STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185046	A. Building B. Wing	01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Springlake Health & Rehabilitation Center	509 North Hayden Avenue Salem, KY 42078

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38981 Based on interview, record review, and facility policy review, it was determined the facility failed to consult with the resident's physician when there was a significant change and a need to alter treatment significantly for one (1) of eighteen (18) sampled residents (Resident #35). Resident #35 refused breakfast and lunch on 10/14/18, 10/15/18, 10/17/18 and 10/18/18 and only ate twenty-five (25) percent at supper; and his/her twenty-four (24) hour intake totaled 600 milliliters (mL) 10/14/18; 580 mL on 10/15/18; 600 mL on 10/16/18; and, 420 mL on 10/17/18 and 10/18/18; however, the facility failed to make the Physician/APRN aware of the resident's continued refusals of meals and decrease in fluid intake per facility policy. On 10/18/18 at 8:09 AM, Resident #35 experienced an episode of vomiting, he/she did not eat or drink at breakfast and would not take his/her morning medications. At 9:44 AM on 10/18/18, the resident experienced another episode of vomiting. Additionally, the resident's blood pressure was low, and a urinalysis (UA) was ordered on 10/16/18 but was not obtained prior to the resident's transport to the emergency roiagnom on [DATE]. However, there was no documented evidence of Physician/APRN notification of the resident's continued vomiting on 10/18/19, low blood pressure, or that staff were unable to obtain the 10/16/18 ordered UA, so treatment could be altered; per facility policy. The findings included: Review of facility policy titled Nonfiction of Change, dated July 2017, revealed the residents' physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition, potential discharge, room transfer or death. The facility has adopted the current INTERACT Tools Change in Condition: When to report to the Physician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN). The program is an evidence based program that may be utilized by the nurse when needed and does not supersede the clinical judgement of the licensed nurse. (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of the INTERACT Version 4.0 Tool, updated June, 2018, revealed the Physician, PA or APRN should be notified immediately for any symptom, sign or apparent discomfort that is acute or sudden in onset; and a marked change in relation to usual symptoms and signs; or unrelieved by measures already prescribed. Non-immediate notification would be for new or worsening symptoms that do not meet the above criteria. Additional review revealed a listed sign or symptom to report included diminished appetite, with immediate notification for no oral intake two (2) consecutive meals; and non-immediate notification would be for significant decline in food and fluid intake in the resident with marginal hydration and nutritional status. A second listed symptom to report was vomiting with immediate notification if persistent or recurrent (two [2] or more within twelve [12] hour) vomiting, with or without abdominal pain, bleeding, distention/fever; and non-immediate notification would be for intermittent recurrent vomiting without immediate notification criteria met. Record review revealed the facility admitted Resident #35 on 03/09/18 with diagnoses which included Cerebral Palsy, unspecified; and Other Seizures. Review of the Quarterly Minimum Data Set, dated dated [DATE], revealed the facility assessed Resident #35's cognition as severely impaired as the resident was unable to complete a Brief Interview of Mental Status (BIMS) exam indicating the resident was not interviewable. Further review of the Quarterly MDS revealed Resident #35 required total care with all activities of daily living (ADL's); and the resident was incontinent of bowel and bladder. Review of the Intake and Output Record for October, 2018, revealed Resident #35 had refused breakfast and lunch on 10/14/18, 10/15/18, 10/17/18 and 10/18/18 and only ate twenty-five (25) percent at supper on each of these days. On 10/16/18, the resident ate fifty (50) percent of breakfast and twenty-five (25) percent of lunch and dinner. Further review revealed the resident's fluid intake was poor. On 10/14/18, twenty-four (24) hour intake totaled 600 milliliters (mL); on 10/15/18: 580 mL; on 10/16/18: 600 mL; and, on 10/17/18 and 10/18/18: 420 mL for each day. The resident's usual average fluid intake for twenty-four (24) hours was 1000 ml per day. Review of the Nurse's Progress Notes dated 10/17/18 at 4:14 PM revealed RN #1 was alerted Resident #35 wasn't acting right. Vital signs were, blood pressure 102/48 (base line 128/68), temperature 103.3 degrees Fahrenheit, heart rate 120 (base line 65), resident awake and alert, grinding teeth at times. At 4:37 PM, RN #1 telephoned the Physician's Assistant (PA) (who was back-up call for the Advanced Practice Registered Nurse {APRN}) and received orders for Tylenol 650 mg suppository to be given then and every six (6) hours as needed for elevated temperature; and a UA per in and out catheterization. Further review of the Nurse's Progress Notes revealed an in and out catheterization (cath) was not attempted until 10/17/18 at 9:00 PM by RN #3 , almost five (5) hours after the order was received. The attempt was unsuccessful due to only a scant amount of urine obtained. Further review revealed there were two (2) other entries made in the Nurse's Progress Notes, on 10/17/18 at 6:26 PM and on 10/18/18 at 9:44 AM by RN #1 revealing the resident had incontinent episodes and staff were unable to obtain a urine specimen. Review of the Nurse's Progress Notes, dated 10/18/18 at 8:09 AM, by Registered Nurse (RN) # 1 revealed Resident #35 did not eat any breakfast this morning or drink any fluid. He/she would not take morning medications with liquids or food. The RN documented she was informed by a nurse assistant that the resident has vomited greenish fluid earlier that morning. and the resident's temperature was 99.1 degrees Fahrenheit. Further review of the Nurse's Progress Notes, dated 10/18/18 at 9:44 AM, by RN #1, revealed Resident #35 vomited greenish bile fluid, approximately 100 milliliters (mL). (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	However, further clinical record review revealed there was no documented evidence the Physician, PA, or APRN was notified of the severe decrease in food or fluid intake; that the resident had two (2) episodes of vomiting on 10/18/18 at 8:09 AM and 9:44 AM; or that the staff had not obtained the UA ordered on 10/16/18. Review of the Clinical Situation, Background, Assessment and Review (SBAR) Form for Resident #35, dated 10/18/18 at 4:30 PM, (almost seven (7) hours after the last documented emesis) completed by RN #1, revealed under 'Situation', 'The change in condition, symptoms, or signs I am calling about is/are', Resident has been vomiting green bile looking fluid X 3 over 2 days; just not acting right in general; not eating or drinking; was given an enema earlier today due to constipation and temp of as high as 103.3 however now is 99.2. The APRN was notified and orders received to notify the resident's family and let them decide if they want the resident sent to the emergency room (ER) for evaluation. Review of the Nurse's Progress Notes dated 10/18/18 at 6:57 PM, by RN #1, revealed Resident #35 was transported, by family in a private vehicle, to the ER. Review of the Hospital Discharge Summary revealed Resident #35 was admitted to the hospital on 10/18/18 at 9:00 PM with diagnoses of Urosepsis, Acute Renal Failure Syndrome, Abdominal Pain, and Fecal Impaction. Review of the Discharge Physician's Note revealed, on admission, the resident was also hemoconcentrated initially and with hydration, labs improved. After treatment, the resident was discharged from the hospital on 10/22/18. Interview with RN #1 on 01/11/18 at 2:22 PM and on 01/23/19 at 11:41 AM (Post Survey) revealed she worked day shift on 10/17/18 and 10/18/18. RN #1 stated she had not been monitoring the Intake and Output sheets as she did not know where they were located and no one had told her she needed to do so. Interview (Post Survey) with the APRN on 01/25/19 at 9:33 AM revealed she knew Resident #35 had been having some vomiting because she ordered Zofran on 10/16/18, however, she was not aware the resident had vomited two (2) times on 10/18/18 (8:09 AM and 9:44 AM). The APRN further stated she was aware the resident had not been eating well, however, she was not made aware of how poor the resident's food and fluid intake had been. Additionally, the APRN stated had she been made aware of the severity of the resident's illness (more vomiting, severity of lack of food and fluid intake, and low blood pressure) she would have initiated intravenous fluids or sent the resident to the ER sooner. The APRN further stated had she been contacted by the facility, it probably would have made a difference in the severity of the resident's illness and the outcome as well. Interview (Post Survey) with the Director of Nursing (DON) on 01/24/19 at 8:52 AM revealed she felt like RN #1 completed a full assessment and she trusted the RN nursing judgment on when to notify or not notify the physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36603 Based on observation, interview, record review and facility policy review, it was determined the facility failed to implement a comprehensive person-centered care plan for one (1) of eighteen sampled (18) residents (Resident #22). Observations on 01/09/19 revealed staff failed to implement Resident #22's care plan related to turning and repositioning every two hours and floating heels. The findings include: Review of facility policy titled, Resident Assessment Care Plan Development, dated 11/28/17 revealed the intent is to ensure the timeliness of each person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident's representative, if applicable, is involved in developing the care plan and making decision about his/her care. Record review revealed the facility admitted Resident #22 on 10/09/16 with diagnoses which included Diabetes Mellitus, Altered Mental Status, a history of pressure wounds, and Rheumatoid Arthritis. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 11/09/18 revealed the facility assessed Resident #22's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Review of Resident #22's Comprehensive Care Plan for potential for skin breakdown related to decreased mobility, Diabetes, Vascular Disease, and incontinence, dated 08/16/16 revealed interventions, dated 07/20/18, to float heels while in bed and encourage to turn and reposition upon rounds while in bed. However, observations on 01/09/19 at 8:30 AM, 10:09 AM, 11:33 AM, 12:07 PM, 3:00 PM, 3:35 PM, and 3:45 PM, revealed Resident #22 remained on his/her left side with no evidence of the resident being turned and repositioned; and heels being floated per care plan during this time. In addition, observation on 01/10/19 at 8:24 AM revealed Resident #22 being assisted with breakfast with heels noted to be flat on the bed. Interview with Certified Nurse Aide (CNA) #6 on 01/09/19 at 4:30 PM revealed Resident #22 should be turned every two (2) hours from side to side. She stated she did turn the resident at 4:15 PM but she did not check to see if his/her heels were off the bed. She revealed she was not sure the last time the resident was turned and repositioned. Interview with CNA #2 on 01/10/19 revealed Resident #22 should be turned from side to side every two (2) hours and feet floated. She stated the resident should only be on his/her back at meal time because of a wound to his/her bottom, but she had failed to ensure his/her heels were floating. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 01/11/19 at 5:38 PM revealed she expected staff to follow the care plan for each resident. She stated nursing staff should turn Resident #22 every two (2) hours due to a pressure wound to the coccyx, and float heels at all times while in bed as indicated on his/her care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 36603 Based on observation, interview, record review and facility policy review, it was determined the facility failed to review and revise a Comprehensive Care Plan for one (1) of eighteen (18) sampled residents (Resident #43). Observation of a skin assessment for Resident #43 on 01/09/19 revealed the resident was on pressure reducing mattress; however, review of the Comprehensive Care Plan revealed Resident #43 had a Low Air Loss(LAL) mattress in place. The care plan had not been revised when the Low Air Loss Mattress was discontinued. The findings include: Review of facility policy titled,Resident Assessment Care Plan Development, dated 11/28/17 revealed the intent is to ensure the timeliness of each person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident's representative, if applicable, is involved in developing the care plan and making decision about his/her care. Record review revealed the facility admitted Resident #43 on 11/17/15 with diagnoses which included Traumatic Subarachnoid Hemorrhage with loss of consciousness of unspecified duration, and sequela related to trauma from a Motor Vehicle Accident (MVA). Review of the Annual Minimum Data Set (MDS) assessment, dated 10/30/18 revealed the facility assessed Resident #43's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was not interviewable. Observation of Resident #43's skin assessment and treatment on 01/09/19 at 9:00 AM by Licensed Practical Nurse (LPN) #2, revealed Resident #43 was on a pressure reducing mattress, there was a healed pressure ulcer on right buttock, and a Stage II pressure ulcer to the left hip. However, review of the Comprehensive Care Plan for at risk for pain related to Diabetes, immobility, history from trauma from Motor Vehicle Accident (MVA), and resident has a history of pressure injury and remains at risk for reacquiring due to immobility and incontinence, dated 11/30/15, revealed the care plan had not been revised to include the pressure ulcer on the right hip was healed, a Stage II pressure ulcer had developed on the left hip, and the LAL mattress was discontinued. Interview with LPN #2 on 01/09/19 at 10:00 AM revealed she was not aware of the new open area to the left buttock or the right buttock pressure ulcer had healed. She stated she was aware the LAL mattress was no longer in place. Interview with the Minimum Data Set (MDS) Nurse, who is responsible for updating the care plan, on 01/11/19 at 3:24 PM, revealed she, at the time of the changes, was not reviewing Physician Orders every day and realized things were getting missed. She stated now all orders were reviewed at the morning meeting and care plans were updated daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 01/11/19 at 3:35 PM revealed she expected all orders to be reviewed daily and care plans updated on a daily basis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38981 Based on interview, record review and review of facility policy, it was determined the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice to prevent hospitalization for one (1) of eighteen (18) sampled residents (Resident #35). Record review revealed Resident #35 had a decline in intake, episodes of vomiting from 10/14/18-10/16/18, and constipation. The Advanced Practice Nurse Practitioner (APRN) saw Resident #35 on 10/16/18 and ordered a stool softener for constipation and an antiemetic for nausea and vomiting. On 10/17/18 at 4:14 PM, the resident had symptoms of temperature of a 103.3 degrees Fahrenheit, heart rate 120 (base line 65), blood pressure 102/48 (base line 128/68) and was grinding his/her teeth at times. The Physician Assistant and APRN were contacted with orders received for labs and Tylenol. However ,further record review revealed there was no evidence a complete nursing assessment was completed per facility policy when the resident's change in condition was first identified on 10/16/18 and no evidence ongoing assessments were completed per policy due to the resident's continued refusal of meals, vomiting, and lack of bowel movements. The resident was hospitalized [DATE] to 10/22/18 with diagnoses of Sepsis, Acute Renal Failure Syndrome, Abdominal Pain and Fecal Impaction. The findings included: Review of the facility policy titled, Standard of Nursing Practice, last revised May 2018, revealed residents having any change in condition will have a complete nursing assessment performed and documented. A complete nursing assessment may include but is not limited to: vital signs with temperature, bowel sounds, lung sounds, oxygen saturation level, skin appearance, mental status, review of meal intakes over a twenty-four hour period, and review of bowel elimination record over the last three (3) days. On-going monitoring may be required to identify the resident's response to clinical interventions and if resolution is achieved. The resident's response will determine the frequency of the assessment. Reasons to assess the resident's condition more frequently include vomiting and/or diarrhea, new onset or increased complaints of pain, increased confusion. Monitoring a change in condition requires the nurse to include an entry in the progress notes. Communication to the physician will require completion of a SBAR (Situation, Background, Assessment, Recommendation) tool. Monitoring a resident's condition may have multiple entries in the resident's medical record and include progress notes, observations, and assessment tools. Record review revealed the facility admitted Resident #35 on 03/09/18 with diagnoses which included Cerebral Palsy, unspecified; and Other Seizures. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/07/19, revealed the facility assessed Resident #35's cognition as severely impaired as the resident was unable to complete a Brief Interview of Mental Status (BIMS) exam indicating the resident was not interviewable. Further review of the Quarterly MDS revealed Resident #35 required total care with all activities of daily living (ADL's); and the resident was incontinent of bowel and bladder. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Intake and Output Record for October, 2018, revealed Resident #35 started having a decreased intake of food and fluid on 10/14/18. On 10/14/18 and 10/15/18, the resident refused breakfast (prior average intake 40%), only had bites for lunch (prior average intake 50%), and only ate twenty-five (25) percent for supper (prior average intake 35%), each day. The resident drank 120 milliliters (mL) of fluid for each of the six (6) meals on these two (2) days (average prior fluid intake was 240 mL each meal). On 10/16/18, the resident ate fifty (50) percent of breakfast, and twenty-five (25) percent for lunch and supper; and, drank 120 ml fluid with each meal. Further review of the Intake and Output Record revealed the resident had one (1) small bowel movement on 10/14/18, none on 10/15/18 and one (1) small on 10/16/18. Review of the Nursing Progress Notes dated 10/14/18-10/16/18 revealed there was no documented evidence the resident was assessed related to having any decline in his/her food and fluid intake, being constipated, or having nausea/vomiting peer facility policy. However, further review of the Nurse's Progress Notes revealed on 10/16/18 at 10:57 AM, the APRN assessed Resident #35 and ordered Colace (stool softener) two times a day for constipation and Zofran (antiemetic) 4 milligrams (mg) every four (4) hours as needed for nausea and vomiting. In addition, there was no evidence a SBAR was completed per facility policy to ensure the Nurse Practitioner had all the information of an assessment. Review of the APRN's Progress Note dated 10/16/18 revealed nursing staff stated Resident #35 had only two (2) bowel movements in the last fourteen (14) days and was also having some issues with occasional vomiting. On physical exam, the APRN assessed the resident to have pale, warm and dry skin; bowel sounds present, abdomen was soft, round and nontender. Orders were given for Docusate Sodium ten (10) mL orally two (2) times per day and Zofran ODT four (4) mg every six (6) hours as needed. Interview with Registered Nurse (RN) #4 on 01/23/19 at 6:33 PM, revealed she worked on 10/15/18, day shift. RN #4 did not recall why the Docusate was increased or why Zofran was ordered on 10/16/18. The RN stated she thought the resident had a history of constipation. Additionally, the RN could not recall if anyone had alerted her of the resident's decreased food and fluid intake. Interview (Post Survey) with RN #2 on 01/24/19 at 9:03 AM, revealed she documented the APRN's visit on 10/16/18 at 10:57 AM. She stated she did not recall the reason for the increase in Docusate or the new order for Zofran. RN #2 further stated if the Docusate was increased, the resident was probably having problems with constipation. The RN did not recall if the resident was having nausea or vomiting at that time. Further review of the Intake and Output Record for October, 2018 revealed on 10/17/18 the resident refused food and fluid for both breakfast and lunch and ate fifty percent of supper on 10/17/18. His/her fluid continued to decline with daily, twenty-four (24) hour, fluid intake total of 420 mL (normal fluid intake averaged one-thousand [1000] mL per day or more). In addition, the resident had one (1) medium bowel movement on 10/17/18. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Notes dated 10/17/18 at 3:21 AM revealed Resident #35 was tolerating the increase in Docusate without adverse effects and the resident did not request Zofran this shift. Further review revealed there was no documented evidence the resident was assessed again due to the resident refusal of both breakfast and lunch, and decline in fluid intake per facility policy. On 10/17/18 at 4:14 PM (approximately thirteen (13) hours after last assessment), the nurse was alerted the resident wasn't acting right and the resident's vital signs were blood pressure: 102/48 (base line 128/68), temperature: 103.3 degrees Fahrenheit, heart rate: 120 (base line 65), with resident awake and alert, and grinding teeth at times. Registered Nurse (RN) #1 attempted to contact the APRN two (2) times and text her as well with no response. RN #1 telephoned the Physician's Assistant (PA) and received orders for Tylenol 650 mg suppository to be given then and every six (6) hours as needed for elevated temperature and a UA per in and out catheterization. Tylenol was given at that time. Further review of the Nursing Notes revealed on 10/17/18 at 4:46 PM, the APRN returned telephone calls with orders for a CBC, CMP, and to check bowel sounds. Temperature at that time was 102.3 degrees Fahrenheit and bowel sounds were positive in all four (4) abdominal quadrants. Review of the Nurse's Progress Notes revealed Resident #35 had emesis of greenish fluid, did not eat any breakfast or drink any fluid, and would not take his/her morning medications with food or fluid on 10/18/18 at 8:09 AM, and was given an enema at 9:12 AM with only small results. At 9:44 AM, the resident had emesis of green fluid again. Further review of the Intake and Output Record for October, 2018 revealed on 10/18/18 the resident refused food and fluid for lunch. Further review of the Nursing Notes revealed there was no documentation of the resident's condition or of ongoing assessments per facility policy from 10/18/18 at 9:44 AM to 2:37 PM. On 10/18/18 at 2:37 PM vital signs were: blood pressure 92/42, heart rate 109, respirations 22 and temperature 99.8 degrees Fahrenheit Review of the facility's Observation Detail List Report (Situation, Background, Assessment, Recommendation, SBAR) completed on 10/18/18 at 5:10 PM by RN #1 revealed the ARPN was notified on 10/18/18 at 4:30 PM regarding Resident #35's condition. The report revealed the resident's symptoms started on 10/17/18 and it was reported to the ARPN the resident had vomited green bile three (3) times over two (2) days; the resident had not been acting right in general; the resident was not eating or drinking; and, was having fever and had been given Tylenol Suppositories two (2) times. Vital signs were blood pressure 94/68; heart rate 109; respirations 18; and temperature 99.3 degrees Fahrenheit. The SBAR indicated there were no gastrointestinal/abdomen or gastrourinary changes and revealed the resident was not having pain. The APRN gave an order to let the family decide if they wanted the resident sent to the ER. Review of the Nurse's Notes, revealed RN #1 spoke to Resident #35's brother on 10/18/18 at 5:52 PM and at 6:27 PM, Resident #35 was in stable condition and was transported to the hospital ER in a private vehicle by his/her brother. Review of the Hospital Labs obtained at the hospital dated 10/18/18 revealed Resident #35's Blood Urea Nitrogen (BUN) was 38 (7-25); Creatinine 2.9 (0.6-1.2); and [NAME] Blood Cells (WBC) 33.9 (4.0-10.0); and review of the UA results revealed the urine was dark yellow, cloudy with moderate amount of blood, with 3+ Bacteria (normal is none). Review of the Hospital Discharge Summary revealed Resident #35 was admitted to the hospital on 10/18/18 at 9:00 PM with diagnoses of Urosepsis, Acute Renal Failure Syndrome, Abdominal Pain, and Fecal Impaction. Review of the Discharge Physician's Note revealed, on admission, the resident was also hemoconcentrated initially and with hydration, labs improved. After treatment, the resident was discharged from the hospital on 10/22/18. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Springlake Health & Rehabilitation Center	509 North Hayden Avenue Salem, KY 42078

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with RN #1 on 01/11/18 at 2:22 PM and on 01/23/19 at 11:41 AM (Post Survey) revealed she worked day shift on 10/17/18 and 10/18/18. RN #1 stated Resident #35 was one to get constipated very easily, but she was not sure exactly the circumstances surrounding the increase in the Colace or the Zofran because she had only recently started working at the facility. RN #1 revealed she could not recall if the resident was having bowel movements at the time she administered the enema on 10/18/18 at 9:12 AM. Additionally, RN #1 stated she was not made aware of the resident being constipated or that the resident had decreased food and fluid intake. RN #1 stated she had not been monitoring the Intake and Output sheets as she did not know where they were located and no one had told her she needed to do so. Interview (Post survey) with RN #3 on 01/24/18 at 8:07 AM, revealed she worked 10/16/18 through 10/18/18, night shift. RN #3 stated she does not recall why the Docusate was increased nor did she have to give Resident #35 Zofran for nausea or vomiting. RN #3 further stated she could not recall if anyone alerted her to the resident's decreased food and fluid intake, however, she monitored the Intake and Output sheets as often as she could. Additionally, RN #3 stated a small bowel movement was normal for the resident. Interview with the Physician's Assistant (PA) on 1/11/19 at 2:08 PM revealed a reasonable time to obtain a straight cath UA would have been two (2) to four (4) hours. Interview with the APRN on 01/11/19 at 2:41 PM revealed she would have expected the UA and the results to be called back her within three (3) to four (4) hours after the UA was ordered, and if the UA could not be obtained, she would have expected the facility to notify her. The APRN further stated if the UA had been obtained quicker with the results called to her, she would have ordered intravenous fluids and antibiotics and possibly avoided hospitalization . She revealed she always tries to treat the residents at the facility first before sending out. Further interview (Post Survey) with the APRN on 01/25/19 at 9:33 AM revealed she knew Resident #35 had been having some vomiting because she ordered Zofran on 10/16/18, however, she was not aware the resident had vomited two (2) times on 10/18/18 (8:09 AM and 9:44 AM). The APRN further stated she was aware the resident had not been eating well, however, she was not made aware of how poor the resident's food and fluid intake had been. Additionally, the APRN stated had she been made aware of the severity of the resident's illness (vomiting, poor food and fluid intake, and low blood pressure) she would have initiated intravenous fluids or sent the resident to the ER sooner. The APRN further stated had she been contacted by the facility, it probably would have made a difference in the severity of the resident's illness and the outcome as well. Interview with the Director of Nursing (DON) on 01/11/19 at 11:33 AM and on 01/24/19 (Post Survey) at 8:52 AM revealed Resident #35 was having, what staff thought was, regular bowel movements, but after talking with the family, discovered the resident normally had extra large bowel movements. The DON stated RN #1 completed a full assessment of Resident #35 on 10/17/18 at 4:14 PM when the change occurred. The DON stated that RN #1 documented an assessment in the progress notes and notified the physician but failed to complete a SBAR per policy. The DON stated the expectation would have been for RN #1 to complete a SBAR per policy. Additionally, the DON stated that a full assessment was completed on 10/18/18 at 4:30 PM and a SBAR was completed but not documented in the nurse's notes. She would have expected the assessment to be documented in the nurse's progress notes as well as on the SBAR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36603 Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure two (2) of eighteen (18) sampled residents received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing (Residents #22 and #43). Resident #22 was to be turned and repositioned from side to side and heels floated; however, observations on 01/09/19 throughout the day revealed staff failed to turn and reposition the resident and float heels per care plan as the resident remained on his/her left side and heels were not floated from 8:30 AM through 3:45 PM. Further observation on 01/09/19 revealed staff failed to change gloves and wash hands after removing a soiled dressing from Resident #22's pressure ulcer and before applying a new dressing per facility policy. In addition, the facility failed to ensure Resident #43 was assessed when a new Pressure Ulcer was identified to his/her left hip, and failed to obtain treatment orders for the pressure ulcer per facility policy. Staff also continued to initial a Low Air Loss (LAL) mattress was in place after it was discontinued. The findings include: 1. Record review revealed the facility admitted Resident #22 on 10/09/16 with diagnoses which included Diabetes Mellitus, Altered Mental Status, a history of pressure wounds, and Rheumatoid Arthritis. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 11/09/18 revealed the facility assessed Resident #22's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Further review of the MDS revealed the resident required total assist of two (2) with bed mobility. Review of Resident #22's Comprehensive Care Plan for potential for skin breakdown related to decreased mobility, Diabetes, Vascular Disease, and incontinence, dated 08/16/16 revealed interventions, dated 07/20/18, to float heels while in bed and encourage to turn and reposition upon rounds while in bed. Review of a Weekly Pressure Ulcer Progress Report for Resident #22 revealed a pressure wound was identified to the coccyx on 09/11/18 with treatment in place to clean the wound with Normal Saline (NS), apply collagen and cover with a dry dressing. Further review of the report revealed the wound was still open on 01/02/19. Observations on 01/09/19 at 8:30 AM, 10:09 AM, 11:33 AM, 12:07 PM, 3:00 PM, 3:35 PM, and 3:45 PM revealed Resident #22 was lying on his/her left side with no evidence the resident was turned every two (2) hours; and, his/her heels were not floated throughout the observations. In addition, observation on 01/10/19 at 8:24 AM revealed Resident #22 being assisted with breakfast with heels noted to be flat on the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nurse Aide (CNA) #6 on 01/09/19 at 4:30 PM revealed Resident #22 should be turned every two (2) hours from side to side. She stated she turned the resident at 4:15 PM but she did not check to see if his/her heels were off the bed, and was not sure the last time the resident was turned and repositioned. Interview with CNA #2 on 01/10/19, revealed Resident #22 should be turned from side to side every two (2) hours and feet floated. She stated the resident should only be on his/her back at meal time because of a wound to his/her bottom, but she had failed to ensure his/her heels were floating. In addition, observation of wound care for Resident #22 on 01/10/19 at 3:21 PM revealed Licensed Practical Nurse (LPN) #2 washed her hands, applied gloves, then removed the old soiled dressing. However, LPN #2 failed to wash her hands and change gloves before applying the clean dressing to the coccyx wound. Interview with LPN #2 on 01/11/19 at 02:57 PM revealed she really did not remember if she washed her hands or changed gloves after removing the soiled dressing or not, but knew she should have. Interview with the Director of Nursing (DON) on 01/11/19 at 5:38 PM revealed she expected staff to turn Resident #22 every two (2) hours due to a pressure wound to the coccyx, and to float heels per care plan. She stated she also expected staff when doing a dressing change, to wash hands and change gloves after removing dirty dressing and before applying clean dressing. 2. Record review revealed the facility admitted Resident #43 on 11/17/15 with diagnoses which included Traumatic Subarachnoid Hemorrhage with loss of consciousness of unspecified duration, and sequela related to trauma from a Motor Vehicle Accident (MVA). Review of the Annual MDS assessment, dated 10/30/18 revealed the facility assessed Resident #43's cognition as severely impaired with a BIMS score of 99 which indicated the resident was not interviewable. Further review of the MDS revealed the resident was totally dependent on two (2) staff for bed mobility. Review of Resident #43's Comprehensive Care Plan for at risk for pain related to Diabetes, immobility, history from trauma from Motor Vehicle Accident (MVA), and resident has a history of pressure injury and remains at risk for reacquiring due to immobility and incontinence, dated 11/30/15, revealed an intervention for a LAL mattress for wound healing. Further review of care plan revealed an open area to right buttock, dated 12/11/18. Review of Resident #43's Treatments Flowsheet dated January 2019 revealed an order for LAL mattress for wound healing, start date 06/29/17. Further review revealed licensed staff were initialing the LAL mattress was in place daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #43's skin assessment and treatment by LPN #2 with assistance from CNA #1, and Treatment Nurse/Registered Nurse (RN) #2, on 01/09/19 at 9:00 AM revealed Resident #43 was not on a LAL mattress per care plan but was on a pressure relief mattress. Further observation revealed the pressure ulcer on the right buttock had healed but there was a dirty patch dressing on the left hip that was not dated or initialed. The new area under the dressing was described by staff to be a Stage II pressure ulcer which measured 1.5 centimeters (cm) x 1.5 cm X 0.1 cm, with a beefy red center; and peri-wound macerated related to frequent incontinence. At the time of the assessment, both nurses were not aware of the healed right buttock wound or the new wound to the left buttock. Further review of the January 2019 Physician Orders, Treatment Flowsheet and Comprehensive Care Plan revealed no documented evidence an order had been obtained for the pressure ulcer on the left buttock, even though there was a dressing in place; and no evidence the pressure ulcer to the right buttock was healed. Interview with LPN #2 on 01/09/19 at 10:00 AM revealed she was not aware of the new open area to the left buttock. She stated she was aware the LAL mattress was no longer in place but continued to sign the treatment record and realized she should have initialed and circled her initials indicating not in use. Interview with the Director of Nursing (DON) on 01/11/19 at 3:35 PM revealed she was trying to track down the nurse who applied a treatment to the left buttock without order or documentation of the wound. She stated she expected all orders to be reviewed daily and care plans updated on a daily basis.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38981 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for two (2) of eighteen (18) sampled residents (Resident #44 and #35). On 10/17/18 at 4:37 PM the Physician's Assistant was contacted regarding Resident #35's change in condition. An order for a Urinalysis (UA) via in and out catheterization was obtained. However, a urine specimen was not obtained for over twenty-four (24) hours. On 10/18/18, the resident was hospitalized with diagnoses which included Urosepsis and Acute Renal Failure Syndrome. In addition, observation of incontinent care on 01/10/19 for Resident #44 revealed the Certified Nurse Aide (CNA) failed to wash the buttocks and rectal area and, also, did not change gloves or wash her hands when going from a dirty to clean area. The findings include: Review of the facility policy titled Standard of Nursing Practice, last revised May 2018, revealed the licensed nurse that receives an order and notes the order is responsible to carry the order through by placing in the achieve Matrix, on the [Medication Administration Record or Treatment Administration Record] MAR or TAR, and communicating order specifics to appropriate departments. Review of the facility policy titled Laboratory Test, dated 06/2008, revealed the licensed nurse receiving the order for any laboratory test will document the order on the appropriate Physician's order form, transcribe the order onto the the tracking log, include the type of laboratory test to be done; the licensed nurse working night shift will review the log for all labs to be done; once the lab is completed, the licensed nurse on duty will enter the date the lab was obtained onto the tracking log. The licensed nurse receiving the lab results will complete the tracking form by entering the date the lab result was received and physician notification. Record review revealed the facility admitted Resident #35 on 03/09/18 with diagnoses which included Cerebral Palsy, unspecified; and Other Seizures. Review of the Quarterly Minimum Data Set, dated dated [DATE], revealed the facility assessed Resident #35's cognition as severely impaired as the resident was unable to complete a Brief Interview of Mental Status (BIMS) exam indicating the resident was not interviewable. Further review of the Quarterly MDS revealed Resident #35 required total care with all activities of daily living (ADL's); and the resident was incontinent of bowel and bladder. Review of the Nurse's Progress Notes dated 10/17/18 at 4:14 PM revealed Registered Nurse (RN) #1 was alerted Resident #35 wasn't acting right. Vital signs were, blood pressure 102/48 (base line 128/68), temperature 103.3 degrees Fahrenheit, heart rate 120 (base line 65), resident awake and alert, grinding teeth at times. At 4:46 PM, RN #1 telephoned the Physician's Assistant (PA) (who was back-up call for the Advanced Practice Registered Nurse {APRN}) and received orders for Tylenol 650 mg suppository to be given then and every six (6) hours as needed for elevated temperature; and a UA per in and out catheterization. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Lab Tracking Form dated 10/18/18 revealed an entry for Resident #35 with ordered tests of CBC and CMP, and was collected at 2:02 AM; however, there was no entry for the UA order or collection per facility policy. Further review of the Nurse's Progress Notes revealed an in and out catheterization (cath) was not attempted until 10/17/18 at 9:00 PM by RN #3 , almost five (5) hours after the order was received. The attempt was unsuccessfully due to only a scant amount of urine obtained. Further review revealed there were two (2) other entries made in the Nurse's Progress Notes, on 10/17/18 at 6:26 PM and on 10/18/18 at 9:44 AM by RN #1 revealing the resident had incontinent episodes and staff were unable to obtain a urine specimen. However, there was no documented evidence staff attempted to conduct an in and out cath from 10/17/18 at 9:00 PM until 10/18/18 at 6:27 PM, after the order was obtained and prior to going to the hospital. Review of the facility's Observation Detail List Report (Situation, Background, Assessment, Recommendation, SBAR) completed on 10/18/18 at 5:10 PM by RN #1 revealed the resident's symptoms started on 10/17/18 and it was reported to the ARPN the resident had vomited green bile three (3) times over two (2) days; the resident had not been acting right in general; the resident was not eating or drinking; and, was having fever and had been given Tylenol Suppositories two (2) times. Vital signs were blood pressure 94/68; heart rate 109; respirations 18; and temperature 99.3 degrees Fahrenheit. The APRN gave an order to let the family decide if they wanted the resident sent to the ER. Review of the Nurse's Notes, revealed RN #1 spoke to Resident #35's brother on 10/18/18 at 5:52 PM and at 6:27 PM, Resident #35 was in stable condition and was transported to the hospital ER in a private vehicle by his/her brother. Review of the Hospital laboratory results dated [DATE] for a Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP) and a Urinalysis (UA) revealed the resident's BUN was 38 (7-25); Creatinine was 2.9 (0.6-1.2); WBC was 33.9 (4.0-10.0); and the UA results indicated the urine was dark yellow, cloudy with moderate amount of blood, with 3+ Bacteria (normal is None). Review of the Hospital Discharge Summary revealed Resident #35 was admitted to the hospital on 10/18/18 at 9:00 PM with diagnoses of Urosepsis, Acute Renal Failure Syndrome, Abdominal Pain, and Fecal Impaction. After treatment, the resident was discharged from the hospital back to the nursing home on 10/22/18. Interview (Post Survey) with RN #3 on 01/24/18 at 8:07 AM, revealed she worked 10/16/18 through 10/18/18, night shift. The RN stated she attempted to obtain a urine specimen on 10/17/18 at 9:00 PM, but was unsuccessful because the resident was always incontinent of urine and there was no urine in the bladder. The RN stated she did not make another attempt to obtain the specimen. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview with RN #1 on 01/11/18 at 2:22 PM and on 01/23/19 at 11:41 AM (Post Survey) revealed she was not aware of the lab process according to policy, and could only report what she had done when she received the order for the UA. RN #1 stated when she received orders, I can hope that I get to it and if not, I pass it to the next shift. RN #1 stated she received the order for the UA on 10/17/18 at 4:46 PM, but did not attempt to obtain the UA that day and reported the need to get the UA to the oncoming RN (RN #3). RN #1 further stated she did not know why she did not obtain the specimen at that time. RN #1 revealed on 10/18/18 she attempted to get the UA but was unsuccessful and when she removed the catheter, there was a mucous plug on end of of the catheter, so she completed the SBAR and called the APRN. She revealed she contacted Resident #35's brother per the APRN's directive. RN #1 stated she did not make another attempt to obtain a specimen before the resident went to theER on [DATE] at 6:27 PM. Interview with the Physician's Assistant (PA) on 1/11/19 at 2:08 PM revealed a reasonable time to obtain a straight cath UA would have been two (2) to four (4) hours. Interview with the APRN on 01/11/19 at 2:41 PM revealed she would have expected the UA and the results to be called back her within three (3) to four (4) hours after the UA was ordered, and if the UA could not be obtained, she would have expected the facility to notify her. The APRN further stated if the UA had been obtained quicker with the results called to her, she would have ordered intravenous fluids and antibiotics and possibly avoided hospitalization . She stated she always tries to treat the residents at the facility first before sending out. Interview with the Director of Nursing (DON) on 01/11/19 at 11:33 AM revealed she expected staff to obtain a straight cath UA in a timely manner and to keep the APRN or doctor informed if they were unable to obtain the specimen. The DON further stated the APRN should have been notified that they were unable to obtain the specimen. 2. Review of the facility Certified Nurse Aide (CNA) form titled Perineal Male Care Competency, not dated, revealed: 9. Expose perineum only. 10. Retract foreskin if resident uncircumcised, grasp penis, cleaning tip, using circular motion, using water and soapy washcloth. Starting at meatus of the urethra and working outward. 11. Rinse the area with another washcloth, using the same circular motion. 12. Return foreskin to its natural position immediately after rinsing. 13. Clean shaft of penis. Rinse and dry the area. 14. Assist the resident to flex knees and spread legs as much as possible. Clean the scrotum. Rinse well pat dry. 15. Assist resident to turn side to side, away from the CNA. 16. With a new soapy washcloth, clean rectal area. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	17. Using washcloth clean from scrotum to rectal area in a single stroke, using clean area of washcloth with each stroke. Record review revealed the facility admitted Resident #4 on 01/03/18 with diagnoses which included Unspecified Sequelea of Cerebral Infarction, Vascular Dementia with behavioral disturbance, Hemiplegia and Hemiparesis. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/15/18 revealed the facility assessed the resident was unable to complete a Brief Interview for Mental Status (BIMS) which indicated the resident's cognition was severely impaired and he/she was not interviewable. Further review of the MDS revealed the resident required extensive assist of two (2) for toileting and extensive assist of one (1) with hygiene. Observation on 01/10/19 at 4:40 PM revealed CNA #2 performed peri care and she was accompanied by the Unit Manager and Registered Nurse (RN) #2. Further observation revealed each of the staff washed their hands, applied gloves, and CNA #2 cleaned the peri area per protocol and policy, but failed to wash the buttocks and rectal area. In addition, observation revealed when cleaning of the peri area was completed, CNA #2 did not wash her hands or change gloves but continued with applying the resident's brief, clothing, and assisted him/her out of bed without ever washing her hands or changing gloves. Interview with CNA #2 on 01/11/19 at 5:41 PM revealed she realized after finishing, she failed to wash the rectal area, and also she knew to always wash her hands and change her gloves after completing the cleaning procedure but just forgot. Interview with the Unit Manager on 01/11/19 at 5:45 PM revealed the CNA said she should have cleaned the buttocks area, washed hands and changed gloves when going from dirty to clean. Interview with the DON, on 01/11/19 at 5:50 PM revealed she expected the nursing staff to follow policy and CNA competency check off list while providing incontinent care, and to wash the buttocks as well as the peri area. She stated staff should wash hands and change gloves after providing incontinent care, and before applying a clean brief, clothing, and bed linen. 36603

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Salem Springlake Health & Rehabilitation Center	509 North Hayden Avenue Salem, KY 42078

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38981 Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure there was sufficient nursing staff to provide transfers timely and provide basic care needs and showers for three (3) of eighteen (18) sampled residents (Residents #4, #10, and #202). The findings include: Review of the facility policy titled Nursing Coverage, not dated, revealed it is the policy of this facility to ensure that the residents receive the appropriate and needed care and services at all times and that all nursing personnel are available to meet this need. The licensed practical nurses (LPN's) and registered nurses (RN's) are expected to provide direct care to our residents as the resident's need presents or at least four (4) hours per shift. This direct care includes but is not limited to transporting the resident to the bathroom, helping the resident meet their toileting needs, cleaning the resident; and providing activities of daily living (ADL) care to the resident. The facility nursing management team including the assistant director of nursing (ADON), unit manager, and minimum data set (MDS) nurses are expected to provide and help with direct care as needed. The facility nursing managers that are RN's are expected and required to provide supervisory roles and would be included in the required RN staffing hours. At least six (6) hours of their shift must be dedicated to assessment of the resident, developing critical decisions in regards to the resident care, supervising the LPN's and the nurse aides, and ensuring that the residents' plan of care is appropriate to meet the residents' needs as well as being carried out by the nursing staff. 1. Record review revealed the facility admitted Resident #4 on 08/09/17 with diagnoses which included Amyotrophic lateral sclerosis, abnormal posture, other ideopathic scoliosis, muscular dystrophy, and quadriplegia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/10/18, revealed the facility assessed Resident #4's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident's was interviewable. Additionally, the Quarterly MDS revealed the resident required total care with one (1) to two (2) staff assists with all ADL's, specifically transfers with assistance of two (2) staff using a mechanical lift; and resident had functional limitations in range of motion to bilateral upper and lower extremities. Interview with Resident #4 on 01/09/19 at 8:30 AM, revealed the facility had been having staffing problems for about three (3) months. The resident stated on one occasion, he/she asked to get up at approximately 7:30 AM but was not able to get up until approximately 12:30 PM. Additionally, the resident stated there are times when he/she would like to get up to go to the dining room for lunch but is not assisted up. The resident stated he/she has been told by staff because it takes two (2) staff to get him up, his care impedes on the care of other residents and he/she will be assisted up when all the other work is done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Nurse Assistant (NA) #4 on 01/10/19 at 4:46 PM revealed she was working on the day Resident #4 requested to get up at 7:30 AM. NA #4 stated there were two (2) Certified Nurse Assistants (CNA's) and herself working that day. She stated she was assigned to Resident #4's side, another CNA was assigned to the other side, and a CNA floated between both sides (there were approximately twenty-five to thirty {25 to 30} residents on each side). NA #4 revealed Resident #4 required a mechanical lift and assistance of two (2) staff for transfers. The NA stated she asked the other CNA's to assist her but they were busy and could not help her with the transfer until approximately 12:30 PM. 2. Record review revealed the facility admitted Resident #202 on 12/21/18 with diagnoses which included other specified fracture of unspecified pubic, sequela; Unsteadiness on feet; other abnormalities of gait and mobility; and fracture of superior rim of unspecified pubis, sequela. Review of the Admission MDS assessment, dated 01/01/19, revealed the facility assessed Resident #202's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Additionally, the Admission MDS assessment revealed the resident required extensive assistance of one (1) staff for bathing, and required human assistance to stabilize when turning to face the other direction. Review of the Intake & Output record for January, 2019, revealed between 01/01/19 and 01/11/19, Resident #202 received showers on 01/01/19, 01/08/19, and 01/15/19, three (3) showers in eleven (11) days. Interview with Resident #202 on 01/08/19 at 3:02 PM revealed this place is understaffed and he/she cannot get a shower according to her preference. He/she stated sometimes when the staff come to assist him/her with a shower, he/she was in too much pain to get it at that time. He/she revealed the staff would never come back to assist him/her later; and if he/she asked for assistance later was told by the staff they did not have time to provide assistance. Interview with Certified Nurse Aide (CNA) #1 on 01/11/19 at 9:22 AM revealed if a resident declines a shower, the nurse is notified. The CNA stated it is documented that the shower was declined at that time and passed on to the next shift; and sometimes they go back later and reoffer the shower but there is not always time to do that. 3. Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses to include Heart Failure, Diabetes, and Hemiplegia. Review of the Quarterly MDS dated [DATE] assessed the resident to have a BIMS score of eight (8) and determined to be interviewable. The MDS further revealed he/she required total assist of one (1) with hygiene and bathing. Interview with Resident #10's daughter on 01/10/19 at 2:45 PM revealed she had to complain constantly about her family member not getting a shower. She stated on Monday, her family member had laid two (2) hours in a dirty brief without getting changed. She revealed she felt a lot of resident's weren't getting their showers. She stated the facility frequently smelled of urine and feces, and she noted a resident urinated in the floor at one time and told the nurse who stated she knew, and was waiting on someone to clean it up. She further revealed her family member had told her about the showers and incontinent episode, and knew what he/she was talking about. Review of Resident #10's December 2018-January 2019 shower sheet revealed he/she only received six (6) showers/bedbaths between 12/26/18 and 01/10/19. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA #6 and CNA #2 on 01/10/19 at 4:15 PM revealed there was not enough staff to get the job done. They stated on an average there is two (2) CNA's on each side with one nurse, and probable about one (1) day a week, only one (1) CNA per side and one (1) Nurse. The interview further revealed some of the nurses help out, others do not. They stated they are only able to get the essential care provided and have to leave the rest. They also revealed the facility had now changed the shower schedules to two (2) showers a week verses three (3) a week due to not enough staff. They stated if residents request a bed bath on the other days, they will receive one, if not they do not get one unless heavily wet or soiled. Interview with NA #4 on 01/08/19 at 4:35 PM, during afternoon meal pass observation revealed there is not enough staff in the facility. She stated she was passing trays by herself because the other scheduled CNA was in the Dinning Room. She further revealed she is expected to pass all three (3) halls 400, 500 and 600, and feed the dependent residents in one and one-half (1.5) hours by herself. She also stated last Friday 01/04/19 she was the only one to work the shift. She stated she had worked six (6), twelve (12) hour shifts in a row because of lack of staff. Interview with CNA #5 on 01/09/19 at 10:45 AM revealed there are usually three (3) CNA's scheduled on each side (unit). CNA #5 stated if someone called in, administration would try to call in staff, but if no one would come in, they work short. Interview with CNA #7 on 01/09/19 at 10:35 AM revealed staffing is short once in a while. CNA #7 stated she usually works up front but was working the floor on this day because the facility was short staffed. CNA #7 further stated she does not get pulled to the floor very often. Interview with Registered Nurse (RN) #4 on 01/09/19 at 10:30 AM revealed CNA's are short today, there are two (2) CNA's for side one (1). RN #4 stated they try to have three (3) CNA's per side each day. She further stated adequate staffing is hit and miss. Interview with RN #3 on 01/10/19 at 2:18 PM revealed staffing is not well, CNA's call in all the time. RN #3 stated there are usually two (2) CNA's scheduled for each side (unit) but at least one (1) CNA calls in every day. RN #3 revealed when this happens, there is one (1) CNA on each side and one (1) floats between the two (2) sides. RN #3 further stated this is not enough staff to meet the care needs of the residents; the most important care gets done such as rounds, incontinent care, turns, and fall prevention but baths do not always get done. She stated she tried to get the medications passed in a timely manner, but at times, they are late because she helps the CNA's. RN #3 stated the facility is short staffed about fifty (50) percent of the time, mainly due to call ins. Additionally, RN #3 stated she has talked to the Director of Nursing (DON) about the problem, but it continues and staff just try to provide care the best they can. Interview (Post Survey) with RN #2 on 02/23/10 at 2:37 PM, revealed she is the unit manager for both sides, the entire facility, and the Director of Nursing (DON) completes the daily schedule, however, the DON was not working on the day of the interview. RN #2 stated there is no one with the title staffing coordinator. RN #2 stated the usual staffing for day shift was five (5) certified nurse assistants (CNA's), two (2) nurses, and she and the DON are there during the week. Staffing for night shift was four (4) CNA's and two (2) nurses. RN #2 further stated sometimes it was difficult to replace a person should they call in and she was not aware of any shift working short staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 01/11/19 at 5:30 PM revealed she is not aware of complaints or concerns related to staffing. The DON stated staff call in and we get the shift covered. She stated she feels there is adequate staffing based on the numbers. The DON further stated she expected all staff to come to her or other licensed staff if they cannot get assistance with a resident in a timely manner. Additionally, the DON stated she rarely had to come in on off shifts or weekends to cover a shift. The DON stated there should be two (2) CNA's on each side and one (1) CNA to float sides and one (1) licensed nurse on each side. Interview with the Administrator on 01/11/19 at 4:23 PM, when told about staffing concerns stated well good, now maybe cooperate will let us get some more staff in here. 36603

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35748 Based on observation, interview, and review of the facility policy and procedure, it was determined the facility failed to ensure drugs used in the facility are labeled in accordance with currently accepted professional principles. Observation on 01/09/19 of two (2) of four (4) medication carts revealed a medication not dated when opened on the Six Hundred (600) medication cart. The findings include: Review of the facility policy titled, Storage and Expiration of Medications, Biological's, Syringes, and Needles, last revised 10/31/16, revealed once any medication or biological is opened, the facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Observation of the 600 hall medication cart, on 01/09/19 at 11:05 AM, revealed one (1) vial of Humalog insulin was opened, however, it was not dated per facility policy. Interview with Licensed Practical Nurse (LPN) #1 on 01/09/19 at 11:06 AM, revealed the insulin vials should be dated when opened because most insulin's expire after twenty-eight (28) days once opened. She stated it must have been overlooked. Interview with the Director of Nursing (DON) on 01/11/19 at 5:26 PM and post telephone interview on 01/25/19 at 10:25 AM, revealed she expected the nurses to date insulin vials when opened. She stated during orientation and training the nurses are informed of the facility policy on dating medications when opened.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35748 Based on observation, interview, and facility policy review, it was determined the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Observation of the kitchen, on 01/08/19, revealed food stored in the refrigerator and freezer were opened and not dated. Further observation of a dinner meal on 01/08/19, revealed staff did not remove soiled gloves and wash their hands after removing and replacing their eye glasses. Review of the facility Census and Condition, daed 01/09/19, revealed fiftey-four (54) of fifty-five (55) residents received their meals from the kitchen. The findings include: 1. Review of the facility policy titled, Storage Procedures, last revised November 2017, revealed food should be covered and dated. Further review revealed all foods in the freezer are to be labeled and dated with use-by dates clearly marked. Observation of the freezer on 01/08/19 at 3:02 PM, revealed a box of donuts open and not dated. Further observation of the refrigerator revealed a cup of cottage cheese, not dated. 2. Review of facility policy titled Hand Washing from the Dietary Manual, Chapter 7.2-1 of 2, last revised July 2016 revealed: Employees will use proper hand washing techniques to prevent the spread of infection. 1. Hand washing: a. When entering the Dietary Department, after using the restroom, before starting to word. b. Prior to handling raw meat, poultry, or seafood. c. Touching hair, face, glasses, or body. d. After taking out garbage, putting away stock, cleaning. e. Sneezing, coughing or using a tissue. f. Handling chemicals that might effect food safety, taking out garbage. g. Eating, drinking, smoking, or chewing gum or tobacco. h. Handling money (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Cleaning tables or busing dirty dishes. Touching clothing or aprons. j. Leaving and returning to the kitchen/prep area. k. Touching anything else that may contaminate hands, such as dirty equipment, work surface, wash clothes. Hand Antiseptic: If passing trays to residents, hand antiseptic can be applied a minimum after every thirty resident. If direct contact with resident or any resident belonging's, then staff should wash hands. Observation of a dinner meal, on 01/08/19 at 4:11 PM, revealed Dietary Aide #1 removed her glasses twice and placed them onto her face. Further observation revealed she did not wash her hands after removing and replacing her glasses and prior to touching the clean dishes. Interview with Dietary Aide #1 on 01/09/19 at 3:34 PM, revealed she should have removed her gloves and washed her hands after removing her glasses and putting them on. She stated the glasses are considered unclean items and she should have realized it. Interview with the Dietary Manager on 01/09/19 at 3:25 PM, revealed she expected all food items stored in the refrigerator and freezer to be dated when prepared or opened. She further stated she would have expected the cook to change her gloves after touching unclean items during meal pass. 3. Observation of a meal hall pass on 01/08/19 at 4:35 PM by Certified Nurse Aide (CNA) #4 revealed she passed, and set up trays on halls 400, 500, and 600 for the residents that did not go to the dining room to eat. The observation further revealed CNA #4 opened the food cart doors, then opened food in packaging without gloves (cornbread muffins and saltine crackers), removing them from the plastic wrapper with her bare hands. The observation also revealed the CNA picked at areas on her face, and pulled up her pants with her hands but continued to pass and touch food without washing her hands or using gloves to touch the food. Further observation revealed she was noted to remove a used wet wash cloth from the bed side tray in resident room [ROOM NUMBER], but did not wash hands prior to going to the next room. CNA #4 also picked up a plastic cup that had fallen off the resident's bedside tray; however, did not wash her hands or use hand gel and continued to pass meal trays. Interview with CNA #4, on 01/08/19 at 6:00 PM revealed she was the only one to pass the trays on three halls, and was expected to pass the trays and feed the residents in one and one-half hours, so she forgot to wash her hands and wear gloves because she was in a hurry. She stated she realized she was to wash her hands or use hand gel, and touch food only with gloved hands, but just was not thinking. Interview with the Director of Nursing (DON) on 01/11/19 at 5:52 PM, revealed she expected the CNA to wash or sanitize hands between each resident while passing trays and to never touch the food with bare hands. She stated the CNA was expected to use gloves. 36603

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35748 Based on observation, interview, and facility policy review, it was determined the facility failed to 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 for one (1) of eighteen sampled residents (Resident #22) related to improper hand hygiene during wound care. Observations of a medication pass on 01/10/19, revealed staff touched a medication with their bare hand. The findings include: Review of the facility's policy titled, General Dose Preparation and Medication Administration, last revised 01/01/13, revealed facility staff should comply with facility policy, applicable law and the State Operations Manual, when administering medications. The policy further revealed, facility staff should not touch the medication when opening a bottle or unit dose package. Observation of a medication administration pass on 01/10/19 revealed Registered Nurse (RN) #1, removed a medication from a blister pack with her bare hand and placed the medication in a cup for administration. Interview with RN #1 on 01/10/19 at 11:30 AM, revealed she should not have touched the medication with her bare hands because of contamination. She stated she was nervous and should have caught herself. Interview with the Director of Nursing (DON) on 01/11/19 at 5:26 PM, revealed she would expect nurses to pop medications into the medication cups and not use their bare hands. She stated nurses should waste medications that have touched unclean surfaces and not administer them.