistance with eating staff should have provided the resident assistance with his/her meal. On 3/5/20 at 4:46 pm, an interview with the IDON revealed she was not aware Resident #15 required assistance to eat and was not aware that assistance had not been provided. The IDON stated she was not sure if the facility had a policy on assisting residents with their Activities of Daily Living (ADLs). On 3/6/20 at 10:00 am, the facility's Director of Quality (DOQ) was interviewed and stated the facility did not have a policy on assisting residents with their ADLs. The DOQ stated if the resident required assistance with his/her meal the resident should have been assisted.
F 0684 **Level of harm** - 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 observation, interview, and record review, the facility failed to recognize that a resident had sustained a fracture and did not seek medical attention for 14 days after the event occurred for one resident (Resident #15) of 15 sampled residents. This delay resulted in harm of ongoing pain and distress until a [DIAGNOSES REDACTED]. Findings: Review of Resident #15's Face Sheet revealed he/she was admitted to the facility on [DATE]. Review of his/his/her [DIAGNOSES REDACTED]. Review of Resident #15's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/25/19, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision-making abilities, did not reject cares, required supervision for mobility on the unit using a walker, could not participate in a pain interview but displayed no non-verbal indicators of pain such as grimacing, moaning, guarding, or rubbing a specific body part. Review of Resident #15's Nursing Notes (NN) revealed: On 9/10/19 at 4:05 pm, . nonverbal. Lying in bed this am after waking up, bruise noted on and around right ankle. CNA told staff on 9/9 (9/9/20) about elder dragging his/his/her ankle while being moved in wheelchair, no bruising noted yesterday per CNA . The note did not document when Resident #15's physician was notified of the bruising or what the physician's response was. The note did not document when Resident #15's family was notified. 9/12/19 at 1:04 pm, . Targeted Moods/Behaviors: Screaming/Disruptive sounds slapping hands on legs/thighs this am . 9/13/19 at 3:30 am, . [MEDICATION NAME] HCl 5 mg tablet given for pain/discomfort restlessness, rubbing his/his/her leg, gnawing on his/her own fingers, agitated, wakeful . 9/14/19 at 12:55 am. . Indicators or possible indicators of pain . repetitive behaviors, sticking fingers in his/her mouth, slapping at self, chewing on covers . 9/14/19 at 10:46 am, . Increased (signs and symptoms) of pain by elder, Elder will recoil with touch of (right) foot . Reported bruising of (right) ankle on 9/10. Bruising still present, no swelling noted. Assessment: Per SOAP (Subjective/Objective/Assessment/Plan) note and nursing observation. Elder's foot has been dragging while in wheelchair. Bruising was observed yesterday and again today. Appears to be decreasing. Plan: Will continue to monitor. Elder is on

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	025024	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE SEWARD MED & CARE CENTER LTC	2203 OAK STREET (P.O. BOX 430) SEWARD, AK 99664

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) scheduled [MEDICATION NAME] for pain and has (as needed) medication available. Due to PT/OT not being available on the weekends, a draw sheet was tied across elder's wheelchair footrests to keep legs from dragging and off the ground. Educated CNAs to monitor . The note did not document when the resident's physician was notified or what the physician's response was. On 9/17/19 at 3:04 pm, . Mood/Behavior: Rejection of Care Kicking/Hitting. Intervention reassured, redirected, reoriented. Outcome: unchanged . On 9/18/19 at 10:16 pm, . [MEDICATION NAME] HCl 5 mg tablet given for pain/discomfort restlessness, slapping (at) his/his/her right leg, digging in mouth with fingers, chewing on bed covers, moaning at intervals . On 9/21/19 at 2:55 am, . Indicators or possible indicators of pain: repetitive behaviors, sticking fingers in his/her mouth, slapping (at) self, chewing on covers . On 9/23/19 at 12:05 am, . Mood/Behavior: Displayed anger with self and/or others, spitting out medication, throwing/smearing food/waste. Interventions: left alone and re-approached, redirected. Outcome: unchanged . On 9/24/19 at 7:34 pm, . (Nurse Practitioner) also looked at right ankle bruising that occurred from 9/9 when elder had his/her right foot caught under wheelchair per report. Bruising noted 9/10 (9/10/19) but has increased . bruising has spread to top of foot and up lower leg area . X-ray ordered after 7 pm . There was no copy in the medical record for x-ray results for Resident #15 or the physician's orders [REDACTED]. Review of Resident #15's Physician's Progress Notes, documented by the prior medical director, for 10/11/19 revealed, . 9/9/19: Elder had right foot caught under wheelchair . 9/24/19 . x-ray (right) ankle for right ankle pain, swelling, ecchymosis after fall (with) foot caught under wheelchair (with) result consistent (with) nondisplaced ankle fracture . 9/25/19: (Non-weight bearing to the right lower extremity). PT eval for splinting. Elevate (right lower extremity) while in bed X 14 days. Cool packs to (right) ankle and (every two hours as needed for) 7 days . 9/26/19: air cast over sock (right ankle) when (out of bed); skin checks to area daily . Review of Resident #15's care plan revealed a Need/Preference area on 1/23/20 of, . I can't complete cares on my own because I have [MEDICAL CONDITION]. I show this by not participating in my ADL's (Activities of Daily Living) and not understanding instructions . An approach of, . I move about the unit with the help of 1 person, I use a wheelchair with calf supports/pads . also dated 1/23/20. On 3/4/20 at 1:00 pm, the facility's Director of Quality (DOQ) provided a copy of Resident #15's care plan, and a printout of some of the changes that had been made to the resident's care plan since September 2019. The DOQ stated, Unfortunately, we are struggling with our system a little and it seems as though not all of the care plan changes are showing up. The care plan changes we have provided you are the only ones we could find, prior to the January 23 care plan. Review of the care plan updates provided revealed no care plan for his/her mobility or pain levels prior to the current care plan, or what care plan may have been in place at the time of the resident's injury. An interview with the Interim Director of Nursing (IDON) on 3/5/20 at 4:54 pm revealed he/she had just started working at the facility around the time Resident #15 fractured his/her ankle and had not been completely aware of the circumstances at the time. The IDON stated after he/she began working at the facility it became apparent that the nurse manger in charge of wound care and was responsible to report changes in status of the residents to facility leadership was either not documenting or falsifying documentation, so was terminated. The IDON stated that nurse would have been the person to whom the bruising was likely reported, and no record was made of what had been done to respond to the bruising. The IDON stated communication between the lodges and management was obviously still an issue. The IDON agreed that 14 days between the onset of bruising and the identification of a fracture was too long. An interview with the DOQ on 3/5/20 at 5:15 pm revealed facility leadership had been unaware of Resident #15's fracture until it was called to their attention by the surveyors. The DOQ stated, We didn't have any policies on how to handle those types of things at the time, and definitely no consistent practice. We made some management changes around that time, including the Administrator and Director of Nursing. Then we had a complaint survey and they found we weren't identifying things like this as something we should investigate, and we got a deficiency. I can tell you what should happen now. If the nurse sees bruising, (he/she) would generate an Unusual Occurrence Report which starts a whole investigation that includes notifying the doctor and making sure we have treatment going. I agree 14 days was too long, and there were too many signs that (he/she) may have had a fracture at the time. I wouldn't want to wait that long, and I wouldn't want my parent to wait that long. The DOQ stated it was not the facility's practice to monitor bruising each day or each shift, only that the nurse should continue to document on it daily until it was resolved. The DOQ stated the facility did not have a system or policy for how frequently to monitor residents for pain, and typically a pain assessment was only completed if a nurse used an as needed pain medication for a resident. An interview with CNA #1, CNA #2, and CNA #6 on 3/5/20 at 5:45 pm revealed CNA #1 had been on duty on 9/9/19 when she noticed Resident #15's right foot had fallen off of the foot pedal and was dragging under the wheelchair at an odd angle as the resident was propelling his/herself towards the dining table. CNA #1 stated she told the nurse about it at the time and the nurse instructed him/her to put the resident's foot back on the foot pedal. CNA #1 stated he/she was not sure if the nurse did anything else when he/she was informed, and that the nurse was a traveling nurse who no longer worked in the facility. CNA #1 stated the following day, when the bruising was noted, she reminded the nurse of the wheelchair pedal incident the day before. CNA #1 stated at that time, the nurse told one of the people down the hill, gesturing towards a nearby building where the nurse managers and other administrative personnel have offices. CNA #6 stated he/she worked with the resident over the next few days, and the resident's foot kept falling off the foot pedal and getting caught either in or under the foot pedals. So finally, the nurse tied a sheet behind the resident's foot pedals to keep his/her feet in place. CNA #6 stated a few days after that, an x-ray was done, we got a padded footrest, and they put a cast on (his/her). The CNAs reported the foot appeared to be causing pain for the resident when it would fall off the foot pedal and drag behind or under the footrests but improved once the padded footrest was in place and the cast was placed. Both CNAs denied that Resident #15 fell at any time, as documented in the physician's progress note. An interview with the DOQ on 3/6/20 at 10:00 am revealed the facility did not have a policy regarding monitoring a change in resident condition, physician notification, or pain management. The DOQ stated, We had a really hard time with our previous medical director, in terms of policies and communication. Our new medical director has not been here long enough to fix anything yet, he is trying to concentrate on assessing each of the residents first. On 3/6/20 at 12:01 PM, an interview with Resident #15's physician, who was also the facility's Medical Director (MD), revealed that the MD had assumed care of Resident #15 in January 2020, and could not speak to the timeframe between Resident #15's injury and [DIAGNOSES REDACTED]. The MD stated if the resident had bruising and showed signs of pain that is unusual for his/her or unrelieved with current treatments then 14 days was too long to wait to have it addressed. The nurse in charge of Resident #15's care at the time of the incident, and his/her previous physician, were unavailable for interview during the survey and are no longer employed by the facility.
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, interview, and record review, the facility failed to provide care and services to prevent pressure ulcer development for one resident, (Resident #13) of 15 total sample residents. Failure to provide care and services for a resident unable to care for themselves resulted in the development of a pressure ulcer. Findings: Review of Resident #13's Face Sheet revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #13's Significant Change of Condition Minimum Data Set (MDS) assessment with an Assessment Reference Date of 1/14/20 revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating moderately impaired cognition; no rejection of care; extensive assistance from two people required for bed mobility; and the resident was at risk of developing pressure ulcers with two stage 1 pressure ulcers present. Review of Resident #13's care plan revealed a Need/Preference area of, . I can't complete cares on my own . because I have pain and/or discomfort, physical challenges, behavioral issues, and impaired cognition. I show this by having a hard time moving, voicing frustration, acting out verbally and being unsocial, beginning 1/27/20. The associated care plan approaches documented, . Special precautions . I am at high risk for pressure ulcers. Reposition me at routine intervals throughout the day and night . beginning 2/12/20, and . reposition me at least every two hours as I allow in bed . beginning 2/26/20. Observation of Resident #13 on 3/2/20 from 1:52 pm until 4:15 pm revealed the resident laying on his bed with the head of his bed elevated to approximately 40 degrees. The resident was positioned on his/her back with hi/hers heels floated on his/her bed. The resident remained in that position without movement and no staff entered the room to offer or assist the resident to reposition the resident before the end of the observation at 4:15 pm. On 3/3/20 at 11:30 AM, an interview with the Assistant Director of Nursing (ADON) revealed the physician had just examined the resident and diagnosed a new stage 2 pressure ulcer to the resident's sacrum. The ADON reported the physician had ordered an air mattress and treatment for [REDACTED].#7 on 3/4/20 at 9:27 am revealed she had worked regularly with Resident #13 since admission. CNA #7 stated it is unusual for Resident #13 to get out of bed even for meals. CNA #7 stated Resident #13 had a new pressure ulcer on his/her buttocks. The CNA described Resident #13 as having some

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE SEWARD MED & CARE CENTER LTC	2203 OAK STREET (P.O. BOX 430) SEWARD, AK 99664

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) challenging behaviors, such as swinging at staff or calling the police at times when staff approach to assist. CNA #7 stated the resident had better hearing in the left ear than the right, so it was best to approach from the left side and get his/her attention to explain cares and get permission to continue before proceeding. CNA #7 said Resident #13 has no core strength and needs staff to lift his/her buttocks off the mattress during repositioning to keep his/her skin from sliding across the mattress. CNA #7 stated, Some of the CNAs are afraid to go in there to take care of him/her because he/she scares them, but I tell them to get in there anyway, so was not surprised to learn of the previous days' observation. On 3/5/20 at 4:54 pm an interview with the Interim Director of Nursing (IDON) revealed her expectation would be that staff would approach Resident #13 to offer repositioning at least every two hours. The IDON stated that failure to offer repositioning could lead to skin breakdown. On 3/6/20 at 10:00 am, the Director of Quality (DOQ) provided a facility policy on skin assessments but stated as far as repositioning that would be considered an Activity of Daily Living (ADL) and the facility did not have a policy for ADL's. On 3/6/20 at 11:30 am, Resident #13's physician confirmed the resident had a newly diagnosed stage 2 pressure ulcer. When informed of the surveyor's observation, the physician stated, I would expect they would at least offer repositioning. That's something we will be working on.
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to maintain adequate nutrition for one resident (Resident #15) of 15 total sample residents. This failure resulted in the harm of severe weight loss for a resident with a stage 3 pressure ulcer. Findings: Review of Resident #15's Face Sheet revealed he/she was admitted to the facility on [DATE]. Review of his/her [DIAGNOSES REDACTED]. Review of Resident #15's Registered Dietician (RD) progress notes dated 9/13/19 revealed, . continues to be fairly stable nutritionally, generally eating 75-110% of 2-3 meals/day and 1-2 snacks . Review of Resident #15's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/24/19, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision making abilities, did not reject cares, required limited assistance after set-up for eating, had an unhealed stage 3 pressure ulcer, and had experienced unplanned weight loss of greater than 5% in 30 days or 10 % in 180 days. Review of Resident #15's RD progress notes dated 10/25/19 revealed, . overall has declined nutritionally . intake is only fair at 25-100% 2-3 meals/day and occasional snack; fluid intake is also fair at 1000-1500 (milliliters)/day generally . Weight has been trending down slowly in previous 6 months from being stable at (approximately) 140 lbs. Current weight loss is (approximately) 14 lbs. or 9.4% in 6 months and 5.6 (pounds) or 4.3% in 1 month. This is concerning nutritionally. Discussed with staff who do state intake has declined. Encouraged them to assist and promote improved (oral) intake as able. Suggest to increase supplements to (twice daily) and change to Boost Plus . There was no physician's order written or documentation that the staff followed the RD's suggestions. Review of Resident #15's RD progress notes dated 11/7/19 revealed, . (His/Her) weight is slowly trending down, now with a loss of (approximately) 15 lbs. in 6 months. Intake is poor and he/she is having days where (he/she) is documented with no intake of meals . fluid intake is better so perhaps increasing Boost Glucose Control to (twice daily and as needed) . would help . No order written or documentation the Boost Glucose Control was increased or provided to the resident. Review of Resident #15's RD progress notes dated 11/21/19 revealed, . reviewed plan of care and emailed (physician) with continued concerns for (Resident #15's) weight . per verbal order, added Magic Cup (ice cream type supplement) in the afternoon and (as needed) for poor (oral) intake . No order was written or documentation the Magic Cup was provided and consumed by the resident. Review of Resident #15's Physician's Progress Note, (by previous physician), dated 12/2/19 revealed unintended weight loss listed as part of the Current Problem List, as well as a stage 3 pressure injury to the right buttock which had been present since March 2019. The MD progress note documented current supplements as [MEDICATION NAME] two scoops with breakfast and Boost Glucose Control 240 milliliters with breakfast. The physician's progress note did not document additional routine or as needed Boost available, or the inclusion of a Magic Cup. The progress note documented Resident #15 had multiple abnormal laboratory values noted from the last laboratory draw on 10/22/19, including hemoglobin at 5.0 (normally 12 - 16). No follow-up could be found in the record to the abnormal laboratory values. Review of Resident #15's significant change of condition MDS with an ARD of 1/7/20, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision making abilities, did not reject cares, required limited assistance after set-up for eating, had an unhealed stage 3 pressure ulcer, and had experienced unplanned weight loss of greater than 5% in 30 days or 10 % in 180 days. On 10/1/19, the resident weighed 130.2 lbs. On 1/7/20, the resident weighed 119 pounds which is a -8.60 % loss. Review of Resident #15's care plan under the Need/Preference (dated 1/14/20) of I experience unintended weight loss because I have dementia, need reminders to keep eating. I show this by 11.5% weight loss (17 lbs.) in previous 6 months and meet criteria for moderate protein/calorie malnutrition . revealed the approaches of, . serve large portions at breakfast because I eat best at breakfast time . encourage me to consume adequate protein, fluid, and meal intake to promote wound healing and stabilize weight loss . continue to monitor need to adjust supplement type and/or amount daily . beginning 1/14/20. The facility could not provide a previous care plan for Resident #15. Review of Resident #15's RD progress notes dated 1/15/20 revealed, . has continued to decline nutritionally . he/she is ordered to receive supplements Boost Plus (twice daily) . and Magic Cup in the afternoon, and both can be used (as needed) . RD has observed Elder at meal times occasionally making no effort to eat. Encouraged staff to assist him/her as needed to promote improved (oral) intake . meets the criteria for moderate protein/calorie malnutrition . Recommend assisting Elder as needed with eating . Review of Resident #15's physician's orders revealed a diet order on 1/24/20 for Level II Mechanically Altered (Moist Ground) food texture; two scoops of [MEDICATION NAME] in coffee or yogurt each morning; Boost Glucose Control (no amount specified) morning, afternoon, and as needed; and a Magic Cup every afternoon and as needed. The supplement orders specified a [DIAGNOSES REDACTED]. Orders given per current physician. On 11/5/19, the resident weighed 125.4 lbs. On 2/5/20, the resident weighed 114.4 pounds which is a -8.77 % loss. Review of Resident #15's RD progress notes dated 2/14/20 revealed, . continues to decline nutritionally despite adjustments to (his/her) supplement regimen . requiring more assistance with feeding, but often refuses help. RD has observed (him/her) at meals making no effort to eat . Review of Resident #15's care plan under the Need/Preference of I can't complete my cares on my own because I have [MEDICAL CONDITION] and I show this by not participating in my ADLs . revealed the approach of, . I eat but I need to be fed . beginning 2/19/20. Review of Resident #15's nutritional supplement Certified Nursing Assistant (CNA) documentation for 1/1/20 through 3/4/20 in his/her CNA tasks revealed the facility did not document which of his/her supplements had been provided, the quantity provided, or how much of the supplement was consumed. Review of Resident #15's Medication Administration Record [REDACTED]. Continued review of the MAR indicated [REDACTED]. Review of Resident #15's meal intake documentation for 1/1/20 through 1/31/20 revealed: Breakfast: Did not eat seven of 31 opportunities (times offered), ate 25% three of 31 opportunities, ate 50% five of 31 opportunities, ate 75% of breakfast three of 31 opportunities, and ate 100% 13 of 31 opportunities. Morning snack: Did not eat 31 of 31 times. Lunch: Did not eat seven of 31 opportunities, ate 25% nine of 31 opportunities, ate 50% four of 31 opportunities, ate 75% five of 31 opportunities, ate 100% six of 31 opportunities. Afternoon snack: Did not eat 24 of 31 opportunities, ate 100% seven of 31 opportunities. Review of Resident #15's meal intake documentation for 2/1/20 through 2/29/20 revealed: Breakfast: Did not eat 11 of 29 opportunities, ate 25% four of 29 opportunities, ate 50% two of 29 opportunities, ate 75% one of 29 opportunities, ate 100% 11 of 29 opportunities. Morning snack: Did not eat 28 of 29 opportunities, ate 100% one of 29 opportunities. Lunch: Did not eat six of 29 opportunities, ate 25% five of 29 opportunities, ate 50% six of 29 opportunities, ate 75% two of 29 opportunities, ate 100% 10 of 29 opportunities. Afternoon snack: Did not eat 20 of 29 opportunities, ate 50% one of 29 opportunities, ate 100% seven of 29 opportunities. Dinner: Did not eat five of 29 opportunities, ate 25% three of 29 opportunities, ate 50% one of 29 opportunities, ate 75% one of 29 opportunities, ate 100% 19 of 29 opportunities. An interview with Licensed Nurse (LN) #1 on 3/2/20 at 9:30 am revealed he/she was a traveling nurse and this was his/her second day working in the facility. The LN stated he/she covered both the Raven Lodge, where Resident #15 resided, and the Lupine Lodge, which was housed in the building next door. The LN stated he/she had received a brief orientation to the residents and expectations of how to divide his/her time between the two lodges and, It seems I will spend the bulk of my time in the other lodge because those residents get more medications. During a dining observation on 3/2/20 at 12:03 pm, Resident #15 was sitting at the dining table in his/her wheelchair. Certified Nursing Assistant (CNA) #1 placed a bowl of pureed food, a glass of water and a glass of juice, and a plastic spoon in front of Resident #15. CNA#1 sat between Resident #15 and another resident. CNA #1 began to assist the other resident with his/her meal but did not assist Resident #15. At 12:09 PM, Resident #15 picked up his/her plastic spoon and laid it upside down on top of his/her water glass but did not attempt to eat. At 12:10 pm, CNA #1 placed a metal spoon into

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) Resident #15's bowl and instructed him/her to eat but provided no assistance. Resident #15 picked up the spoon without scooping any food into the bowl of the spoon, placed the empty spoon in his/her mouth, removed the spoon, scowled at it, and dropped it on the floor. CNA #1 picked up the spoon, left the table, then returned with a new spoon. Resident #15 picked up the spoon but did not attempt to eat. CNA #1 instructed Resident #15 to eat and gestured towards his/her own mouth. Resident #15 laid the spoon on the table next to his/her bowl and mimicked CNA #1's pointing gesture, then dropped his/her chin to his/her chest. At 12:13 pm CNA #1 instructed Resident #15 to eat. Resident #15 picked up the spoon and tapped it on the side of the bowl but did not attempt to feed him/herself. Resident #15 laid the spoon on the table again. At 12:17 pm, Resident #15 picked up the spoon, dipped the back of the spoon into his/her food, then placed the spoon in his/her mouth and licked the food off the back of the spoon. At 12:23 pm, Resident #15 again placed her spoon in the bowl of food, though the spoon was upside down. Resident #15 placed the spoon, still upside down, into her mouth then removed it and dropped it on the floor. At 12:36 pm, CNA #1 removed Resident #15's bowl from the table and told Resident #15 he/she did not have to eat lunch if he/she didn't want to. There was no LN present in the Raven Lodge during this observation. On 9/3/19, the resident weighed 133.2 lbs. On 3/3/20, the resident weighed 113.8 pounds which is a -14.56 % loss. An observation to observe the weighing of this resident was not made available. Observations made of Resident #15 on 3/3/20 revealed the resident was in his/her bed and asleep at 7:30 AM. An interview with CNA #3 at that time revealed Resident #15 had not yet been up that morning and had not had breakfast. CNA #3 reported that Resident #15 would remain in bed until after the wound nurse arrived to change the dressing on (his/her) coccyx wound, then staff would get the resident up for breakfast. No staff were observed to approach Resident #15's room until the wound nurse arrived. At 9:54 am, the wound nurse and CNA #1 were observed to go into Resident #15's room. At 10:11 am, CNA #1 brought Resident #15 to the dining table in a wheelchair and went into the kitchen area of the lodge to prepare Resident #15's breakfast. CNA #1 demonstrated how (he/she) placed a frozen puree regular size portion of French toast into a steamer. At 10:40 am, CNA #1 removed the pureed food from the steamer, placed it into a bowl, brought it to the table, and assisted Resident #15 to eat. Resident #15 was receptive to assistance and consumed the entirety of the meal. Resident #15 made no attempt to feed (himself/herself) during the observation. An interview with Resident #15's physician, who was also the facility's Medical Director (MD) on 3/3/20 at 11:30 am revealed the MD had assumed care for Resident #15 in late January from the previous medical director. The MD stated the facility had apprised him of Resident #15's pressure ulcer, which he had just examined, but had not made him aware the resident was also losing weight. The MD stated that though he had not had a chance to evaluate Resident #15's weight loss, in general he would expect staff to follow physician's orders for diet and supplements, document the amount of supplements consumed to evaluate their effectiveness as an intervention, and offer cues and assistance at meals per the resident's plan of care. The physician stated a resident's nutritional status was very important in promoting wound healing. Resident #15's previous physician was no longer available for interview at the time of survey. An interview with Resident #15's Family Member (FM) on 3/3/20 at 11:27 am revealed the FM had been informed about a week and a half ago that the resident was losing weight for the past 6 months. The FM reported, They told me (he/she) just wasn't interested in food anymore. The FM stated (he/she) did not live nearby and as such was unable to visit the resident regularly. The FM stated they were not sure what interventions the facility had implemented to address Resident #15's weight loss. On 3/3/20 at 4:47 pm, Resident #15 was observed sitting at the dinner table with a bowl of pureed chicken noodle soup in front of him/her. The resident was sitting with his/her head down, chin on her chest, and eyes closed. He/she was not eating. CNA #1 and CNA #3 were sitting at the table, each of them feeding a different resident. Neither CNA had offered cues or assistance to Resident #15 by the end of the observation at 5:02 pm. te resident failed to consume any of the meal. There was no LN in the lodge during this meal observation. An observation of the lunch meal on 3/4/20 at 11:22 am revealed Resident #15 readily accepting assistance from CNA #6 to consume his/her lunch. The resident ate 100% of the meal when provided assistance. There was no LN in the lodge during this meal observation. On 3/4/20 at 4:26 pm, an interview with CNA #1 and CNA #3 revealed they were the primary caregivers for Resident #15. The CNAs reported they both knew Resident #15 required assistance at meals and had informed the MDS nurse of this approximately one month ago so the resident's care plan could be updated. The CNAs reported they had not assisted Resident #15 during the meal observations when a third staff member was not available because there were two other residents who required assistance to eat and they had been told they could only assist one resident at a time due to infection control concerns. The CNAs reported that they were aware Resident #15 had been losing weight, but they had been instructed they only had to inform a nurse if a resident lost more than three pounds in a week. CNA #1 stated, If a resident loses more than three pounds in a week, I have to send an email to the people who work down there (gesturing towards the building where the nurse managers and other administrative personnel have offices), but (Resident #15) was only losing about two and a half pounds a week. CNA #1 stated that since Resident #15's weight loss never met the criteria for email notification, he/she told whoever was the nurse for Resident #15 whenever these losses were noted. CNA #1 stated, The problem is, we don't see the nurse very much down here (Raven Lodge), and it's usually a traveling nurse anyway. We can tell them, but there might be another nurse the next day. The CNAs reported they were responsible to administer Resident #15's supplements but were unable to access the physician's orders. CNA #1 stated he/she knew Resident #15 was to have a Boost supplement with breakfast and dinner but did not know about the Magic Cup. CNA #1 stated he/she was not aware that Resident #15 could have additional Boost or Magic Cups as needed and did not know how he/she would determine when to administer an as needed supplement. CNA #1 stated they did not always chart on the meal or snack logs that they had given Resident #15 a supplement or whether the resident had consumed it. CNA # 1 stated, I didn't know it was important to do that. I thought they just knew if she was getting them or not. On 3/5/20 at 10:35 am, interview with the MDS nurse revealed he/she recalled CNA #1 and CNA #3 telling him/her Resident #15 was no longer feeding himself/herself and the care plan needed to be adjusted, which is when he/she updated the resident's Activities of Daily Living (ADL) care plan to reflect that need. The MDS nurse stated he/she was not sure what approaches were in Resident #15's nutritional care plan, as it was the RD who developed that portion of the resident's care plan. The MDS nurse stated he/she was not sure where the facility documented that supplements were given or how much was consumed. On 3/5/20 at 1:50 pm, an interview with the RD revealed Resident #15 had been declining nutritionally for about a year. The RD stated Resident #15's intake and ability to feed his/herself has really, really dropped off. The RD stated, The problem as I see it is (he/she) does not get the assistance (he/she) needs with eating. (He/She) can refuse assistance vehemently at times, but often I see (him/her) sitting there with food in front of (him/her) and nothing is going on. (He/Her} head is down, eyes are closed, and no one is paying attention to (him/her). The RD described Resident #15's current nutritional status as, Borderline moderate to severe malnutrition. The RD stated he/she was also frustrated with the lack of documentation regarding whether supplements had been provided or were consumed. The RD stated, As far as I can tell, if it's documented, it's documented in with the fluid intakes. But since they don't break out which fluid the resident consumed, I don't know if (he/she) was drinking water or Boost. The RD responded, Absolutely not when asked if the current information he/she received from the facility regarding Resident #15's supplement intake was adequate to accurately assess the effectiveness of those interventions. The RD stated he/she reviewed the weights for all residents in the facility weekly, including Resident #15, and was aware that the resident had experienced significant weight loss. The RD stated he/she had repeatedly emailed the Interim Director of Nursing (IDON) about Resident #15's weight loss along with concerns that Resident #15 was not getting assistance consistently and supplements were not being documented but had received no response. On 3/5/20 at 4:46 pm, an interview with the IDON revealed, There was a disconnect in communication between the dietician and the whole team. I was not aware until today that (Resident #15) had been losing weight. The IDON stated he/she had been working in the facility for approximately six months and had been concentrating on other aspects of resident care that were more pressing than weight loss, especially since he/she did not know the facility had a resident with the degree of weight loss Resident #15 had experienced. Regarding the administration of a supplement, the IDON stated it would not necessarily be her expectation that the LNs administer supplements when the physicians order them, but if CNAs are administering those supplements to the residents they should be documented. The IDON stated, I was informed by my team today that the documentation of whether they were given is hard to find. The IDON stated, The CNAs can access physician orders. There's no reason they shouldn't know if the residents should be getting a supplement. They also know they can feed more than one resident at a time, and it's not true that they have to wait for a resident to lose three pounds in a week before they email me. The IDON stated he/she was not sure whether the facility had policies on administration of supplements, weight loss, or assisting residents with eating. The IDON stated it would have been his/her expectation that Resident #15 had received his/her supplements and diet texture as ordered by the physician, assistance at meals per his/her plan of care, and other interventions such as larger portions at breakfast as recommended by the RD. On 3/6/20 at 10:00 am an interview

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F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 7) with the Director of Quality (DOQ) revealed the facility did not have policies on ADLs, following physician's orders, or administration of supplements. The DOQ stated it was not always the practice of Resident #15's previous physician to include RD recommendations like supplements as a physician's order, and often that physician did not want things such as consumption documented by an LN. The DOQ stated, That's a bummer, really, given how much weight (heshe) lost. Review of the Facility Nutrition Program policy, dated 3/2019, revealed, . Ensure that the Elders are served the correct prescribed diet & ordered adaptive equipment . Evaluate food and fluid intake for each Elder and document amounts eaten . Assess nutritional needs and risks of all Elders in the facility, help assure appropriate meals & other nutritional interventions are provided . Assist staff in identifying specific factors in individual Elders (medical conditions, medications, etc.) that may be affecting an Elder's appetite, nutritional needs, nutrition utilization, and hydration status .
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on interview and review of employee training records, it was determined the facility failed to provide required in-service training and competency checks for six of seven Certified Nurse Aides (CNAs). This failed practice could impact residents residing in the facility if staff were not trained or competent to provide cares. Findings: An interview with the Director of Quality (DOQ) on 3/6/20 at 10:00 am revealed the facility did not have documentation in employee files that any of the six CNAs reviewed had completed training hours or competency checks within the past calendar year, and had no evidence that performance evaluation had been completed for the CNAs. All six had facility abuse training in the past year. After searching for more documentation, on 3/6/20 at 10:30 the DOQ reported the facility's most recent training for CNAs had been completed in December 2018. The DOQ stated the facility became aware in the fall of 2019 that the former Director of Nursing, was not honest in (his/her) documentation or reporting to Administration as to the state of the residents or staff in the facility, and was subsequently terminated. The DOQ stated he/she had no way of determining which staff should have had performance evaluations based on the review of the records he/she had done thus far, so the presumption was all of the CNAs now required in-servicing and competency checks. The DOQ stated the facility did not have a current policy to address required training and competency checks for CNAs, but this would be brought to the attention of the facility's Quality Assurance committee so it could be addressed.
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, interview, and record review, the facility failed to provide diet textures as ordered by the physician for one Resident #15 of 15 total sample residents. This failure had the potential to contribute to unplanned weight loss. Findings: Review of Resident #15's Face Sheet revealed he/she was admitted to the facility on [DATE]. Review of his/her [DIAGNOSES REDACTED]. Review of Resident #15's significant change of condition Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/7/12, revealed he/she was unable to participate in a cognitive assessment but was evaluated by staff as having severely impaired decision making abilities and had experienced unplanned weight loss. Review of Resident #15's physician's orders [REDACTED]. Dining observations on 3/2/20 at 12:03 pm, 3/3/20 at 10:11 am, 3/3/20 at 4:47 pm, and 3/4/20 at 11:22 am revealed Certified Nursing Assistant (CNA) #1, CNA #2, and CNA #3 provided Resident #15 puree texture foods. There was no Licensed Nurse (LN) present for these observations. The CNA's received training in the abdominal thrust technique December 2018. An interview with CNA #1 and CNA #3 on 3/4/20 at 4:26 pm revealed they both thought Resident #15 required a puree texture diet. The CNAs reported due to the facility's design of four lodges each of which houses five to ten residents, the lodge Resident #15 lived in shared a LN with the adjacent lodge, and the LN was usually in the other lodge at mealtime. The CNAs reported they were unable to access physician orders. The CNA's prepare the meals for the residents in this Lodge. The pureed food is prepackaged and heated to acceptable temperature. An interview with the Registered Dietician on 3/5/20 at 1:50 PM revealed Resident #15 should be receiving a Level II mechanical soft diet, which would have chopped foods and ground meats, but not be a smooth texture. An interview with the Interim Director of Nursing (IDON) on 3/5/20 at 4:24 PM revealed if the physician's orders [REDACTED].#15 should receive that texture unless the LN instructed the CNAs otherwise. Review of the facility's Facility Nutrition Program policy dated 03/2019 revealed, . Ensure that Elders are served the correct prescribed diet .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to ensure effective hand hygiene was performed during a wound care treatment; the facility also failed to ensure the Infection Control Policies were reviewed annually to ensure up to date with current practice. The has the potential to affect all 28 resident. Findings: 1. Observation of sacral wound care on 3/4/20 at 10:00 am revealed the Interim Manager LTC Nursing (NMGR) perform the following ineffective hand hygiene practices: -10:00 am: handwash at the bathroom sink where NMGR turned on the water, wet hands, applied soap, performed a two second hand-scrub, turned off the water, then pulled a paper towel -10:09 am: changed gloves without any hand hygiene -10:13 am: changed gloves without any hand hygiene -10:16 am: changed gloves without any hand hygiene -10:20 am: hand wash at the bathroom sink where NMGR turned on the water, wet hands, applied soap, performed a four second hand-scrub, turned off the water, pulled a paper towel -10:31 am: changed gloves without any hand hygiene -10:34 am: changed gloves without any hand hygiene -10:44 am: hand wash at the bathroom sink where NMGR turned on the water, wet hands, applied soap, performed a two second hand-scrub, turned off the water, pulled a paper towel. In an interview on 3/5/20 at 5:31 PM, the Interim Director of Nursing stated an expectation that We wash our hands. Wet the hands, apply soap, 20 second friction (hand rubbing), rinse off, get a paper towel and then turn off water with the paper towel. Review of NMGR's hand hygiene competency with the Quality Assurance Coordinator (QAC), on 3/6/20 at 11:17, showed last education was completed in December 2018. QAC stated, We didn't get to do a skills fair last December. Review of the Providence St. Joseph Health Hand Hygiene Policy, last revised 9/2019, showed: .Gloves Gloves are a protective barrier for the healthcare worker and patients according to Standard Precautions. . b. Gloves are removed when the need for protection no longer exists and hand hygiene should be practiced immediately after removal of gloves. . Hand Hygiene Techniques: a. First, wet hands with water b. Apply soap to hands. Spread soap over entire area of hands, wrists, under nails, and between fingers. c. Rub hand together vigorously for at least (in bold print) 15 seconds, covering all surfaces of hands and fingers d. Rinse hands with water and dry thoroughly with a disposable towel e. Use towel to turn off faucet. If possible, use the same towel to open the door 2. On 3/6/20 at 1:00 pm a review of the facility policy titled Infection Control Program during the Infection Control survey task, it was noted the policy was Last Revised 12/2010 and Next Review 12/2011 was at the top of the page. In an interview on 3/6/20 at 1:14 pm, after looking at the Last Revised date, the QAC thought perhaps it was just that policy that hadn't been reviewed, and referenced the Transmission Based Precautions (TBP) policy also provided. Review of the Standard Precautions and Transmission Based Precautions policy showed Last Revised: 08/2015 and Next Review: 08/2016. The Quality Assurance Coordinator, looking in the facility laptop for policies reviewed, stated, I don't have any proof the policies are reviewed annually.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.** Based on record review and interview of administrative staff, the facility failed to develop written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics as part of the Antibiotic Stewardship Program. This failure has the potential to affect any of the 29 residents currently residing in the facility. Findings: In an interview for the Infection Control task of the survey process, the Quality Assurance Coordinator (QAC) provided an undated 2020 PSMH (Providence Seward Mountain Haven) Antibiotic Stewardship Plan that stated: Accountability: Development of procedures and if policies are needed will be completed by the DON (Director of Nursing). In an interview on 3/6/20 at 1:05 PM, the Quality Assurance Director stated, We do not have written antibiotic use protocols specifically. The 2020 PSMH Antibiotic Stewardship Plan is a general plan. I don't have a written protocol to review signs and symptoms and identify what infection, I do not have written protocols regarding antibiotic stewardship.