STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195305	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LAFOURCHE NURSING & REHAB	146 E. 28TH STREET CUT OFF, LA 70345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey #LA00050972	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a nurse reported bruising on a resident which was discovered on a weekly skin	F 609	F609 1. Corrective action for resident #3	4/8/19

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

Electronically Signed | 03/13/2019

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F 609	Continued From page 1 assessment. This deficient practice was identified for 1 (Resident #3) of 5 sampled residents, and had the potential to affect any of the 85 residents who resided in the facility as documented on the facility's Alphabetical Resident Census List. Findings: Review of the facility's Online Tracking Incident System (OTIS) reports for the last 3 months revealed no OTIS reports regarding Resident #3. Review of the record revealed Resident #3 had a fall on 01/28/19 and was assessed with no injuries. Further review of the record revealed Resident #3 had a weekly skin assessment on 01/29/19, and bruises were discovered on his buttocks. Review of Resident #3's hospital records of 02/10/19 revealed the following: Buttocks: has a very deep purple bruise that is linear and circular in nature starting along the lateral upper thigh and extending around the buttocks and sacral area to the other side. Bruise is approximately 8cm in width and very dark purple. In an interview on 02/26/19 at 01:55pm, Resident #3 recalled going to the hospital some time in February 2019, and was told he had bruises all over his lower back and legs. Resident #3 stated he had no idea how the bruising occurred. In a joint interview on 02/27/19 at 12:00pm, S1 Director of Nursing (DON) and S4 Corporate Nurse confirmed bruises on residents should be reported to the DON to initiate an investigation in order to determine if a bruise was an injury of	F 609	identified for the alleged deficient practice by: a. Investigation and OTIS (#234214) completed for injury of unknown origin. The OTIS investigation unsubstantiated abuse/neglect. 2. All residents had the potential to be affected by the alleged deficient practice. Corrective action was accomplished for these residents by: a. Skin Integrity Reviews (skin assessments) were conducted on all residents and all identified were issues reported to DON for injury of unknown origin investigation and OTIS completion if required. No other residents identified. 3. The measures that were put in place to ensure that the alleged deficient practice will not recur are: a. In-service by DON began on 03/06/2019 with nursing staff addressing reporting of injuries of unknown origin to DON. b. Skin Integrity Reviews (skin assessments) will be conducted on each resident weekly and any issues will be reported to DON for injury of unknown origin investigation and OTIS completion if required. 4. The facility plans to monitor its performance to make sure that solutions are sustained by:	

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F 609	Continued From page 2 unknown origin. S1 DON confirmed she was not aware of bruises on Resident #3's buttocks which was identified on 01/29/19, and the bruises should had not been reported to her for investigation. S1 DON further confirmed no investigation was conducted regarding the bruising on Resident #3's buttocks.	F 609	a. DON/Designee will conduct audits of skin assessments 2 times weekly for 8 weeks and then weekly to ensure any issues reported to DON for injury of unknown origin investigation and OTIS completion if required. b. Any problems discovered will be addressed with reeducation and/or progressive discipline. c. Results of monitoring will be reviewed at next scheduled QAPI meeting to determine effectiveness and make changes as deemed necessary.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		4/8/19

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F 655	Continued From page 3 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident received wound care treatment daily as ordered. This deficient practice was identified for 1 (Resident #5) of 5 sampled residents, and had the potential to affect any of the 85 residents who resided in the facility as documented on the Alphabetical Resident Census List. Findings: Review of the record revealed Resident #5 was admitted to the facility on 02/21/19 with diagnoses which included, in part, cellulitis/Abscess of buttock.	F 655	F655 1. Corrective action was accomplished for Resident #5 identified for alleged deficient practice by: a. Completing wound care on 02/26/2019 and then daily. b. S3 Wound Treatment Nurse was suspended, investigation and OTIS (#233783) completed. OTIS investigation substantiated neglect and S3 Wound Treatment Nurse terminated.	

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F 655	Continued From page 4 Review of Resident #5's baseline care plan revealed under skin care, in part, provide treatments as ordered. Review of Resident #5's physician's verbal orders revealed the following: 02/22/19 at 11pm: Right buttock I&D (Incision and Drainage) site/wound and cleanse with Normal Saline (NS) lightly, pack with calcium alginate ribbon, cover with clean dry dressing daily. Lateral aspect of right foot: cleanse with NS, pat dry, apply santyl and calcium alginate dressing to wound bed only, cover with clean dry dressing daily. 02/22/29 at 11pm: between right 3rd and 4th, and 4th and 5th toes: paint with betadine and OTA (Open to Air) daily. Right great toe amputation site: monitor for changes/worsening. Paint with betadine, OTA daily. Review of a hand written statement dated 02/26/19, and signed by S3 Wound Treatment Nurse revealed, in part, a notation which read, Resident #5's wound care was not done on 02/25/19. I was pulled to the floor and could not get to all wound care. Review of Resident #5's February 2019 Treatment Administration Record (TAR) revealed voided initials on the 02/25/19 slot for wound care. Observation on 02/27/19 at 11:10am revealed Resident #5 had a wound on his right foot and right buttock. In an interview at this time, Resident #5 stated on Monday, 02/25/19, he went to the wound treatment nurse and asked her when she was going to do his wound treatment.	F 655	2. The alleged deficient practice had the potential to affect all residents. Corrective action was accomplished for these residents by: a. Residents were identified by a review of Treatment Administration Records (TARs). b. Wound care duties were reassigned to other nursing staff, and all care provided on 02/26/2019 and then daily or as ordered by Physician. 3. The system put in place to ensure the alleged deficient practice does not recur is: a. In-service will be completed by DON with nursing staff addressing the importance of providing wound care treatments as ordered. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: a. DON/Designee will conduct random audits of TARs on 25% of identified residents 2 times weekly for 8 weeks then weekly to ensure wound care provided as ordered. b. DON/Designee will conduct random interviews with 25% of cognitive residents with wound care orders 2 times weekly for 8 weeks then weekly to ensure wound care provided as ordered.	

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F 655	Continued From page 5 Resident #5 stated S3 Wound Treatment Nurse told him she was done with wound treatment for the day, and if she had time, she wound tend to his wounds. Resident #5 confirmed he had no wound care on 02/25/19, and reported this to S1 Director of Nursing (DON). In an interview on 02/27/19 at 12:00pm, S1 DON confirmed Resident #5 reported to her he did not receive wound care treatment on 02/25/19. In an interview on 02/27/19 at 03:05pm, S2 Assistant Director of Nursing (ADON) stated she signed the TAR on 02/25/19 in error, and then voided her initials on the 02/25/19 slot. S2 ADON confirmed she did not provide wound care to Resident #5 on 02/25/19.	F 655	c. Any problems discovered will be addressed with reeducation and progressive discipline. d. Results of monitoring will be reviewed at next scheduled QAPI meeting to determine effectiveness and make changes as deemed necessary.	

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F 000	INITIAL COMMENTS Complaint Survey #LA00051560	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a resident was free from neglect as evidenced by: 1.) Failing to provide incontinent care every two (2) hours; and 2.) Failing to ensure a resident who fell, was not left on the floor soiled with vomit, blood, urine, and feces, for an extended period of time. This deficient practice was identified for 1 (Resident #1) of 5 sampled residents, and had the potential to affect any of the 92 residents who resided in the facility as documented on the facility's Alphabetical Resident Census list. Findings: Review of the facility's abuse training material	F 600	F-600 Abuse and Neglect 1-Corrective Actions were accomplished for residents affected by the alleged deficient practice by: a-An Inservice held on 5-13-2019 on is ongoing for Q2hr rounds, also ensuring a resident is not left on the floor for any extended period of time. b-Resident #1 found to be affected by the alleged deficient practice had corrective actions accomplished , by changing R#1 room closer to the nurses station for closer observation, and also placing a fall mat to R#1 floor at bedside.	6/7/19

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Electronically Signed | 05/13/2019

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F 600	Continued From page 1 presented by S2Director of Nursing (DON) revealed, in part, neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident #1's nurses' notes entry dated 04/08/19 at 06:00am revealed, in part, Resident was found on the floor on his abdomen, near the bed. The right side of his face was red and swollen, and he had multiple skin tears to his extremities. Both knees with reddened areas. Resident was noted with vomit which contained undigested pills. Review of a witness's written statement dated 04/08/19 revealed, in part, when I entered the room, Resident #1 was lying face down in his vomit. When asked, Resident #1 said that he fell out of the bed, and had been there all night. When we turned him over, his left arm was full of blood, and he had a brush burn to his left knee that was full of blood. We got him up and cleaned and changed him because he was full of urine and vomit. Review of a witness's written statement dated 04/11/19 revealed, in part, when I walked in the room, Resident #1 was on the floor, lying in vomit, and there was a round pill in his vomit. Resident #1 told us he had been there all night. Emergency Medical Service (EMS) said it looked like he was there for a while because of the dried blood on the floor. After Resident #1 left, as I was cleaning the blood, it was stuck to the floor and dark in color.	F 600	2-All Residents have the potential to be affected by the alleged deficient practice: a-Review of Incident/Accident Reports of residents having a fall in the last 30 days will identify any resident who may have fallen or been left on the floor too long due to Q2hr rounds for incontinent rounds not being made. 3-Measures put in place to ensure the alleged deficient practice will not recur are: a-Q2hr rounds/incontinent care will be documented on the residents ADL flowsheet every shift. b-Q4hr direct care observations will be documented on the MAR by nursing to ensure a resident is not left on the floor an extended period of time. c-The DON/Designee will perform random documentation/audits on 25% of residents Q4hrs rounding 3x week for 6 weeks then weekly x 6 weeks. 4-The Facility will monitor its performance to make sure solutions are sustained by: a-The DON/Designee will review findings of the rounding documentation audits at weekly morning QA meeting with the IDT. If problems persist progressive discipline will be enforced. 5-Date of completion will be 6-7-2019.	

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F 600	Continued From page 2	F 600		

Review of Resident #1's hospital record, triage note dated 04/08/19 revealed, in part, Resident #1 had a fall, which occurred at a nursing home last night. Resident reported, "I fell out of bed last night and screamed all night for someone to help me." Had dried blood to the upper and lower extremities. EMS reported emesis with pill fragments and dried blood was on the floor by the patient's bed. He was shivering and reported he was cold.

Review of Resident #1's April 2019 Certified Nursing Assistant (CNA) Flowsheet regarding incontinent care provided every two (2) hours and prn (as needed) revealed there was no documentation that Resident #1 was provided incontinent care every two (2) hours on any shift from 06:00am on 04/07/19 through 06:00am on 04/08/19.

Review of S3CNA Payroll/Status Change notice dated 04/10/19 revealed documentation that she was terminated for neglect on a resident/failure to follow policy & procedure. Review of S3CNA's Separation Notice revealed, in part, reason for separation was documented as neglect of a resident, and date of separation was 04/10/19.

In an interview on 04/29/19 at 11:20am, S2DON stated Resident #1 had a fall on 04/08/19, in which he was found on the floor at about 06:00am. S2DON stated he had a skin tear, with dried blood, and told the nurse he had been there all night long. S2DON confirmed this was an allegation of neglect.

In an interview on 04/30/19 at 12:28pm, S4CNA stated S3CNA was terminated because she never checked on Resident #1 during her shift which

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F 600	Continued From page 3 was from 04/07/19 at 10:00pm through 04/08/19 at 06:00am. S4CNA further stated that when she arrived for her shift at 06:00am on 04/08/19, she assisted other staff members cleaning up Resident #1. Resident #1 had dried blood on him and the floor, and vomit with undigested medications was pasted to his face. S4CNA stated Resident #1 was soiled with urine and feces, and from experience, felt that Resident #1 "had been there a while." S4CNA stated Resident #1 was so soiled, that there was no way he had been changed at 04:00am. In an interview on 04/30/19 at 01:12pm, S5Human Resources stated she was instructed by her superior to document S3CNA's reason for termination was neglect, because S3CNA had not checked on Resident #1 every two (2) hours during her shift. S5Human Resources refused to name her superior.	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		6/7/19

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F 609	Continued From page 4 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to report to the State Survey Agency and other officials: 1.) An allegation of neglect and an injury of unknown origin on 04/08/2019; and 2.) An injury of unknown origin on 04/15/2019. This deficient practice was identified for 1 (Resident #1) of 5 sampled residents, and had the potential to affect any of the 92 residents who resided in the facility as documented on the Alphabetical Resident Census list. Findings: Review of the facility's policy titled Reporting Abuse to State Agencies and Other Entities/Individuals revealed, in part, all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as me be required by law. Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State	F 609	F-609 Reporting of Alleged Violations 1-Corrective Action for R#1 identified for the alleged deficient practice by: a-A SIMS (#979) investigation was opened on 4-15-19 and an investigation for an injury of unknown origin was closed. The SIMS investigation was unsubstantiated for Abuse/Neglect. b-A SIMS investigation will be completed related to 04/08/19 fall. 2- Other residents will be identified by review of incident reports for the past 30 days to identify any resident who may have fallen or been left on the floor for too long or any other care giver neglect noted and submit a SIMs investigation accordingly. 3- Measures put in place to ensure the alleged deficient practice will not recur: a-An in service on 5-2-19 was held with the DON/Administrator on completion of SIMS reporting per occurrence as	

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F 609	Continued From page 5 licensing/certification agency, the Ombudsman, the resident's responsible party, Adult Protective Services, Law enforcement officials, the resident's physician, and the facility medical director. Review of the facility's abuse training material presented by S2Director of Nursing (DON) revealed, in part, neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Injuries of unknown origin was defined, in part, as the source of the injury was not observed by any person. Further review revealed additional incidents which required reporting included, in part, falls (unwitnessed, resulted in the resident sent to the hospital, or falls that result from accidental contact with objects or other persons.) 1.) Allegation of Neglect and injury of unknown origin on 04/08/2019: Review of Resident #1's nurses' notes entry dated 04/08/19 at 06:00am revealed, in part, Resident was found on the floor on his abdomen, near the bed. The right side of his face was red and swollen, and he had multiple skin tears to his extremities. Both knees with reddened areas. Resident was noted with vomit which contained undigested pills. Review of a witness's written statement dated 04/08/19 revealed, in part, when I entered the room, Resident #1 was lying face down in his vomit. When asked, Resident #1 said that he fell out of the bed, and had been there all night. When we turned him over, his left arm was full of blood, and he had a brush burn to his left knee	F 609	applicable. b-The DON/Administrator will investigate all allegations of neglect/abuse and or injuries of un known origin. c-SIMS reporting and Completion will be entered by the DON/Administrator promptly and will be reported to state licensing agency promptly d-The DON will review all Incident/Accidents reports for any occurrences of neglect/abuse and will report promptly accordingly to state licensing agency. 4- The facility plans to monitor its performance to ensure solutions are sustained by: a-The DON/Designee will audit all SIMs for compliance for initiating and completing investigations as applicable for Abuse/Neglect. Audits will be completed weekly x 4 weeks x 3 months by the DON/Administrator/Corporate RN for timely completion. 5-Date of completion 6-7-2019.	

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that was full of blood. We got him up and cleaned and changed him because he was full of urine and vomit
Review of a witness's written statement dated 04/11/19 revealed, in part, when I walked in the room, Resident #1 was on the floor, lying in vomit, and there was a round pill in his vomit. Resident #1 told us he had been there all night. Emergency Medical Service (EMS) said it looked like he was there for a while because of the dried blood on the floor. After Resident #1 left, as I was cleaning the blood, it was stuck to the floor and dark in color.
Review of Resident #1's hospital record, triage note dated 04/08/19 revealed, in part, Resident #1 had a fall, which occurred at a nursing home last night. Resident reported, "I fell out of bed last night and screamed all night for someone to help me." Had dried blood to the upper and lower extremities. EMS reported emesis with pill fragments and dried blood was on the floor by the patient's bed. He was shivering and reported he was cold.
Review of S3Certified Nursing Aide's (CNA) Payroll/Status Change notice dated 04/10/19 revealed documentation that she was terminated for neglect on a resident/failure to follow policy & procedure. Review of S3CNA's Separation Notice revealed, in part, reason for separation was documented as neglect of a resident, and date of separation was 04/10/19.
Review of the facility's last 3 months of Online Incident Tracking System (OTIS) reports revealed there was no report in regards to Resident #1, and his allegation of neglect which occurred on 04/08/19.
In an interview on 04/29/19 at 11:20am, S2DON stated Resident #1 had a fall on 04/08/19, in which he was found on the floor at about

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06:00am. S2DON stated he had a skin tear, with dried blood, and told the nurse he had been there all night long. S2DON confirmed this was an allegation of neglect, and further confirmed she did not complete an OTIS report in regards to allegation.
In an interview on 04/30/19 at 02:30pm, S1Administrator stated he did not complete an OTIS/SIMS report for allegation of neglect which was made on 04/08/19 regarding Resident #1.

2.) Injury of Unknown Origin on 04/15/2019:
Review of Resident #1's nurses' notes entry dated 04/15/19 at 09:50pm revealed, in part, the nurse was called to Resident #1's room and observed him lying of the floor with skin tears and a laceration to the bridge of his nose. Resident #1 was transferred to a local hospital for evaluation.
Review of Resident #1's hospital records with an admission date of 04/16/19 revealed, in part, the resident rolled out of bed and fell to the floor at the nursing home. This is the second fall that he has had in the last two (2) weeks. He was found to have a skin tear at the bridge of his nose, with multiple skin tears and bruising to the left hand, arm, elbow, and bilateral knees. He had a Computed Tomography (CT) scan and was found to have an acute hemorrhage. He will be admitted for further treatment.
Review of the facility's last 3 months of OTIS/State Information Management System (SIMS) reports revealed Resident #1 had a report generated on 4/16/19, due to an incident which occurred on 04/15/19, which was incomplete.
In an interview on 04/30/19 at 10:45am, S2DON stated Resident #1 had an unwitnessed fall on 04/15/19 which resulted in an Emergency Department (ED) visit to a local hospital, and he

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F 609	Continued From page 8 was then transferred to another hospital for neurological evaluation. S2DON stated she was not trained on the new SIMS reporting system, and therefore did not meet the reporting time requirements. S2DON stated she received an email reminder from State Office, stating that the report was due on 04/23/19. S2DON confirmed the SIMS report regarding Resident #1's injuries on 04/15/19 was still not completed.	F 609		

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F 000	INITIAL COMMENTS Recertification Survey	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 (Resident #76) of 3 residents reviewed for activities of daily living (ADLs), was	F 561	F 561 SELF-DETERMINATION	11/10/19

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

Electronically Signed | 10/10/2019

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F 561	Continued From page 1 provided a shower when requested. This deficient practice had the potential to affect any of the 95 residents residing in the facility as documented on the Resident Census and Conditions of Residents form (CMS Form 672). Findings: Review of Resident #76's record revealed an admit date of 08/08/19 with diagnoses, in part, of Systolic and Diastolic Heart Failure, Chronic Obstructive Pulmonary Disease and Pulmonary Fibrosis. Review of Resident #76's Minimum Data Set (MDS) with an Assessment Reference Date of 08/15/19 revealed a Brief Interview for Mental Status score of 12 (score of 8-12 moderate cognitive impairment). Further review of Resident #76's MDS revealed it was very important to her to choose between a tub, bath, shower or sponge bath, and she required one person assistance with activities of daily living, including bathing. In an interview on 09/23/19 at 11:50am, Resident #76 stated she wanted an evening shower and was told by the Certified Nursing Assistants (CNAs) that she could not have a shower when she wanted one because they did not have enough staff. She stated she was not receiving a shower when she requested one. She stated her shower days were on Tuesdays and Thursdays only and not on the weekends. She stated she had gone four to five days with no shower. Review of the shower log for Resident #76's hall dated August 2019 revealed no documentation that Resident #76 received a shower, or refused a shower on the following dates: 08/16/19, 08/17/19, 08/18/19, 08/24/19, 08/25/19,	F 561	1. Assistance with bath of choice will be offered/provided to Resident #76 to meet hygiene needs. 2. All residents will be observed to identify any bathing needs. Bath of choice will be offered/provided to identified residents to meet hygiene needs. 3. Nurses and CNAs will be re-educated by the CNA Supervisor or her designee on providing bathing of choice to residents to meet hygiene needs and documentation of ADL care. 4. The CNA Supervisor or designee will make observation rounds on one hall per day, five days a week, to monitor performance and documentation of ADL care. The Social Services Director or designee will interview a random mix of 10 residents per week to ensure bathing of choice provided to residents to meet hygiene needs. Results of observations and interviews will be documented on monitoring tool. Monitoring will be completed for 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at time of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed at the next Quarterly QAPI meeting for review of process efficiency.	

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08/26/19, 08/27/19, 08/28/19, 08/29/19, 08/30/19, 08/31/9.

Review of the shower log for Resident #76's hall dated September 2019 revealed documentation to be done on 2p-10p shift under Resident #76's name. Further review of the shower log dated September 2019 revealed documentation of Resident #76 received a shower was on 09/23/19.

Review of Resident #76's CNA flowsheets dated August 2019 and September 2019 revealed no documentation of a shower being given on the following dates: 08/27/19 through 08/31/19 and on 09/01/19, 09/03/19, 09/05/19, 09/06/19, 09/08/19, 09/09/19 through 09/11/19, 09/13/19, 09/18/19, 09/19/19 and 09/22/19. There was no documented evidence of Resident #76 refusing her showers on the above mentioned dates.

In an interview on 09/25/19 at 11:04am, S6CNA Coordinator stated they have two shower aides for the facility and they rotate the two facility halls for baths/showers (one week they provide bath/showers on Monday, Wednesday and Fridays on one hall of the facility, and the other hall would get bath/showers on Tuesday and Thursdays and then they switch days the following week). S6CNA Coordinator confirmed they did not have any shower aides on the weekends, and if a resident had a bath/shower on Thursday, they would not receive another shower until Monday. When asked if she thought that was a problem, she stated yes. She confirmed if a resident requested a shower on the weekend, the floor CNAs would be responsible for doing the bath/shower. S6CNA Coordinator stated she was aware that Resident #76 asked for her showers

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on the 2:00pm to10:00pm shift, but she did not verify if Resident #76 was receiving her showers as requested. S6CNA Coordinator agreed a resident had the right to choose the type of bath and the time of the bath. S6CNA Coordinator reviewed the shower log for Resident #76's hall and Resident #76's CNA flowsheets for the months of August and September 2019 and confirmed there was no documentation that Resident #76 received a shower on the above mentioned dates and no documentation of any refusals on those above mentioned dates. S6CNA Coordinator confirmed it was a problem if a resident did not receive a shower for 4 or 5 days in a row.

In an interview on 09/25/19 at 11:10am, S17CNA stated she was the shower aide for Resident #76's hall. S17CNA stated on 08/13/19 they switched to showering by halls instead of rooms because it was less confusing to the residents. S17CNA stated one week they provide baths/showers to one entire hall on Monday, Wednesdays and Fridays, and the other hall would have bath/showers on Tuesday and Thursdays, and then they alternate on the following week. S17CNA confirmed if a Resident received a shower on Thursday, they would not receive another bath/shower until Monday; and if they received a shower on Friday, they would not receive another bath/shower until Tuesday. S17CNA was asked if she thought that was a problem, and she stated yes. S17CNA stated Resident #76 had requested to her on 08/27/19 to have her showers on the 2:00pm-10:00pm shift. S17CNA stated she had informed the CNAs on the evening shift that Resident #76 requested her showers on their shift. S17CNA stated the floor CNAs would document on the CNA flowsheets if

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F 561	Continued From page 4 they gave Resident #76 a shower. S17CNA stated if Resident #76 had refused her shower, the CNAs should have documented an "R" for refusal. S17CNA reviewed the shower log dated September 2019 and she confirmed she did not shower Resident #76 on the above mentioned dates for September and wrote 2p-10pm for Resident #76 because that was the time she requested her shower. S17CNA confirmed she worked 6:00am-2:00pm. S17CNA reviewed Resident #76's CNA flowsheets for August and September 2019 and confirmed there was no documentation that Resident #76 received a shower, or refused a shower on the above mentioned dates. In an interview on 09/26/19 at 8:15am, S2Director of Nursing (DON) stated she was unaware the shower schedule had changed to alternating halls on Monday, Wednesday, Friday, then Tuesday and Thursdays. S2DON confirmed she was unaware that showers were not given on the weekends unless requested by the resident. Surveyor informed S2DON there was no documentation of Resident #76 having a shower on the 2:00pm to 10:00pm shift as requested for 4 and 5 days in a row. Surveyor asked S2DON if she thought that was a problem, and she stated yes, it was a problem.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		11/10/19

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results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to: 1. Notify Resident #20's physician and responsible party with a new area of skin breakdown for 1 of 3 residents reviewed for skin conditions; and 2. Notify Resident #87's responsible party of an accident in a timely manner for 1 of 3 residents reviewed for accidents in a total of 19 residents reviewed in the investigative stage. This deficient practice had the potential to affect any of the 95 residents residing in the facility as documented on the Resident Census and Conditions of Residents form (CMS Form 672). Findings: Resident #20 Review of Resident #20's September 2019 physician orders revealed, in part: cleanse areas of excoriation to the right ischium and apply barrier cream as needed, cleanse areas of excoriation to the left ischium and apply barrier cream as needed, and cleanse areas of excoriation to the sacrum and apply barrier cream as needed. Further review revealed to cleanse the groin and buttock daily and apply calmoseptin with ketoconazole 2% ointment. Review of Resident #20's nurses notes dated 09/17/19 revealed MASD (Moisture Associated Skin Damage) still present to the resident's groin and buttock with treatment continued. Review of Resident #20's Weekly Skin Integrity	F 580	F 580 NOTIFICATION OF CHANGES 1. A. Resident #20□s physician and responsible party was notified of a new area of skin breakdown 09/26/19. B. Resident #87□s responsible party was notified of fall on 09/24/19. 2. A. A review of body audits and wound reports for a 4-week lookback will be completed to identify residents who experienced a new area of skin breakdown. Chart audits will be completed on identified residents to ensure notification of physician and responsible party completed. Any issues identified will be corrected at time of discovery. B. A review of Incident/Accident reports for a 4-week lookback will be completed to identify residents who experienced an accident. Chart audits will be completed on identified residents to ensure notification of physician and responsible party completed. Any issues identified will be corrected at time of discovery. 3. The DON or designee will inservice nursing staff on the importance of timely notification of resident□s physician and responsible party when a change in condition occurs.	

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F 580	Continued From page 7 Review dated 09/17/19 revealed MASD to groin and buttock. Observation on 09/25/19 at 4:12pm with S7LPN/Treatment Nurse (Licensed Practical Nurse) of Resident #20's body audit revealed wounds to the resident's right ischium, left ischium, and right buttock. Observation revealed an open area of the skin on the resident's scrotum approximately nickel sized with beefy red tissue to the wound bed. Further observation revealed the periwound (tissue around the open wound) was red and non-blanching (skin returns to normal skin tone from red to skin tone when pressed). S7LPN/Treatment Nurse stated the wound to Resident #20's scrotum was a new wound. Review of Resident #20's nurse's notes dated 09/26/19 revealed weekly body audit completed with new excoriated area noted to scrotum. In an interview on 09/26/19 at 11:19am, S7LPN/Treatment Nurse stated since the observation of the new wound to Resident #20's scrotum yesterday the only thing completed was applying calmaseptine (barrier) cream to the new wound. S7LPN/Treatment Nurse and S8LPN/Treatment Nurse stated they have not notified Resident #20's physician or responsible party of the new wound since identification of the new wound to present time. In an interview on 09/26/19 at 11:37am, S2DON (Director of Nursing) stated Resident #20's physician and responsible party should have been notified immediately upon the finding of the new skin condition.	F 580	4. A. DON or Designee will conduct a chart audit 3 x weekly on residents identified from the review of weekly body audits and communication forms to ensure physician and responsible party are notified of new skin issues. B. DON or Designee will conduct a chart audit 3 x weekly on residents identified from the review of Incident/Accident reports to ensure physician and responsible party are notified of accidents. Results of audits will be recorded on monitoring tool. Monitoring will be completed for 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at time of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed at the next Quarterly QAPI meeting for review of process efficiency.	

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Review of Resident #20's Fax Sheet dated as faxed to Resident #20's Physician on 09/26/19 at 12:02pm revealed in part: upon body assessment an excoriation to the resident's scrotum and buttock noted. Further review revealed the resident does get calmoseptine applied daily please advise on treatment.

Resident #87
Review of Resident #87's face sheet revealed his stepdaughter was the responsible party.

Review of Resident #87's Minimum Data Set with an Assessment Reference Date of 09/04/19 revealed a Brief Interview for Mental Status score of 8 (score of 8-12 was moderately cognitively impaired).

In an interview and observation of Resident #87 on 09/26/19 at 9:05am, revealed a clear dressing to Resident #87's left forearm with the top layer of the skin removed and the area covered was red in color. The surveyor asked Resident #87 what happened, and he stated on Tuesday, 09/24/19, there was an accident on the van, and he fell out of his wheelchair when the driver put on the brakes and he landed on the floor.

Review of the facility's resident incident report dated 09/24/19 at 9:00am revealed documentation of the off premises incident involving Resident #87, and the equipment in use was a wheelchair and transportation van.

Review of Resident #87's hospital discharge paperwork revealed an encounter date and time of 09/24/19 at 9:55am, and his stepdaughter listed as the emergency contact. Further review of the emergency room (ER) notes dated

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09/24/19 revealed in part, the following:
Todays visit: Reason for Visit - Diagnosis, injury of head-initial encounter, fall, skin tear of left forearm without complication-initial encounter, multiple abrasions and acute sinusitis.

Review of Resident #87's nurse's notes revealed no documentation regarding the injury to Resident #87's left forearm or documentation that the responsible party was notified. Further review of Resident #87's nurse's notes revealed the last nurse's note in the record was dated 08/08/19.

In an interview on 09/26/19 at 11:40am, Resident #87's stepdaughter stated her father had cataract surgery on the morning of 09/24/19 and was on his way back to the nursing home when he fell out of his wheelchair in the van. She stated she received a phone call from the hospital's ER to let her know her dad was in the ER on 09/24/19 at 10:33am. She stated the nursing home did not notify her that Resident #87 was involved in an accident and was taken to the ER. She stated she called the facility and spoke to Resident #87's nurse, and she was not aware of Resident #87's fall in the van and was unaware that Resident #87 was in the ER at the hospital.

In an interview on 09/26/19 12:40pm, S3Assistant Director of Nursing (ADON) stated if a Resident has a fall and/or injury, the responsible party would be notified. S3ADON reviewed Resident #87's record with the surveyor and confirmed there was no documentation of the incident on 09/24/19 and no documentation that the responsible party was notified of the fall in the van on 09/24/19.

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F 580	Continued From page 10 There was no documented evidence, and the provider did not present any documented evidence, that the responsible party was immediately notified of a fall, which required a visit to the ER.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		11/10/19

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F 609	Continued From page 11 Based on observations, interviews, and record reviews, the facility failed to report an injury of unknown origin within 2 hours of discovery for 1 (Resident #8) of 19 sampled residents. This deficient practice had the potential to affect any of the 95 residents who resided in the facility as documented of the Resident Census and Conditions of Residents form (CMS-672). Findings: Review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/19 revealed, in part, Resident #8 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated he was severely cognitively impaired. Review of Resident#8's Falls Risk Assessment dated 09/04/19 revealed a score of ten (10) which indicated he was a high risk for falls. Review of the facility's Abuse Investigating and Reporting policy revealed, in part, an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Review of Resident #8's nurse's notes dated 09/23/19 at 2:25pm revealed Resident #8 complained of pain to his left wrist. Resident #8 stated he fell 2 days ago and did not report it, and denied any other injuries. Vital signs were normal, and there was no deformity noted to the left wrist.	F 609	F 609 ABUSE REPOTING 1. The facility entered a SIMS report (#8282) related to Resident #8□s alleged injury of unknown origin resulting in serious bodily injury on 09/25/19. SIMS report completed on 09/30/19. 2. A review of Incident/Accident reports for a 4-week lookback will be completed to ensure any other incidents/accidents resulting in an injury of unknown origin or serious bodily injury have been reported for investigation. Any required SIMS reports will be completed based on review findings. 3. Facility staff will be inserviced on policy/procedure related to timely reporting of an injury of unknown origin or serious bodily injury to Administrator or Director of nursing so that investigation can begin and SIMS report submitted timely. 4. DON or designee will review Incident/Accident reports 3x weekly to ensure immediate notification of Administrator and/or DON of an injury of unknown origin or serious bodily injury and completion of required SIMS reports. Results will be recorded on monitoring tool. Monitoring will be completed for 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at time of discovery. Re-education will be conducted as	

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F 609	Continued From page 12 The physician was notified. Resident sent to a local Emergency Room (ER) for evaluation. Review of Resident #8's nurses' notes dated 09/23/19 at 7:30pm revealed, in part, Resident #8 returned to the facility with a diagnosis of a closed fracture of the distal end of the left radius (bone in forearm). Review of the Health Standards Incident Report revealed this incident was entered on 09/25/19 at 09:34am, but was discovered on 09/23/19 at 2:25pm. An interview and observation was conducted with Resident #8 on 09/24/19 at 8:30am. Resident #8 was observed with his left arm immobilized with an ace bandage/splint from his fingers to above his elbow. Resident #8 stated he fell. In an interview on 09/25/19 at 9:15am, S3Assistant Director of Nursing (ADON) stated Resident #8 told S1Administrator his wrist hurt from an unwitnessed, unreported fall 2 days earlier. In an interview on 09/25/19 at 11:21am, S2Director of Nursing (DON) confirmed Resident #8 had a fractured wrist which was discovered on 09/23/19. S2DON confirmed Resident #8's fractured wrist was an injury of unknown origin. S2DON further confirmed this injury of unknown origin was not reported until 09/25/19. S2DON confirmed Resident #8's injury of unknown origin should have been reported in a timely manner and was not. In an interview on 09/25/19 at 11:52am, S1Administrator stated on 09/23/19, Resident #8	F 609	deemed necessary. Results of monitoring will be reviewed at the next Quarterly QAPI meeting for review of process efficiency.	

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F 609	Continued From page 13 complained of left wrist pain. When asked, Resident #8 stated he fell last week. S1Administrator confirmed Resident #8's injury was of unknown origin, and further confirmed the injury was not reported in a timely manner as required.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: 1.) ensure a Prothrombin Time/International Normalized Ratio (PT/INR) was drawn as ordered (Resident #87); 2.) ensure neurochecks were performed after an unwitnessed fall on the facility's transportation van (Resident #87); 3.) ensure the Certified Nursing Assistant (CNA) transported a resident safely in the facility's transportation van (Resident #87); and 4.) ensure a care plan was revised after an unwitnessed fall and change in order for bloodwork (Resident #87). This deficient practice was evidenced in 1 (Resident #87) of 6 residents reviewed for unnecessary medications and had the potential to affect any of the 95 residents residing in the	F 684	F 684 QUALITY OF CARE 1. Resident #87 no longer resides in facility. The facility van is out of service until a replacement seatbelt obtained and installed. 2. A. The facility will conduct a review of current physician□s orders for a 4-week lookback period to identify other residents with orders to draw PT/INR. Chart audits will be completed on identified residents to ensure PT/INR was drawn as ordered. Any identified issues will be reported to physician for corrective action at time of discovery. B. The facility will conduct a review of	11/10/19

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F 684	Continued From page 14 facility as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents. Findings: Review of Resident #87's record revealed an admit date of 02/07/19 with diagnoses, in part, of Atrial Fibrillation, and a Prosthetic Heart Valve. Review of Resident #87's Minimum Data Set with Assessment Reference Date of 09/04/19 revealed in part, a Brief Interview of Mental Status score of 8 (score of 8-12 was moderate cognitively impaired) and he received six days of an anticoagulant during the seven day look back period. Review of Resident #87's Medication Administration Record dated September 2019 revealed he received Coumadin (an anticoagulant medication) 1 milligram by mouth once a day. Review of Resident #87's record revealed a faxed new order for Resident #87 dated 09/10/19 for PT/INR's every two weeks from 09/10/19 through 03/10/20. Review of Resident #87's record revealed no documented evidence of a PT/INR drawn on 09/24/19 as ordered. Further review of the record revealed the last PT/INR results were dated 09/09/19. In an interview on 09/26/19 at 12:00pm, S9Licensed Practical Nurse (LPN) stated she was unaware that Resident #87 had a new order for PT/INR every two weeks. In an interview on 09/26/19 at 12:25pm,	F 684	Incident/Accident reports for a 4-week lookback period to identify residents who experienced an unwitnessed fall. Chart audits will be completed on identified residents to ensure neurochecks were performed after unwitnessed fall. Any identified issues will be reported to physician for corrective action at time of discovery. C. Any resident being transported as a wheelchair passenger in Facility van could be affected. The facility will ensure residents being transported as wheelchair passengers in facility van are safely secured. D. The facility will conduct a review of current physician□s orders to identify other residents receiving anticoagulant medications. Chart audits will be completed on identified residents to ensure care plan revised to reflect the use of anticoagulants with laboratory monitoring. Any issues identified will be corrected at time of discovery. E. The facility will conduct a review of Incident/Accident reports for a 4-week lookback period to identify residents who experienced an incident/accident. Chart audits will be completed on identified residents to ensure care plan revised to reflect. Any issues identified will be corrected at time of discovery. 3. A. The DON or designee will inservice the nursing staff on protocol for processing lab orders to ensure labs are drawn as ordered. B. The DON or designee will inservice the nursing staff on the protocol for	

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F 684	Continued From page 15 S3Assistant Director of Nursing (ADON) stated when there was a new order that was faxed to the Facility, the nurse who received the faxed order should document the order as a telephone order and place the yellow copy of the order in a basket, located on the desk at the nursing station. S3ADON stated the yellow copy would go to the MDS/Care plan nurse, so she could revise the care plan as needed. S3ADON reviewed Resident #87's record and confirmed the order for the PT/INR every two weeks, on 09/10/19, was not transcribed as a telephone order and no one signed or dated the fax upon receipt. S3ADON confirmed with the lab company that Resident #87 did not have a repeat PT/INR on 09/24/19 or 9/25/19 and the last PT/INR drawn was on 09/09/19. In an interview and observation of Resident #87 on 09/26/19 at 9:05am, revealed a clear dressing to Resident #87's left forearm with the top layer of the skin removed and the area covered was red in color. The surveyor asked Resident #87 what happened, and he stated on Tuesday, 09/24/19, there was an accident on the van, and he fell out of his wheelchair when the driver put on the brakes and he landed on the floor. Review of the facility's resident incident report dated 09/24/19 at 9:00am revealed documentation of the off premises incident involving Resident #87, and the equipment in use was a wheelchair and transportation van. Review of Resident #87's hospital discharge paperwork revealed an encounter date and time of 09/24/19 at 9:55am. Further review of the emergency room notes dated 09/24/19 revealed in part, the following:	F 684	performing neurochecks after an unwitnessed fall. C. Upon receipt of replacement seatbelt, the facility will provide training to staff approved to transport residents in the facility van on how to safely secure wheelchairs in the van. D. The DON or designee will inservice the MDS/care plan team on the protocol for revising the care plan to reflect incident/accidents and the use of anticoagulant medication. 4. A. DON or Designee will conduct a chart audit on residents identified from the review of physician orders to ensure PT/INR are being drawn as ordered. B. DON or Designee will conduct a chart audit on residents identified from the review of Incident/Accident reports to ensure neurochecks are performed after an unwitnessed fall. C. Administrator or designee will conduct visual observations on residents being transported in facility van to ensure wheelchair passengers are safely secured. D. DON or Designee will conduct a chart audit on residents identified from the review of physician orders to ensure care plan revised to reflect the use of anticoagulant medication with laboratory monitoring. E. DON or Designee will conduct a chart audit on residents identified from the review of Incident/Accident reports to ensure care plan revised after an unwitnessed fall.	

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F 684	Continued From page 16 Today's visit: Reason for Visit - Diagnosis, injury of head-initial encounter, fall, skin tear of left forearm without complication-initial encounter, multiple abrasions and acute sinusitis. Review of Resident #87's nurse's notes revealed no documentation regarding the injury to Resident #87's left forearm or documentation of an assessment after Resident #87 returned from the ER. Further review of Resident #87's nurse's notes revealed the last nurse's note in the record was dated 08/08/19. Further review of Resident #87's record revealed no documentation of neurochecks performed by the nursing staff after Resident #87's unwitnessed fall on 09/24/19. In an interview on 09/26/19 12:40pm, S3ADON confirmed a resident who was not cognitively intact and had an unwitnessed fall would require neurochecks. S3ADON looked in multiple places for additional documentation on Resident #87 and confirmed she could not locate any other documentation, and 08/08/19 was the last documented nurses note on Resident #87. In an interview on 09/26/19 at 12:55pm, S4Case Mix Index (CMI) nurse stated she was informed of new orders by getting the yellow copy of the order sheets. S4CMI nurse stated she was informed of falls/injuries by talking to the residents nurse and getting an update of anything that may have occurred. S4CMI nurse stated she was informed today that Resident #87 had a fall in the facility's van on 09/24/19. S4CMI nurse confirmed she was unaware Resident #87's PT/INR order had changed from every month to every two weeks on 09/10/19. S4CMI nurse	F 684	Results of audits/observations will be recorded on monitoring tool. Monitoring will be completed 3 x weekly x 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at time of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed at the next Quarterly QAPI meeting for review of process efficiency.	

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F 684	Continued From page 17	F 684		

reviewed Resident #87's care plan and confirmed his care plan was not revised after his unwitnessed fall on 09/24/19 and the change in his PT/INR's to every two weeks.
In an interview on 09/26/19 at 1:45pm, S2DON reviewed the above findings with this surveyor, and confirmed Resident #87's order for PT/INR every two weeks was not transcribed appropriately. S2DON further confirmed Resident #87's labs were not drawn as ordered, and Resident #87's care plan was not revised to reflect the new orders. S2DON had no additional documentation to present and had no additional comment.

Review of the facility protocol titled, "how to secure wheelchair bound resident in transport van" revealed, in part:
1.) Ensure resident is forward facing in the van;
2.) Secure the wheelchair to the can floor using 4 straps - Ensure the seatbelt straps are attached to the same metal ring on the securing strap and the seat belt is not looped over the wheelchair arms, position the seat belt low across the residents hips and hook the seat belt, then tighten the seat belt appropriately, complete one last check on all straps to ensure wheelchair is secured.
3.) If any securing equipment is broken, missing, or malfunctioning, do not transport the resident and notify the administrator immediately. Do not transport a wheelchair bound resident in the transport van until repairs are made.

In an interview on 09/26/19 at 11:00am, S15CNA, who transported Resident #87 on 09/24/19, stated she had been trained on how to restrain a wheelchair resident for transport in the facility van. S15CNA stated when she put Resident #87

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F 684	Continued From page 18 in the van on 09/24/19 she could not secure a seatbelt across his hips because there was none present in the van. She stated it had been a few months since she transported a resident because she was the fill-in transporter. In an interview on 09/26/19 at 11:20am, S11Quality Assurance Director stated she was present in the facility on 09/24/19 when S15CNA returned to the facility in the van. S11Quality Assurance Director stated she inspected the van and the wheelchair was strapped correctly, but there was no lap belt seatbelt available for use in the van. She stated the van was immediately taken out of commission and was not to be used at this time. In an interview on 09/26/19 at 11:25, S2DON confirmed when Resident #87 returned from the emergency room, on 09/24/19 after the unwitnessed fall in the facility van, neurochecks were not implemented. S2DON confirmed neurochecks should be completed for any unwitnessed fall and confirmed Resident #87's fall was unwitnessed. The provider did not present any additional documentation regarding the above mentioned findings.	F 684		
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.	F 849		11/10/19

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(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to

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alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual,

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and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the

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F 849	Continued From page 22 medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to collaborate care with the hospice agency to assure that a resident's catheter was changed as ordered for 1 (Resident #25) of 1 sampled residents reviewed for hospice services in a total investigative	F 849	F 849 HOSPICE CARE 1. Resident #25□s catheter was changed on 09/25/19. The facility will assume responsibility for changing	

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F 849	Continued From page 23 sample of 19. This deficient practice had the potential to affect any of the 5 residents who received hospice services as documented on the facility's Census and Conditions of Residents Form. The total facility census was 95 as documented on the facility's Census List. Findings: Review of Resident #25's Minimum Data Set with an Assessment Reference Date of 06/24/19 revealed Resident #25 received hospice care and had an indwelling catheter. Observation on 09/23/19 at 10:33am revealed Resident #25's catheter drainage bag was labeled, "7/16/19- CATH" and "8/1/19- bag changed." Review of Resident #25's September 2019 Physician Orders revealed orders to admit to hospice agency, change suprapubic catheter every month and as needed, and change drain bag monthly and as needed. Review of Resident #25's Treatment Administration Record (TAR) from July 2019 revealed the suprapubic catheter was changed by the hospice agency on 07/16/19. Further review revealed no documented evidence that the catheter drainage bag was changed. Review of Resident #25's TAR from August 2019 revealed no documented evidence that the suprapubic catheter was changed. Further review revealed no documented evidence that the catheter drainage bag was changed. Review of Resident #25's TAR for September 2019 revealed no documented evidence that the	F 849	Resident #25□s catheter as ordered. Resident #25□s Hospice Agency will be notified the facility will be assuming responsibility for changing her catheter as ordered. 2. A. The facility will conduct a review of current physician□s orders to identify other residents receiving hospice services. Hospice Agencies providing services to identified residents will be notified the facility will be assuming responsibility for changing urinary catheters as ordered. B. The facility will conduct a review of current physician□s orders for a 4-week lookback to identify other residents with orders for urinary catheter. Chart audits will be completed on identified residents to ensure catheter was changed as ordered. Any issues identified will be corrected at time of discovery. 3. A. The DON or her designee will inservice nursing and treatment nurse staff on the facility protocol for providing/documenting urinary catheter changes as ordered. 4. DON or Designee will conduct a chart audit on 25% of residents identified from the review of physician orders to ensure urinary catheter is changed as ordered. Results of audits will be recorded on monitoring tool. Monitoring will be completed weekly x 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at time	

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F 849	Continued From page 24 suprapubic catheter was changed. Further review revealed no documented evidence that the catheter drainage bag was changed. Review of the 12/04/18 hospice agency and facility's Long-Term Care Agreement, Section V Admission and Coordination of Services, subset 5.1.1 Coordination of Services read, in part, Hospice and Nursing Facility shall coordinate, establish, and agree upon a coordinated plan of care for Hospice patients residing in Nursing Facility which reflects the hospice philosophy of care. Subset 5.1.4 read, in part, Hospice and Nursing Facility will promptly inform the other of any change in the condition of the Residential Hospice Patient. In an interview on 09/24/19 at 1:44pm, S7Treatment Nurse stated each resident on hospice had a hospice binder which had general information for the resident, but communication with the hospice agency was completed face to face. In an interview on 09/25/19 at 08:40am, S3Assistant Director of Nursing (ADON) stated the hospice agency was in charge of changing Resident #25's suprapubic catheter. In a phone interview on 09/25/19 at 11:26am, the hospice agency's Director of Nursing stated changing the resident's catheter was the responsibility of the hospice agency. She also stated the catheter must be changed every 30 days and as needed. She stated the last time a hospice nurse had been to the facility was 09/17/19. She stated she could not find any documentation that a hospice nurse had changed Resident #25's suprapubic catheter.	F 849	of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed at the next Quarterly QAPI meeting for review of process efficiency.	

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In an interview on 09/25/19 at 11:51am, S7Treatment Nurse confirmed Resident #25's TAR revealed the suprapubic catheter must be changed every month and as needed. She confirmed the dates written on Resident #25's catheter drainage bag indicated the suprapubic catheter had been changed on 07/16/19, and the catheter drainage bag had been changed on 08/01/19. She stated it was out of her scope of practice to change the suprapubic catheter, but it should have been communicated to the hospice agency that Resident #25's suprapubic catheter was not changed since 07/16/19.

In an interview on 09/25/19 at 12:01pm, S3ADON confirmed the dates written on Resident #25's catheter drainage bag indicated the suprapubic catheter was changed on 07/16/19, and the catheter drainage bag had been changed on 08/01/19. She confirmed the hospice agency should have been notified by the facility that Resident #25's suprapubic catheter had not been changed since 07/16/19.

In a phone interview on 09/25/19 at 12:04pm, the hospice agency's Director of Nursing, stated her documentation indicated the facility changed Resident #25's suprapubic catheter on 08/01/19. She denied having any further evidence that Resident #25's suprapubic catheter had been changed since 08/01/19. She confirmed that Resident #25's catheter was not changed in her hospice agency's time frame, nor had they been notified by the facility to change Resident #25's suprapubic catheter.

In interview on 09/25/19 at 4:18pm, S3ADON stated the system for communication is for the

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F 849	Continued From page 26 hospice nurse and facility staff to communicate face to face. She stated once the hospice agency changed a catheter, it should have been documented on the resident's TAR. She stated she believed the wound care nurse assumed the hospice agency was responsible for Resident #25's catheter, and the wound care nurse did not follow up to make sure the proper care had been completed.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		11/10/19

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F 880	Continued From page 27 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 28 Based on observation, record review, and interview the facility failed to: 1. Contain and label the residents' care equipment (Room a, Resident #47); 2. Contain and label the residents' BiPAP (Bilevel Positive Airway Pressure) equipment with the last date changed (Resident #32, Resident #51); 3. Contain and label the resident's CPAP (Continuous Positive Airway Pressure) equipment with the last date changed (Resident #26); 4. Contain and label the residents' oxygen tubing with date the oxygen tubing was changed (Resident #32, Resident #40, Resident #65); 5. Ensure a nebulizer mask and tubing was contained (Resident #10 and Resident #74); 6. Ensure documented evidence of cleaning of the BiPAP mask and tubing (Resident #32); and 7. Ensure a resident with a catheter did not have the catheter tubing touching the floor (Resident #52) in a total screening sample of 95. This deficient practice had the potential to affect any of the 95 residents documented on the Resident Census and Conditions of Residents form (CMS Form 672). Findings: Room a Observation of the bathroom in Room a on 09/23/19 at 10:29am revealed two grey basins and one white basin in the resident bathroom not labeled and uncontained. All three basins were sitting on top of the bedside commode in the bathroom. Further observation revealed two graduated cylinders located on top of the toilet and both were inverted on paper towels and not labeled. Observation of the bathroom in Room a on	F 880	F 880 INFECTION CONTROL 1. A. The two grey basins, white basin, and two graduated cylinders in Room A were removed and disposed of by Nursing. The unidentifiable hairbrush on Resident #47□s end table was removed and disposed of by Nursing. B. CPAP/BiPAP equipment (mask and tubing) are for single-patient use, not disposable, and require cleaning not changing. Review of facility policy for CPAP/BiPAP Support revealed general guidelines for cleaning PAP equipment. PAP equipment for Residents #32, #51, and #26 cleaned and contained by Nursing. Cleaning documented in medical record. C. Resident #32, #40, and #65□s oxygen tubing changed, labeled, and stored properly by Nursing. D. Resident #10 and #74□s nebulizer mask and tubing were changed, labeled, and stored properly by Nursing. E. Resident #52□s catheter tubing repositioned to not touch the floor by Nursing. 2. A. A visual observation will be conducted by staff on all resident rooms, bathrooms, and shower rooms to identify any other areas needing removal of resident personal care items/equipment not labeled/stored properly. Any issues identified will be corrected at time of discovery. B. The facility will conduct a review of current physician□s orders to identify	

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F 880	Continued From page 29 09/24/19 at 10:51am revealed two grey basins and one white basin in the resident bathroom not labeled and uncontained. All three basins were sitting on top of the bedside commode in the bathroom. Further observation revealed two graduated cylinders located on top of the toilet and both were inverted on paper towels and not labeled. Observation of the bathroom in Room a on 09/26/19 at 1:55pm revealed two grey basins and one white basin in the resident bathroom not labeled and uncontained. All three basins were sitting on top of the bedside commode in the bathroom. Further observation revealed two graduated cylinders located on top of the toilet and both were inverted on paper towels. In an interview on 09/26/19 at 1:55pm, S2Director of Nursing (DON) confirmed the above items were not labeled and were uncontained. S2DON stated the items should be labeled with the name of the resident and all items should be contained in a bag. Resident #10 Observation on 09/23/19 at 10:11am, revealed Resident #10's nebulizer mask was uncontained sitting on top of the nebulizer machine. In interview on 09/26/19 at 10:09am, S2Director of Nursing (DON) indicated she was informed of the above deficient practice, and S2DON further indicated the Saturday night nurse was responsible to change out respiratory equipment and put plastic bags out to store resident care equipment in a sanitary manner, and was informed on Monday, that this was not done.	F 880	other residents with orders for respiratory support therapy. Chart audits and visual observations will be completed on identified residents to ensure respiratory support equipment and tubing are being cleaned, changed, and/or stored properly to prevent the spread of infection with PAP equipment cleaning documented in medical record. Any issues identified will be corrected at time of discovery. C. The facility will conduct a review of current physician□s orders to identify other residents with orders for urinary catheters. Visual observations will be completed on identified residents to ensure urinary catheter tubing is positioned properly without touching the floor. Any issues identified will be corrected at time of discovery. 3. A. The CNA supervisor or designee will inservice CNA staff on the importance and process of labeling/storing resident personal care items/equipment to prevent the spread of infection. B. The DON or her designee will inservice nursing staff on the importance and process of ensuring respiratory support equipment and tubing are being cleaned, changed, and/or stored properly to prevent the spread of infection and PAP equipment cleaning documented in medical record. C. The DON or designee will inservice nursing and CNA staff on the importance of positioning urinary catheter tubing to avoid contact with the floor to prevent the spread of infection.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 Resident #26 Review of Resident #26's September 2019 Physician's orders revealed oxygen at Two (2) liters per minute per nasal cannula continuously. Change oxygen tubing every week. Continuous Positive Airway Pressure (CPAP) at 15 with two (2) liters per minute oxygen every night. An observation on 09/23/19 at 11:21am revealed Resident #26 in bed, CPAP mask on the side of her pillow, not bagged or dated. An observation on 09/23/19 at 11:21am revealed Resident #8 had a nasal cannula in place with no date on the oxygen tubing and a humidification chamber on the oxygen condenser, which was not dated. In an interview on 09/23/19 at 11:21am Resident #26 stated she had never seen anyone clean her CPAP mask or change the oxygen tubing. An observation on 09/24/19 at 8:43am revealed Resident #26's oxygen tubing and humidification chamber was not dated. Resident #26's CPAP mask was lying on the bed next to her pillow and was not dated or contained. An observation on 09/25/19 at 9:30am revealed Resident #26's oxygen tubing and humidification chamber was not dated. Resident #26's CPAP mask was lying on the bed next to her pillow and was not dated or contained. Resident #32 Review of Resident #32's record revealed an admit date of 06/22/19 with diagnoses, in part, of Lung Cancer, Heart Failure, and Respiratory Failure.	F 880	4. A. The CNA Supervisor or designee will make observation rounds on one hall per day, five days a week, to ensure resident personal care items/equipment are labeled/stored properly. B. DON or Designee will conduct a chart audit and visual observation 4 x weekly on 25% of residents identified from the review of physician orders to ensure respiratory support devices and tubing are being cleaned, changed, and/or stored properly to prevent the spread of infection and PAP equipment cleaning documented in medical record. C. DON or designee will conduct visual observations 3 x weekly on residents identified from a review of physician□s orders to ensure urinary catheter tubing is positioned properly without touching the floor. Results of audits and observations will be recorded on a monitoring tool. Monitoring will be completed for 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at time of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed at the next Quarterly QAPI meeting for review of process efficiency.	

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	195305	A. BUILDING _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LAFOURCHE NURSING & REHAB	146 E. 28TH STREET CUT OFF, LA 70345

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F 880	Continued From page 31	F 880		

Review of Resident #32's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/29/19 revealed a Brief Interview for Mental Status score of 15 (13-15 was cognitively intact) and was receiving oxygen therapy and non-invasive mechanical ventilation.

Review of Resident #32's physician orders dated September 2019 revealed an order dated 09/03/19 for Bilevel Positive Airway Pressure (BiPAP) 20/10, Tidal Volume (TV) of 600 with four liters (L) oxygen every night.

Review of Resident #32's Medication Administration Record (MAR) dated September 2019 revealed documentation of BiPAP 20/10 TV 600 with 4L oxygen every night at 8:00pm from 09/02/19 through 09/22/19.

Further review of Resident #32's MAR dated September 2019 revealed an order for the following:
-cleanse BiPAP mask with warm soap and water, pat dry and allow to completely air dry daily;
-cleanse BiPAP tubing with warm soap and water, pat dry and allow to completely air dry before use weekly on the 7:00am to 3:00pm shift;
- check oxygen concentrator, remove filter, and clean, change oxygen tubing every week; and
- change oxygen humidifier bottle every week

Further review of Resident #32's MAR dated September 2019 revealed no documented evidence of the above orders being followed.

In an interview and observation on 09/24/19 at 9:38am, Resident #32 was sitting in his room with 4Lcontinuous humidified oxygen per nasal

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F 880	Continued From page 32	F 880		

cannula. Observation of Resident #32's oxygen tubing and oxygen humidifier revealed no date on either one. Further observation of Resident #32's room revealed a BiPAP machine on his bedside table with the BiPAP mask and tubing lying on the bed next to Resident #32's bed and the BiPAP mask was uncontained. Resident #32 stated he did not see anyone cleaning his BiPAP tubing or mask and stated he cleaned it himself.

Observation on 09/25/19 at 12:30pm revealed Resident #32's BiPAP mask and tubing was lying on the bed next to Resident #32's bed and the BiPAP mask was uncontained. Further observation revealed no date on the oxygen tubing and oxygen humidifier.

In interview and observation on 09/25/19 at 4:00pm, S2DON confirmed Resident #32's BiPAP mask was lying on the bed and was uncontained. S2DON confirmed the BiPAP mask should remain in a bag. S2DON observed the oxygen humidifier bottle with the surveyor and Resident #32's oxygen humidifier was dated 09/21/19. S2DON informed surveyor that she had instructed S3ADON to check all the oxygen condensers, and if the water level was high to label the condensers with Saturday's date (09/21/19). S2DON stated if S3ADON would have put today's date on the oxygen humidifier bottle, the weekend nurse would not change them over the weekend. S2DON reviewed Resident #32's MAR dated September 2019 and confirmed there was no documentation of Resident #32's BiPAP mask and tubing being cleaned as ordered and no documentation of the oxygen tubing and humidifier being changed as ordered.

Resident #40

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F 880	Continued From page 33	F 880		

Observation on 09/23/19 at 10:26am, revealed Resident #40's oxygen tubing lying on the bed, uncontained.

In interview on 09/26/19 at 10:09am, S2Director of Nursing (DON) indicated she was informed of the above deficient practice, and S2DON further indicated the Saturday night nurse was responsible to change out respiratory equipment and put plastic bags out to store resident care equipment in a sanitary manner, and was informed on Monday, that this was not done.

Resident #47
Observation on 09/23/19 at 10:21am, revealed Resident #47 had an unidentifiable hair brush on the end table.

In interview on 09/26/19 at 10:09am, S2Director of Nursing (DON) indicated she was informed of the above deficient practice, and S2DON further indicated the Saturday night nurse was responsible to put Ziploc bags out to store resident care equipment in a sanitary manner, and was informed on Monday, that this was not done.

Resident #51
Review of Resident #51's September 2019's Physician's Orders revealed an order for BiPAP nightly 17/6 (inspiratory positive airway pressure/expiratory positive airway pressure) at 35% oxygen.

Observation on 09/23/19 at 2:47pm of Resident #51's room revealed the BiPAP mask was laying on the bed uncontained with no date or information on the mask. Further observation revealed Resident #51's oxygen tubing was laying

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F 880	Continued From page 34	F 880		

on the floor with no date on the tubing.

Resident #52
Review of the facility's infection control policy and procedures for urinary catheter care revealed, in part, to be sure the catheter tubing was kept off the floor.

Observation on 09/25/19 at10:25am, revealed Resident #52's catheter tubing was touching the floor as she was sitting in her wheelchair in her room.

Observation on 09/26/19 at 10:04am, revealed Resident #52's catheter tubing was touching the floor as she was sitting in her wheelchair next to the Director of Nurse's office.

In interview on 09/26/19 at 10:09am, S2Director of Nursing (DON) indicated she was informed of the above deficient practice, and catheter tubing should not touch the floor.

Resident #65
Review of Resident #65's Minimum Data Set with an Assessment Reference Date of 07/26/19 revealed Resident #65 had oxygen therapy in use and received hospice care.

Review Resident #65's Physician Orders revealed oxygen at 2 liters per minute per nasal cannula as needed for shortness of breath.

Observation on 09/23/19 at 10:46am revealed Resident #65 had oxygen in use. Further observation revealed no date present on Resident #65's oxygen tubing.

Observation on 09/24/19 at 09:03am revealed

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F 880	Continued From page 35 Resident #65 had oxygen in use. Further observation revealed Resident #65's oxygen tubing was not dated. In an interview on 09/26/19 at 12:24pm, S3Assistant Director of Nursing confirmed Resident #65's oxygen tubing was not appropriately labeled and dated, and should have been. Resident #74 Observation on 09/23/19 at 10:13am, revealed Resident #74's nebulizer mask was uncontained lying on a bedside table facedown. In interview on 09/26/19 at 10:09am, S2Director of Nursing (DON) indicated she was informed of the above deficient practice, and S2DON further indicated the Saturday night nurse was responsible to change out respiratory equipment and put plastic bags out to store resident care equipment in a sanitary manner, and was informed on Monday, that this was not done.	F 880		

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K 000	INITIAL COMMENTS South Lafourche Nursing & Rehab is not in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The findings that follow in this CMS 2567 demonstrate the non-compliance. The facility is sprinklered, licensed for 102 beds and a census of 94 at time of survey.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the fire alarm system was inspected and tested in accordance with the approved maintenance and testing program in NFPA 72. The fire alarm system gives a sense of security to offer an advance warning in fire and/or smoke emergency. This deficient practice could potentially affect 94 of 94 residents. Findings: During the facility tour, between the hours of 8:00 a.m. to 11:00 a.m. it was observed the fire alarm system was last inspected by a certified inspector on June 21, 2018.	K 345	K □ 345 " No residents were adversely affected by this deficient practice. " All of the Facility□s 94 residents could have been adversely affected by this deficient practice. " The company AAR Electronics are contracted to test and maintain our Fire Alarm System annually so our system can stay in compliance with the NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The above contractor will be contacted to inspect/test system. " The Maintenance Supervisor will be	11/10/19

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

Electronically Signed | 10/10/2019

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K 345	Continued From page 1 Interview with the supervisor revealed the facility was not aware that the required inspection had not been conducted on the fire alarm system.	K 345	responsible to assure that this inspection is done on an annual basis and the NFA will monitor to assure continued compliance. " Corrective actions will be completed by 11-10-19.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the complete, supervised, automatic sprinkler system was inspected and tested in accordance with the requirements of NFPA 13. Activation of the sprinkler system shall trigger notification of the emergency to the fire alarm system within 90 seconds, which results in protection of life and property. This deficiency	K 353	K □ 353 " No residents were adversely affected by this deficient practice. " All of the Facility□s 94 residents could have been adversely affected by this deficient practice. " The company S&S Sprinklers are contracted to inspect and maintain our	11/10/19

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K 353	Continued From page 2 has the potential to affect 94 of 94 residents. Findings: During the facility tour, between the hours of 8:00 a.m. and 11:00 a.m. on 9/27/2019 it was observed the sprinkler system was last serviced by a certified inspector on June 22, 2018. Interview with the supervisor revealed the facility was not aware that the annual and/or quarterly inspections had not been conducted on the automatic sprinkler system and this was also acknowledged by the Administrator during the exit meeting.	K 353	Sprinkler System in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. The above contractor will be contacted to inspect/test system and the LPND provided the system□s water supply. " The Maintenance Supervisor will conduct monthly checks on the sprinkler and water supply system and the NFA will monitor to assure continued compliance. " Corrective actions will be completed by 11-10-19.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		11/10/19

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K 918	Continued From page 3 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the generator or other alternate power source is capable of restoring electrical service within 10 seconds. Generator sets are inspected weekly and a monthly testing program on the emergency generator must be conducted a min. of 12 times a year under load for a min. of 30 minutes. In cases of a power outage the emergency generator powers essential life safety equipment for the facility. The deficient practice had the potential to affect 94 of 94 residents. 12 of 12 months were deficient. Findings: During the record review, between the hours of 8:00 a.m. and 11:00 a.m. on 9/27/2019 it was observed the facility does not have the documentation regarding the generator test. Interview with the supervisor revealed the facility was not aware that all documentation was not complete regarding the inspection/testing of the	K 918	K □ 918 " No residents were adversely affected by this deficient practice. " All of the Facility□s 94 residents could have been adversely affected by this deficient practice. " The Facility□s generator has to restore power to the facility within 10 seconds of an electrical power failure; has to be inspected weekly; and a monthly testing program on the emergency generator shall be conducted a minimum of 12 times per year under load for a minimum of 30 minutes. The Facility□s generator is now functioning according to the above standards and record testing log will be maintained by the Facility□s Maintenance Supervisor and inspected monthly by the NFA. " Corrective actions will be completed by 11-10-19.	

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K 918	Continued From page 4 emergency generator.	K 918		

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F 000	INITIAL COMMENTS Complaint Survey #LA00053295. No deficiencies were cited as a result of this complaint.	F 000		

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.