STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185274	A. Building B. Wing	01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Liberty Nursing and Rehabilitation	774 Liberty Road West Liberty, KY 41472

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 - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39061 Based on interview, record review, and review of facility policy, it was determined the facility failed to notify the physician and/or responsible party (RP), of a change of condition and/or need to alter treatment for two (2) of twenty-eight (28) sampled residents (Residents #4 and #1). Review of documentation for 10/29/18 revealed Resident #4 was noted to have a blood glucose reading of 590 milligrams/deciliter (mg/dL) at 7:00 AM, 559 mg/dL at 8:00 AM, and 559 mg/dL at 12:00 PM. Review of Resident #4's medical record and interview with the resident's physician revealed the facility failed to notify the resident's physician of the elevated blood sugar levels. Review of Resident #1's documented weights for October 2018 revealed the resident had an approximate thirteen (13) pound weight gain in one (1) week. The facility failed to notify the resident's physician and RP of the resident's significant weight gain. The findings include: Interview with the Director of Nursing (DON) on 11/07/18 at 12:02 PM revealed the facility did not have a policy regarding physician notification, but utilized the guidelines at tag F580 for physician notification. Follow-up interview with the DON on 11/08/18 at 7:24 PM revealed residents' RPs and physicians should be notified immediately, or as soon as possible, when significant changes in a resident's weight was identified. 1. Review of Resident #4's medical record revealed the facility admitted the resident on 09/29/15 with diagnoses that included Type 1 diabetes, muscle weakness, abnormal posture, and other abnormalities of gait and mobility. Review of Resident #4's Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) indicating the resident was cognitively impaired. Review of the documentation on the ACC monitoring log revealed on 10/29/18 the resident had blood glucose readings of 590 mg/dL at 7:00 AM, 559 mg/dL at 8:00 AM, and 559 mg/dL at 12:00 PM. Review of the physician orders dated October 2018 revealed the facility was required to notify the physician when Resident #4's blood sugar was less than 70 mg/dL or greater than 450 mg/dL. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of in-service documentation dated 10/04/17, 04/19/18, and 04/23/18 revealed nursing staff had been educated to inform the physician when a resident's blood sugar was less than 70 mg/dL or greater than 400 mg/dL. Interview with Licensed Practical Nurse (LPN) #1 on 11/08/18 at 5:00 PM revealed she was the nurse assigned to Resident #4 on 10/29/18 during the day shift from 6:30 AM-6:30 PM. LPN #1 acknowledged that she was aware of the physician order to be notified of blood sugars of less than 70 mg/dL or greater than 450 mg/dL. Initially, LPN #1 reported that she did notify the physician of the elevated blood sugars, but forgot to document the notification. Then, LPN #1 stated that she thought she made a mistake in recording the blood sugars and did not recall the resident's blood sugars being that high. LPN #1 reported she did not recall obtaining a blood sugar of 590 mg/dL from Resident #4 on 10/29/18 at 7:00 AM. Interview with Resident #4's physician on 11/08/18 at 7:05 PM revealed he was not notified that the resident's blood sugars were elevated, and stated staff should have notified him. The physician stated that the expectation was that staff would follow the physician's orders. Interview with the Administrator and DON on 11/08/18 at 7:25 PM revealed elevated blood sugar occurrences were required to be noted on a 24-hour report. The Interdisciplinary Team (IDT) team reviewed the 24-hour shift report during a morning meeting to ensure elevated blood sugars were addressed. The DON stated that no concerns had been identified for failure to notify the physician. The DON further stated that her expectation was that staff would follow the physician orders for reporting elevations in a resident's blood sugar. 30184 2. Review of Resident #1's medical record revealed the facility admitted the resident on 09/02/10, with current diagnoses that included Unspecified Cerebrovascular Disease and Anxiety Disorder. Review of the most recent Minimum Data Set (MDS) assessment completed on 09/10/18 revealed Resident #1 required extensive assistance of two (2) staff members with bed mobility and dressing, and assistance of one (1) with eating. According to the MDS, the resident's Brief Interview for Mental Status (BIMS) score was three (3), which indicated the resident was not interviewable. Further review of Resident #1's medical record revealed the resident weighed approximately 151 pounds on 10/03/18. On 10/10/18, staff documented that the resident weighed 164 pounds, an approximately thirteen (13) pound weight gain in one (1) week. Continued interview with the DON on 11/08/18 at 7:24 PM revealed the facility held meetings to discuss residents' weights at various times each month to ensure significant changes are addressed; however, she was unaware that Resident #1 had experienced a significant weight gain in October 2018. Interview with Resident #1's RP on 11/08/18 at 2:00 PM, revealed staff had not notified her that the resident had experienced a significant weight gain in October 2018. The RP stated she expected to be notified of significant changes in the resident's weight as soon as the change was identified. Interview with Resident #1's physician on 11/08/18 at 7:05 PM revealed he was not notified of Resident #1's weight gain identified in October 2018 either. He stated if a resident's weight had changed that significantly he would expect to have been notified.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 30184 Based on interview, record review, and review of a facility policy, it was determined the facility failed to protect the rights of one (1) of twenty-eight (28) sampled residents (Resident #1) and two (2) unsampled residents (Residents A and B) to file a grievance. Interviews with Resident #1's responsible party (RP) and Residents A and B revealed they had voiced grievances to facility staff related to long wait times for answering call lights, lack of staff, and/or the taste of food served. However, the facility failed to ensure a prompt resolution of the grievances. The findings include: Review of the facility policy titled Customer Concern (Grievance) Policy, dated July 2018, revealed staff were required to support the patient's/resident's right to voice grievances, to ensure the facility was actively seeking a resolution, and to keep the resident aware of progress toward a resolution. Interview with Resident #1's RP on 11/08/18 at 2:00 PM, revealed she had voiced grievances on multiple occasions related to long call light wait times and the lack of staff in the facility. The RP stated the concerns remained unresolved and the facility had not followed up with her after voicing the concerns. Interviews with Resident A on 11/08/18 at 3:20 PM and Resident B at 3:30 PM revealed they had voiced grievances on multiple occasions because the food tasted horrible. The residents stated there had been no improvement in the food and their grievances remained unresolved. Interview with Registered Nurse (RN) #2 on 11/08/18 at 10:30 AM revealed she was aware that residents had voiced complaints related to the taste and appearance of foods served at the facility. The RN also recalled that residents had voiced complaints related to call lights taking too long to be answered, but could not recall the residents' names. Further interview with RN #2 revealed Resident #1's RP had also voiced complaints that there wasn't enough staff. The RN stated she had not been educated on the facility's grievance process, and was unsure if she had reported the residents' grievances to anyone. RN #2 further stated she was unaware of any corrective actions taken to resolve the residents'/RP's grievances. Interview with RN #4 on 11/08/18 at 2:55 PM, confirmed Resident #1's RP had voiced grievances related to short staffing and waiting too long for call lights to be answered. She also stated some residents (unable to recall the residents' names) had voiced a lot of complaints related to foods served in the facility. RN #4 also stated she had not been trained on the grievance process in the facility, and was unable to recall if she reported the RP's/residents' concerns to anyone and acknowledged no corrective actions had been taken to resolve grievances. Interview with the Administrator on 11/08/18 at 7:24 PM revealed staff were required to complete a concern form when residents and/or their families voiced grievances. He stated grievances should be resolved in three (3) or four (4) days after receipt. According to the Administrator, he was not aware residents had complained about the food served or call light wait times in the facility.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39061 Based on observation, interviews, record review, review of facility policy, review of a facility investigation, and review of photographs, it was determined the facility failed to ensure all alleged violations of abuse were reported to state agencies within two (2) hours for one (1) of twenty-eight (28) sampled residents (Residents #5 (#19). On 11/07/18, the Ombudsman stated she reported an allegation of abuse involving Resident #5 (#19) to the Administrator at approximately 3:30 PM. However, the facility failed to report the allegation to state agencies until 11/08/18, after state surveyors interviewed the Administrator regarding the allegation. The findings include: Review of the facility's Abuse policy, dated June 2018, revealed any allegation of abuse was required to be reported to the Administrator or Director of Nursing. The policy stated such violations would also be reported to state agencies in accordance with existing state law. A review of Resident #5's (#19) medical record revealed the facility admitted the resident on 08/14/14 with diagnoses that included Diabetes, Muscle Weakness, Malaise, and Chronic Pain. Review of Resident #5's (#19) most recent Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident was cognitively impaired. Interview with the Ombudsman on 11/07/18 at 3:45 PM revealed Resident #5 (#19) reported to her that staff were rough when handling the resident and bruising was observed to the resident's arm. The Ombudsman stated she reported the abuse allegation to the Administrator on 11/07/18 at approximately 3:30 PM. Observation of Resident #5 (#19) on 11/08/18 at 8:45 AM revealed the resident had two (2) dark purple bruises to the left lateral elbow. One bruise was approximately quarter size and the other was approximately half-dollar size. When asked what caused the bruising, Resident #5 (#19) responded, They hurt me. Interview with the Administrator on 11/08/18 at 9:07 AM and 9:20 AM, revealed the Ombudsman had reported on 11/07/18 that Resident #5 (#19) had bruising to the arm, but stated the Ombudsman did not mention rough handling; therefore, he did not report an allegation of abuse to state agencies. The Administrator further stated he directed the Director of Nursing (DON) to check on the resident after the Ombudsman's report. However, interview with the Administrator and DON on 11/08/18 at 7:25 PM, revealed the DON was not aware that there had been an allegation of abuse/bruising regarding Resident #5 (#19) until that morning and did not report the allegation. Review of the Self-Reported Incident Form revealed the facility reported on 11/08/18, that a surveyor noted bruising to Resident #5's (#19) left upper arm and the resident stated, They hurt me. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Notes for Resident #5 (#19) revealed staff obtained blood for laboratory testing in the resident's left antecubital (bend of inner arm). Further review revealed on 11/04/18, staff started an intravenous (IV) line in the resident's left forearm; and on 11/06/18, staff started an IV in the resident's left hand. Review of nursing notes dated 11/08/18 at 3:58 PM, revealed the resident had three dark purple bruises to the left arm related to recent IV lines and laboratory testing. The note stated the resident denied pain or discomfort and stated, I don't know why you are worried about my arms there is nothing wrong with them.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 30184 22976 Based on observation, interview, record review, and a review of the facility policy, it was determined the facility failed to ensure care plan interventions were implemented to prevent falls/injury for one (1) of twenty-eight (28) sampled residents (Resident #1 (#34)). Resident #1 (#34) required two staff members to transfer the resident. However, on 12/05/18 one staff member was observed transferring the resident from a wheelchair to bed without the assistance of a second staff member. The findings include: Interview with the Director of Nursing (DON) on 11/08/18 at 7:24 PM revealed the facility did not have a policy related to care plans, but utilized the Resident Assessment Instrument (RAI) User Manual when developing plans of care. Further interview with the DON revealed that when an intervention was added to a resident's comprehensive care plan, it should also be added to the SRNA's care guide, which was used by the SRNAs to provide care. The facility provided a copy of the RAI User Manual, Section 4.7 titled, The RAI and Care Planning, dated October 2018, which stated a care plan was required to describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Further review revealed services provided must be consistent with each resident's written plan of care. Review of Resident #1's (#34) medical record revealed the facility admitted the resident on 09/02/10, and had diagnoses that included Unspecified Cerebrovascular Disease, Anxiety Disorder, Seizure Disorder, and Contractures to Bilateral Upper and Lower Extremities. Review of Resident #1's (#34) most recent Minimum Data Set (MDS) assessment completed on 09/10/18 revealed the resident required extensive assistance of two (2) staff members for bed mobility and transfers. According to the MDS, Resident #1 (#34) was assessed to have severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of three (3). A review of the comprehensive plan of care the facility developed for Resident #1 (#34) initially dated 09/02/10, revealed the facility identified that the resident was at risk for falls and had the potential for skin tears and bruising because the resident needed assistance with activities of daily living. The facility developed interventions/approaches to prevent falls that included two staff members utilizing a mechanical lift and a mesh sling to transfer the resident. Observation of Resident #1 (#34) on 12/05/18 at 1:08 PM revealed one staff member was utilizing a mechanical lift to transfer Resident #1 (#34) from a wheelchair to bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with State Registered Nurse Aide (SRNA) #10 on 12/05/18 at 1:17 PM, revealed two staff members were supposed to transfer the resident utilizing a mechanical lift. However, the SRNA stated she transferred Resident #1 (#34) by herself because the resident had to be back in bed at a specific time and no other staff were available. SRNA #10 stated all other staff were picking up lunch meal trays and were not able to assist. Interview with Licensed Practical Nurse (LPN) #3 on 12/05/18 at 1:39 PM, revealed she monitored to ensure staff were following residents' care plans, but was not aware SRNA #10 needed assistance. LPN #3 stated she was available and would have helped transfer Resident #1 (#34) if the SRNA had asked for assistance. Interview with the Director of Nursing (DON) on 12/05/18 at 2:13 PM revealed the DON made rounds daily and had not identified any concerns with staff not transferring residents in accordance with their plan of care. According to the DON, two (2) staff members should transfer Resident #1 (#34), according to the resident's plan of care.

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F 0657 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39061 Based on interview, record review, and review of the facility policy, it was determined the facility failed to revise the care plan for one (1) of twenty-eight (28) sampled residents (Resident #4) after the resident sustained falls. Resident #4 sustained falls on 10/28/18 at 12:59 PM and 9:00 PM and there was no evidence the facility reviewed and revised the care plan to prevent further falls. On 10/29/18 at 10:15 AM, the interdisciplinary team met to discuss the falls and determined that the falls were the result of hypotension (low blood pressure), but did not develop interventions or revise the care plan to address the concern of hypotension to prevent further falls. On 10/29/18 at 4:30 PM, Resident #4 fell again and sustained a non-displaced left acetabular fracture (hip fracture). The findings include: Review of the facility's Care planning/RAI Process policy dated October 2017 revealed the comprehensive care plan is an interdisciplinary communication tool. The care plan should include measurable objectives and timeframes. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy further stated the care plan should be revised on an ongoing basis to reflect changes in the resident. Review of the facility's policy titled Falls, dated April 2017, revealed when a risk factor for falls was identified, a corresponding intervention addressing that risk factor was developed. Further review revealed that a fall huddle was called to help in investigating circumstances around the fall and to help determine immediate interventions post fall. The policy indicated that the Interdisciplinary Team (IDT) reviewed post fall investigations and summarized the team's recommendations. Review of Resident #4's medical record revealed the facility admitted the resident on 09/29/15 with diagnoses that included muscle weakness, abnormal posture and other abnormalities of gait and mobility, and Type 1 diabetes. Review of Resident #4's Minimum Data Set (MDS) dated [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) indicating the resident was cognitively impaired. Further review of the MDS revealed the resident was assessed to be at risk for falls. Review of Resident #4's comprehensive care plan with a projected goal date of 01/27/19 revealed the facility developed interventions to prevent falls that included wearing non-skid socks, encouraging the resident to use call light for assistance, educating the resident to sit on the side of the bed before ambulating, and encouraging the resident to ask for assistance with ambulation. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing note dated 10/28/18 at 12:59 PM and review of the Resident Fall Analysis RCA [Root Cause Analysis] Worksheet dated 10/28/18 (no time) revealed Resident #4 sustained a fall at 12:59 PM and another fall at 9:00 PM on 10/28/18. There was no evidence of interventions to prevent further falls after the fall at 12:59 PM. The interventions to be implemented to minimize the risk of recurrence that was documented after the 9:00 PM fall was to encourage the resident to use the call light prior to standing and wait for assistance. However, this was already an intervention on the care plan. Review of an IDT note dated 10/29/18 at 10:16 AM revealed that the root cause of the fall that occurred on 10/28/18 at 12:59 PM and on 10/28/18 at 9:00 PM was determined to be hypotension and the new intervention was to notify the resident's brother of the need for a recliner. There was no evidence that the IDT developed interventions and revised Resident #4's care plan to prevent further falls related to the hypotension. Review of a Resident Incident Report dated 10/29/18 at 4:30 PM revealed a nurse aide called staff to Resident #4's room. The report stated that Resident #4 was sitting in a chair in the room and lost his/her balance and fell . The resident was noted to have disorientation and complained of pain to the left side. The resident was transferred to the hospital. Review of the emergency room nursing assessment record dated 10/28/18 at 5:32 PM revealed Resident #4 was nonweight-bearing upon arrival to the Emergency Department. Further review of the physical exam revealed the resident had mild to moderate pain with movement affecting the left hip and iliac crest. Review of the hospital radiology report dated 10/29/18 at 6:39 PM revealed Resident #4 had a non-displaced left acetabular fracture (hip fracture). Interview with Registered Nurse (RN) #3 on 11/08/18 at 2:15 PM revealed that she was part of the IDT and was responsible for updating resident care plans during the morning meetings. RN #3 acknowledged that no immediate interventions were put in place for Resident #4 after the falls on 10/28/18. RN #3 stated that the intervention to obtain a recliner for Resident #4 was discussed in the morning meeting on 10/29/18; however, this intervention was not added to the care plan and was not implemented. She stated the purpose of the recliner was to assist the resident in changing positions to help with the resident getting lightheaded. However, the recliner was not implemented until after the resident sustained another fall on 10/29/18 at 4:30 PM and was diagnosed with a fractured hip. Interview with the Administrator and Director of Nursing (DON) on 11/08/18 at 7:25 PM revealed all incidents/accidents were reviewed daily in the morning meeting. The DON reported that care plans were updated at that time to reflect any changes to the resident's status. The DON stated the IDT decided that Resident #4 needed a recliner to help prevent further falls; however, the intervention was not implemented until after the resident sustained the fall on 10/29/18. The DON stated that they contacted the resident's responsible party about a reclining chair, but did not take any other action to prevent further falls for Resident #4.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39061 Based on observation, interview, record review, and review of a facility policy, it was determined the facility failed to ensure one (1) of twenty-eight (28) sampled residents (Resident #4) received adequate assistance and supervision to prevent accidents. Resident #4 sustained three (3) falls from 10/28/18 at 12:59 PM through 10/29/18 at 4:30 PM. Review of the record revealed that Resident #4's blood pressure after the first fall was 59/42. There was no evidence the facility developed interventions to prevent further falls at that time. Further review of the record revealed the resident fell again on 10/28/18 at 9:00 PM and his/her blood pressure was documented to be 70/68. The intervention implemented after the fall was to encourage the resident to use the call light and wait for assistance, which was already an intervention on the care plan. On 10/29/18 at 4:30 PM, Resident #4 fell again and was transferred to the hospital on 10/29/18 at 5:10 PM and diagnosed with a non-displaced left acetabular fracture (hip fracture). In addition, Resident #1's (#34) care plan required two staff members to transfer the resident to prevent falls. Interview with staff revealed two staff members were required when utilizing a mechanical lift to ensure the resident's safety. However, observation on 12/05/18, revealed one staff member transferred Resident #1 (#34) from a wheelchair to bed utilizing a mechanical lift. The findings include: Review of the facility's policy titled Falls, dated April 2017, revealed that when a risk factor for falls was identified a corresponding intervention addressing that risk factor was developed. Further review revealed that a fall huddle was called to help in investigating circumstances surrounding the fall and to help determine immediate interventions post fall. The policy indicated that the Interdisciplinary Team (IDT) reviewed post fall investigations and summarized the team recommendations. 1. Observation of Resident #4 on 11/06/18 at 10:20 AM revealed the resident sitting on the deck smoking with staff present. Additional observations on 11/06/18 at 1:45 PM, 2:20 PM, and 4:40 PM revealed the resident lying in bed. Review of Resident #4's medical record revealed the facility admitted the Resident on 09/29/15 with diagnoses that included muscle weakness, abnormal posture and other abnormalities of gait and mobility, and Type 1 diabetes. Review of Resident #4's Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6), indicating the resident was cognitively impaired. Further review of the MDS revealed the resident was assessed to be at risk for falls. Review of Resident #4's comprehensive care plan with a projected goal date of 01/27/19 revealed interventions to prevent falls that included non-skid socks, encourage to use call light for assistance, educate the resident to sit on the side of the bed before ambulating, and encourage the resident to ask for assistance with ambulation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Liberty Nursing and Rehabilitation	774 Liberty Road West Liberty, KY 41472

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing note dated 10/28/18 at 12:59 PM revealed Resident #4 was ambulating in the hallway and ambulated approximately 50 feet and fell . The documentation stated that the fall was not witnessed and the resident was assessed and noted to have a blood pressure of 59/42. The note further revealed that the physician was notified and an order for an x-ray of the left femur was obtained. Review of a radiology report dated 10/28/18 at 7:15 PM revealed the conclusion of the mobile x-ray obtained on 10/28/18 was that the resident did not have a fracture of the left hip. Review of the Resident Fall Analysis RCA [Root Cause Analysis] Worksheet dated 10/28/18 (no time) revealed the cause of the fall was loss balance and in the area for interventions to be implemented to prevent recurrence the document stated used w/c [wheelchair] to transport back to room. There was no evidence of interventions to prevent further falls. Phone interview with Licensed Practical Nurse (LPN) #1 on 11/08/18 at 5:00 PM revealed she was assigned to Resident #4 on 10/28/18. She stated she did not witness the fall that occurred at 12:59 PM. LPN #1 stated when a resident sustained a fall, the nurse was required to assess the resident for injury, complete an incident report, notify the physician and family, and contact the Director of Nursing who gave instructions on what staff should do. LPN #1 stated that she called Registered Nurse (RN) #3 after the fall because the Director of Nursing (DON) was unavailable. LPN #1 stated she was not instructed to put any new interventions in place to prevent future falls. Review of Post Fall/Trauma documentation dated 10/28/18 revealed Resident #4 fell again at 9:00 PM on 10/28/18. The documentation stated the resident fell from the bed to the floor due to getting lightheaded and had a blood pressure of 70/68. The document stated that the interventions to be implemented to minimize the risk of recurrence was to encourage the resident to use the call light prior to standing and wait for assistance; however, this intervention had already been implemented prior to the resident's falls on 10/28/18. Attempts were made on 11/08/18 at 4:00 PM and 6:04 PM to interview the nurse working at the time of the fall on 10/28/18 at 9:00 PM, but she was unavailable and did not return calls. The facility provided an IDT note dated 10/29/18 at 10:16 AM that revealed the root cause of the falls that occurred on 10/28/18 at 12:59 PM and 10/28/18 at 9:00 PM was determined to be hypotension and the new intervention was to notify the resident's brother of the need for a recliner. Review of a Resident Incident Report dated 10/29/18 at 4:30 PM revealed that staff was called to Resident #4's room by the aide. The resident was sitting in a chair in the room and lost his/her balance and fell . The resident was noted to have disorientation and complained of pain to the left side. The resident was transferred to the hospital. Review of the emergency room nursing assessment record dated 10/28/18 at 5:32 PM revealed Resident #4 to be nonweight-bearing upon arrival to the Emergency Department. Further review of the physical exam revealed the resident to have mild to moderate pain with movement affecting the left hip and iliac crest. Review of the hospital radiology report dated 10/29/18 at 6:39 PM revealed Resident #4 to have a non-displaced left acetabular fracture (hip fracture). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with SRNA #1 on 11/08/18 at 2:50 PM revealed she provided care for Resident #4 on 10/28/18 and was present on the unit when both falls occurred. Per SRNA #1, on 10/28/18 around noon she witnessed Resident #4 lying in the hallway on his/her left side. She stated the nurse assessed the resident and staff assisted the resident to stand. SRNA #1 reported that Resident #4 was complaining of left hip pain after he/she stood up. SRNA #1 reported that she placed Resident #4 in a wheelchair and took him/her out for a smoke break. SRNA #1 reported that she was not instructed to implement any new interventions after the fall and did routine checks every two (2) hours as usual the rest of the day. SRNA #1 reported that around 9:00 PM on 10/28/18, she heard a noise coming from Resident #4's room. Upon entering the room she witnessed Resident #4 sitting on the floor, facing the door, with a small cut above his/her right eye. After assisting Resident #4 to the bed, the resident became pale and clammy, and his/her blood pressure was low. SRNA #1 reported that the resident was still complaining of left hip pain. SRNA #1 stated she reported to the nurse and the nurse assessed the resident. SRNA #1 stated the staff were instructed to do neuro checks and vital signs per protocol and no new fall interventions were put into place. Interview with the DON on 11/07/18 at 12:02 PM revealed attempts are made to determine the root cause when a fall occurs. She stated that the management staff meets daily, Monday through Friday, and discusses any resident issues during the meeting. The DON stated that all falls were evaluated for a root cause during the meeting, and the plan of care was updated during the meeting. She further stated that when a fall occurs, the nurse assigned to the resident contacts the DON, and immediate interventions are put into place to prevent further falls. The DON was unable to recall any immediate interventions that were put in place for Resident #4 when the two (2) falls occurred on 10/28/18. Interview with RN #3 on 11/08/18 at 2:15 PM revealed she was a member of the IDT and that she was responsible to update the care plan during the morning meetings. RN #3 acknowledged that no immediate interventions were put in place for Resident #4 after the falls on 10/28/18. RN #3 reported that an intervention to obtain a recliner for Resident #4 was discussed in the morning meeting on 10/29/18; however, this intervention was not added to the care plan at that time. Further, RN #3 acknowledged that immediate interventions should have been put in place and documented on the care plan to prevent further falls for Resident #4. Interview with the Assistant Director of Nursing (ADON) on 11/08/18 at 10:30 AM revealed any resident incidents were discussed in the morning meeting daily. New interventions were discussed and put in place on the care plan. It was expected that staff would put immediate interventions in place when a fall occurred. The ADON stated she had not identified any concerns with fall interventions or care plans not being updated. Interview with the Administrator and DON on 11/08/18 at 7:25 PM revealed all incidents/accidents were reviewed daily in the morning meeting. The DON reported that care plans were updated during the meeting to reflect any changes to the resident's status. The DON stated the intervention implemented to prevent further falls for Resident #4 should have been added to the comprehensive care plan and the SRNA care plan. 22976 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. A review of the facility's mechanical lift policy titled Lift Care Safe for All (not dated) revealed residents were assessed on admission to determine what type of assistive transfer equipment was needed. The policy did not address the number of staff required to safely utilize a mechanical lift. However, an interview with the Director of Nursing (DON) on 12/18/18 at 1:30 PM revealed two staff were required to transfer residents when a mechanical lift was used to prevent accidents. Review of Resident #1's (34) medical record revealed the facility admitted the resident on 09/02/10. The resident had diagnoses that included Unspecified Cerebrovascular Disease, Anxiety Disorder, Seizure Disorder, and Contractures to Bilateral Upper and Lower Extremities. Observation on 12/05/18 at 1:08 PM revealed one staff member, SRNA #10 utilized a mechanical lift to transfer Resident #1 (#34) from a wheel chair to the bed. However, a review of Resident #1's (#34) most recent Minimum Data Set (MDS) assessment completed on 09/10/18 revealed Resident #1 (#34) required extensive assistance of two (2) staff members to transfer the resident. In addition, the facility developed a care plan for the resident that stated the resident required total assistance of two staff for transfers with a mechanical lift to prevent falls and injury. Interview with State Registered Nurse Aide (SRNA) #10 on 12/05/18 at 1:17 PM, revealed the SRNA was aware that Resident #1 (#34) required two staff and the use of a mechanical lift to transfer the resident. However, SRNA #10 stated she transferred the resident by herself because other staff were not available. Interview with Licensed Practical Nurse (LPN) #3 on 12/05/18 at 1:39 PM, revealed two staff were required to assist residents when transferring the resident with a mechanical lift to ensure the safety of the resident. Continued interview with the DON on 12/18/18 at 1:30 PM revealed one staff member transferring Resident #1 (#34) in a mechanical lift was a safety hazard for the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38114 Based on observation, medical record review, facility policy review, and interview it was determined the facility had a medication administration error rate greater than five (5) percent. Observation of medication administration on 12/05/18 revealed the facility had a medication administration error rate of thirty-four (34) percent. The findings include: The facility did not have a policy regarding medication administration; however, interview with the facility Director of Clinical Operations on 12/07/18 at 11:30 AM revealed the facility uses Clinical Nursing Skills and Techniques, 9th Edition by [NAME] and [NAME] for their medication administration protocol. 1. Observation of Resident #42 on 12/05/18 at 11:01 AM revealed Licensed Practical Nurse (LPN) #3 administered Metoprolol Extended Release (ER) 25 milligrams (mg) (blood pressure medication) one (1) tablet by mouth. LPN #3 obtained Resident #42's blood pressure and pulse after administering the Metoprolol Extended Release. Further observation at this time revealed Glipizide XL 5 mg was not administered. Review of Resident #42's physician orders for December 2018 revealed the resident was to receive Metoprolol ER 25 mg one (1) tablet by mouth daily for hypertension. The order further stated if the systolic blood pressure was less than 100 or the pulse was less than 60, hold the medication and call the physician. Further review of the physician orders revealed the resident was to receive Glipizide XL 5 mg tablet - administer one tablet by mouth related to Diabetes Mellitus daily. Review of the December 2018 Medication Administration Record (MAR) for Resident #42 revealed the resident was to be administered Metoprolol ER 25 mg tablet at 7:00 AM daily and Glipizide XL 5 mg tablet at 7:00 AM daily. Further review of the December 2018 MAR revealed the resident did not receive the 7:00 AM dose as scheduled for 12/05/18. 2. Observation of Resident #8 on 12/05/18 at 11:09 AM revealed LPN #3 administered Furosemide 20 mg one (1) tablet by mouth, Glipizide 10 mg one (1) tablet by mouth, and Januvia 100 mg one (1) tablet by mouth. Review of Resident #8's physician orders for December 2018 revealed the resident was to receive Furosemide 20 mg one (1) tablet by mouth twice daily, Glipizide 10 mg one (1) tablet by mouth with breakfast and supper, and Januvia 100 mg one (1) tablet by mouth once daily. Review of Resident #8's December 2018 MAR revealed the resident was to be administered Furosemide 20 mg at 7:00 AM and 5:00 PM, Glipizide 10 mg at 7:00 AM and 5:00 PM, and Januvia 100 mg at 7:00 AM. Further review of the MAR revealed the resident did not receive on 12/05/18 the 7:00 AM doses of Furosemide, Glipizide, and Januvia at 7:00 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation of Resident #11 on 12/05/18 at 11:29 AM revealed LPN #3 administered Potassium Chloride ER 20 milliequivalents (meq) one (1) tablet by mouth, Augmentin 875/125 mg one (1) tablet by mouth, and Metoprolol ER 25 mg three (3) tablets by mouth. LPN #3 did not administer a Breo [NAME] Inhaler. LPN #3 obtained Resident #11's blood pressure and pulse after administering the medications. Review of Resident #11's physician orders for December 2018 revealed the resident was ordered to be administered Potassium Chloride ER 20 meq one (1) tablet twice a day, Augmentin 875/125 mg by mouth twice a day for seven (7) days starting on 12/02/18, Metoprolol Tartrate 25 mg tablets three (3) tablets by mouth twice daily and hold if systolic blood pressure is less than 100 or pulse is less than 60, and call the physician, and Breo Ellipta 100-25 micrograms (mcg) Inhaler, administer one (1) puff by mouth twice a day. Review of Resident #11's December 2018 MAR revealed the resident was to be administered Potassium Chloride ER 20 meq at 7:00 AM, Augmentin 875/125 mg at 7:00 AM and 7:00 PM, Metoprolol Tartrate 25 mg three (3) tablets at 7:00 AM and 7:00 PM, and Breo Ellipta 100-25 mcg Inhaler at 8:00 AM and 7:00 PM daily. Further review of the MAR for December 2018 revealed the residents did not receive the Potassium Chloride ER 20 meq, Augmentin 875/125 mg, Metoprolol Tartrate 25 mg three (3) tablets were not administered at 7:00 AM, and the Breo Ellipta 100-25 mcg Inhaler was not administered at 8:00 AM. Interview with LPN #3 on 12/05/18 at 2:22 PM revealed medications being administered to Resident #42 at 11:01 AM, Resident #8 at 11:09 AM, and Resident #11 at 11:29 AM were the medications the residents were to be administered during the 7:00 AM medication pass. LPN #3 revealed she was substantially late administering the medications due to being busy taking care of residents. However, LPN #3 revealed she knew the medications should have been administered between the hours of 6:00 AM and 8:00 AM and she had fallen behind during the medication administration pass. LPN #3 also revealed she had not informed a coworker or the Director of Nursing (DON) that she was late administering medications. Interview with the DON on 12/18/18 at 1:30 PM revealed she was not aware LPN #3 was late administering the 7:00 AM medication pass on 12/05/18. The DON revealed the 7:00 AM medication administration pass can be started at 6:00 AM and should be finished by 8:00 AM. The DON further revealed medication administration pass audits and education are done annually. The DON also revealed she had not previously identified any concerns with the medication administration pass being done timely or concerns with medication errors.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38114 Based on observation, interview, facility policy review, and medical record review the facility failed to ensure that three (3) of twenty-eight (28) sampled residents were free of any significant medication errors. Observation of the medication administration on 12/05/18 revealed seven (7) significant medication errors were observed for Residents #42, #8, and #11. The findings include: The facility did not provide a policy in regard to significant medication errors. Interview with the Director of Clinical Operations on 12/07/18 at 11:30 AM revealed the facility currently uses Clinical Nursing Skills & Techniques, 9th Edition, for their medication administration protocol. 1. Observation of Resident #42 on 12/05/18 at 11:01 AM revealed Licensed Practical Nurse (LPN) #3 administered Metoprolol Extended Release 25 milligrams (mg) one (1) tablet by mouth that was due to be given at 7:00 AM. LPN #3 obtained Resident #42's blood pressure and pulse after administering the Metoprolol ER. Review of Resident #42's physician orders for December 2018 revealed the resident was to receive Metoprolol Extended Release 25 mg one (1) tablet by mouth daily for hypertension and if the systolic blood pressure was less than 100 or the pulse less than 60, hold the medication and call the physician. 2. Observation of Resident #8 on 12/05/18 at 11:09 AM revealed LPN #3 administered Glipizide 10 mg one (1) tablet by mouth and Furosemide 20 mg one (1) tablet by mouth that were due to be given at 7:00 AM. Review of Resident #8's physician orders for December 2018 revealed the resident was to receive Furosemide 20 mg one (1) tablet by mouth twice daily, Glipizide 10 mg one (1) tablet by mouth with breakfast and supper. Review of Resident #8's December 2018 MAR revealed the resident was to be administered Furosemide 20 mg at 7:00 AM and 5:00 PM, and Glipizide 10 mg at 7:00 AM and 5:00 PM. Further review of the MAR revealed the resident did not receive on 12/05/18 the 7:00 AM doses of Furosemide and Glipizide. 3. Observation of Resident #11 on 12/05/18 at 11:29 AM revealed LPN #3 administered Potassium Chloride Extended Release 20 milliequivalents (meq) one (1) tablet by mouth, Metoprolol Extended Release 25 mg three (3) tablets by mouth, and Augmentin 875/125 mg one (1) tablet by mouth that were due to be given at 7:00 AM. LPN #3 did not administer the Breo [NAME] Inhaler. LPN #3 obtained Resident #11's blood pressure and did not obtain the pulse after administering the medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's physician orders for December 2018 revealed the resident was ordered to be administered Potassium Chloride ER 20 meq one (1) tablet twice a day, Augmentin 875/125 mg by mouth twice a day for seven (7) days starting on 12/02/18, Metoprolol Tartrate 25 mg tablets three (3) tablets by mouth twice daily and hold if systolic blood pressure is less than 100 or pulse is less than 60 and call the physician, and Breo Ellipta 100-25 mcg Inhaler, administer one (1) puff by mouth twice a day. Review of Resident #11's December 2018 MAR revealed the resident was to be administered Potassium Chloride ER 20 meq at 7:00 AM, Augmentin 875/125 mg at 7:00 AM and 7:00 PM, Metoprolol Tartrate 25 mg three (3) tablets at 7:00 AM and 7:00 PM, and Breo Ellipta 100-25 mcg Inhaler at 8:00 AM and 7:00 PM daily. Further review of the MAR for December 2018 revealed the residents did not receive the Potassium Chloride ER 20 meq, Augmentin 875/125 mg, Metoprolol Tartrate 25 mg three (3) tablets were not administered at 7:00 AM, and the Breo Ellipta 100-25 mcg Inhaler was not administered at 8:00 AM. Interview with LPN #3 on 12/05/18 at 2:22 PM revealed medications being administered to Resident #42 at 11:01 AM, Resident #8 at 11:09 AM, and Resident #11 at 11:29 AM were the medications the residents were to be administered during the 7:00 AM medication pass. LPN #3 revealed she was substantially late administering the medications due to being busy taking care of residents and she had not asked for assistance from other staff. However, LPN #3 revealed she knew the medications should have been administered between the hours of 6:00 AM and 8:00 AM and had fallen behind during the medication administration pass. LPN #3 also revealed she had not informed a coworker or the Director of Nursing (DON) that she was late administering medications. Interview with the DON on 12/18/18 at 1:30 PM revealed she was not aware LPN #3 was late administering the 7:00 AM medication pass on 12/05/18. The DON revealed the medications should have been given on time due to the significance of the medication and possible effect on the resident. The DON further revealed medication administration pass audits and education are done annually. The DON also revealed she had not previously identified any concerns with the medication administration pass being done timely.

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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. 38114 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to 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 twenty-eight (28) sampled residents (Resident #8). Observation of blood glucose monitoring on 12/05/18, revealed staff did not appropriately clean and sanitize the blood glucose monitoring machine after obtaining a blood sample for blood glucose testing. The findings include: The facility did not provide a policy regarding cleaning the blood glucose monitor; however, the facility did provide a reference manual titled, Assure Platinum Blood Glucose Monitoring System, Quality Assurance/Quality Control Reference Manual, undated. In Section B of the manual, Cleaning & Disinfecting Guidelines, it revealed that a commercially EPA-registered disinfectant detergent or germicide wipe should be used to clean the blood glucose monitor and a second wipe to disinfect the monitor. Observation on 12/05/18 at 11:09 AM of Resident #8 revealed Licensed Practical Nurse (LPN) #3 obtained a blood sample and performed a glucometer check for the resident. LPN #3 exited the resident's room after obtaining the blood glucose reading. LPN #3 was then observed to wrap the blood glucose monitor with an approved germicidal wipe, but failed to cleanse the blood glucose monitor prior to wrapping the blood glucose monitor with the wipe. Interview with LPN #3 on 12/05/18 at 2:27 PM, revealed she had been told to only wrap the blood glucose monitor for five (5) minutes with a disinfectant wipe and allow the blood glucose monitor to sit and dry before using it again. LPN #3 further stated that she had not been told to clean the machine with a disinfectant wipe prior to wrapping the blood glucose monitor. Interview with the Director of Nursing (DON) on 12/18/18 at 1:30 PM revealed the blood glucose monitor should be cleaned before use and after use with each resident. The DON further revealed the blood glucose monitor should be cleaned with an approved disinfectant wipe by cleaning the blood glucose monitor with the wipe followed by a second wipe to wrap the blood glucose monitor to disinfect the monitor. The DON also revealed she had not identified any concerns with staff cleaning the blood glucose monitor improperly.