STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195307	A. BUILDING **01, 02** B. WING _____	**01/15/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Maison Deville Nursing Home is not in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The findings that follow in this CMS 2567 demonstrate the non-compliance. The facility is sprinklered, licensed for 200 beds and a census of 116 at time of survey.	K 000		
K 000	INITIAL COMMENTS Maison Deville Nursing Home is not in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The findings that follow in this CMS 2567 demonstrate the non-compliance. The facility is sprinklered, licensed for 200 beds and a census of 116 at time of survey.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		1/30/20

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

Electronically Signed | 01/31/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

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K 222	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire	K 222		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

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K 222	Continued From page 2 detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on visual observation and testing of the exit doors, the facility failed to provide free egress from all required exits. Access to an unobstructed exit provides occupants with a sense of security to remain calm when an emergency occurs. The deficient practice had the potential to affect 116 of 116 residents. 3 of the egress doors are deficient when tested by remote release at nursing station. Findings: During the facility tour on 1/15/2020, between the hours of 12:30 pm to 3:15 pm it was observed the magnetic door locks located on the 100 hall, 500 hall and the 600 hall did not release when the manual keyed release to unlock all doors located at the nursing stations was activated.	K 222	On 01/15/2020 [redacted] came with the Fire Marshal present to try and trouble shoot the doors. [redacted] again came back and repaired the doors on 01/20/2020. This specific function will now be monitored with the weekly faire safety inspection schedule completed by Maintenance Supervisor	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		1/30/20

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MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

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K 222	Continued From page 3 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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	195307	A. BUILDING **01, 02** B. WING _____	**01/15/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on visual observation and testing of the exit doors, the facility failed to provide free egress from all required exits. Access to an unobstructed exit provides occupants with a sense of security to remain calm when an emergency occurs. The deficient practice had the potential to affect 116 of 116 residents. 3 of the egress doors are deficient when tested by remote release at nursing station. Findings: During the facility tour on 1/15/2020, between the hours of 12:30 pm to 3:15 pm it was observed the magnetic door locks located on the 100 hall, 500 hall and the 600 hall did not release when the manual keyed release to unlock all doors located at the nursing stations was activated.	K 222	On 01/15/2020 [redacted] came with the Fire Marshal present to try and trouble shoot the doors. [redacted] again came back and repaired the doors on 01/20/2020. This specific function will now be monitored with the weekly faire safety inspection schedule completed by Maintenance Supervisor.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke	K 363		1/30/20

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MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

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K 363	Continued From page 5 and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to provide corridor doors that were not closing and latching in the frame. When the doors latch a smoke resistive seal is formed to protect the	K 363	On 01/15/2020 the day of the inspection prior to leaving the building for the day the Maintenance Supervisor adjusted room doors for 306, 325, and 506 to properly	

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K 363	Continued From page 6 room's occupants. The deficient practice had the potential to affect 3 of 25 residents. 2 of 6 corridors had doors that were deficient. Findings: During the facility tour, between the hours of 12:30 pm and 3:15 pm, above mentioned doors did not properly close and latch in the frame to prevent smoke from entering occupant's room. Interview with custodian revealed the facility was not aware of the door to Rooms 306, 325, and 506 did not properly latch to create a seal, when closed, to prevent the transfer of smoke.	K 363	latch. This specific function will now be monitored with the weekly fire safety inspection schedule completed by the Maintenance Supervisor.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based upon visual observation, the common area across from room 325 had electical outlets which were lacking an electrical cover. The electrcal covers are used to prevent touching a live wire and prevent shocking of patients. The deficient practice had the potential to affect 25 of 25 residents. 1 of 5 smoke compartments were deficient. Findings:	K 911	On 01/15/2020 the Maintenance Supervisor replaced the outlet cover and this function will now be added to his weekly inspection of the home.	1/30/20

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MAISON DE'VILLE NURSING HOME	**107 SOUTH HOLLYWOOD DRIVE** **HOUMA, LA 70360**

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K 911	Continued From page 7 During the facility tour, between the hours of 12:30 pm and 3:15 pm, it was discovered that oulets across from room 325 were lacking an electrical cover to prevent touching of live wires. Interview with the custodian reveled that the facility was not aware of the exposed wires located across from 325.	K 911		

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	195307	A. BUILDING _____ B. WING _____	C 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

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F 000	INITIAL COMMENTS Recertification Survey and Complaint #LA00054077. Tag F600 cited as a result of Complaint #LA00054077.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 (#3 and #96) of 6 (#3, #26, #67, #76, #96, and #258) residents were free from physical abuse by other residents. This deficient practice resulted in Immediate Jeopardy on 12/01/2019 at 3:25pm for Resident #3 when he was hit by Resident #67 and fell to the floor sustaining a right femoral neck fracture. Resident #3 and #67 engaged in a verbal altercation on the smoking patio which continued into the dining room of the facility. Resident #67, who had a history of social inappropriateness with disruptive behaviors that included fighting, hitting	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/14/2020

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F 600	Continued From page 1	F 600		

and being combative with other residents, was involved in another physical altercation with Resident #96 on 12/14/2019. The altercation on 12/14/2019 resulted in resident #96 sustaining a small laceration to the posterior head and a small laceration to the left index finger.

The facility implemented corrective actions which were completed prior to the State Agency's completion of its investigation, thus it was determined to be a Past Noncompliance citation.

Findings:

Review of the record revealed Resident #67 was admitted to the facility on 03/20/2013 with diagnoses which included, in part, Alcohol Dependence with Alcohol Induced Persisting Dementia, Major Depressive Disorder; Recurrent, Severe with Psych Symptoms, Intermittent Explosive Disorder, Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbances, Bipolar II Disorder, Schizoaffective Disorder and Alzheimer's Dementia.
Further review revealed Resident #67 was discharged from the facility on 12/30/2019.

Review of Resident #67's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/2019 revealed, in part, Resident #67 had no Brief Interview for Mental Status (BIMS) score, which indicated he was severely cognitively impaired. Further review revealed Resident #67 had verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others) 1 to 3 days in the 7 day prior assessment period.

Review of Resident #67's record revealed a care

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plan was developed which identified Resident #67 with socially inappropriate/disruptive behaviors with targeted behaviors listed, in part, as fighting and hitting. Further review revealed Resident #67 was identified as combative, resident to resident, with incidents listed on 10/01/2019, 12/01/2019, and 12/14/2019. Further review revealed Resident #67 required observation, constant supervision.

Review of Resident #67's nurse's notes dated 12/01/2019 at 3:30pm revealed Resident #67 was transported to a local Emergency Department (ED) to be evaluated due to an altercation between him and Resident #3. Resident #3 provoked Resident #67 by hitting him from behind in the dining room. Further review of the nurse's notes revealed when the nurse heard screams "stop it," she arrived in the dining room and observed Resident #67 kicking at Resident #3 while he was on the floor. Review of the nurses notes also revealed Resident #67 started punching on Resident #3 and the nurse grabbed Resident #67's arm to keep him from hitting Resident #3.

Review of Resident #3's record revealed an admission date of 08/08/2019 with diagnoses which included, in part, Anxiety Disorder and Malignant Melanoma of the Skin.

Review of Resident #3's MDS with an ARD of 11/06/2019 revealed he had a BIMS score of 15 which indicated he was cognitively intact. Resident #3 had no moods or behaviors in the 7 day prior assessment period. Resident #3 had no falls since admission/reentry/prior assessment, and no fractures.

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F 600	Continued From page 3	F 600		

Review of an Investigation of Physical Altercation form dated 12/02/2019 revealed, in part, a witness reported Resident #3 became agitated when Resident #67 asked for a cigarette lighter twice while on the smoking patio. Both residents cursed at each other. The incident continued in the dining room. Resident #67 turned and hit Resident #3 back. Resident #3 tried to hit Resident #67 again, swung, and missed and fell to the floor on his right side.

Review of Resident #3's Hospital discharge summary dated 12/03/2019 revealed, in part, Resident #3 came to ED with a fall. Resident #3 stated he got into an altercation with another resident after drinking vodka. Resident #3 was punched and fell. X-ray positive for impacted right femoral neck fracture and noted limitation to movement.

Review of the facility's incidents involving Resident #67 revealed the following:
06/07/2019 - Resident #67 was seen hitting another resident while on the smoking patio.
10/01/2019 - Resident #67 was trying to steal another resident's milk, when the other resident hit Resident #67's hand, and caused a scratch.
12/01/2019 - Resident #67 hit Resident #3, which caused Resident #3 to fall and suffer a right femoral neck fracture.
12/14/2019 - Resident #67 hit another resident, which caused the resident's chair to flip, hitting the window, and caused the window to crack. The resident had a small laceration to his posterior head, and a small laceration to the left index finger.

Review of Resident #67's nurses notes revealed, in part, the following:

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F 600	Continued From page 4	F 600		

06/07/2019 at 3:35pm - was given report that Resident #67 had physical altercation with another resident today. Resident #67 received an order to send Resident #67 to a local behavioral center. Resident #67 left at 3:35pm. The resident returned to the nursing facility on 06/20/2019.

Review of Resident #67's record revealed Resident #67 was sent out to a local hospital on 12/01/2019 for evaluation after an altercation, was returned to the facility on the same day, and had no new interventions implemented to ensure residents' safety.

In an interview on 01/17/2020 at 10:08am, S3Assistant Director of Nursing (ADON) stated when Resident #67 acted up, the facility sent him to a behavioral hospital, and sometimes to the Emergency Department. S3ADON was unable to provide documented evidence of care plan revisions and interventions with measurable goals to ensure residents' safety.

In an interview on 01/17/2020 at 10:20am, S9Corporate Nurse stated any resident with a history of resident to resident altercations should be monitored closely.

In an interview on 01/17/2020 at 11:45am, S1Administrator stated that Resident #67 did not tolerate other people fussing with him. S1Administrator was unable to provide documented evidence of care plan revisions and interventions with measurable goals to ensure residents' safety.

In an interview on 01/17/2020 at 1:15pm, S15Certified Nursing Assistant (CNA) stated she

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was not aware that Resident #67 required increased supervision.

In an interview on 02/05/2019 at 09:55am, S1Administrator he was unsure if staff were present on the patio when Resident #3 and Resident #67 had a verbal altercation on 12/01/2019.

In a telephone interview on 02/06/2019 at 12:50pm, S23LPN stated on 12/01/2019, she heard screaming, and went to the dining room. S23LPN saw Resident #3 on the ground with Resident #67 swinging at him. Resident #3 and Resident #67 were sent to a local hospital for evaluation. S23LPN confirmed Resident #67 had a history of physical altercations with other residents, and was unsure of any new interventions implemented to ensure residents' safety.

In an interview on 02/06/2019 at 1:19pm S18LPN/Care Plan Nurse stated she was Resident #67's nurse for 3 years, and Resident #67 would lash out if provoked. S18LPN Care Plan Nurse was unable to provide documented evidence of care plan revisions and interventions with measurable goals to ensure residents' safety.

In an interview on 02/07/2019 at 11:45am, S24Corporate Nurse stated on 12/01/2019, S23LPN witnessed a verbal altercation which occurred between Resident #67 and Resident #3, and the incident was reported to S25Weekend Supervisor. S25Weekend Supervisor did not report the incident to S1Administrator until after the physical altercation in the dining room occurred a couple of hours later. S24Corporate

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Nurse stated Resident #3 and Resident #67 were not placed on increased supervision, or monitored more closely after the verbal altercation on the patio.

In a telephone interview on 02/07/2019 at 12:50pm, S23LPN confirmed she reported a verbal altercation which occurred between Resident #3 and Resident #67 on 12/01/2019 to S25Weekend Supervisor. S23LPN further confirmed she did not recall that either of the residents were placed on increased supervision.

In an interview on 02/07/2020 at 12:55pm, S25Weekend Supervisor confirmed she was aware of a verbal altercation which involved Resident #3 and Resident #67 on 12/01/2019 which occurred on the smoking patio. S25Weekend Supervisor stated the residents were separated, and she accompanied Resident #3 to his room because he was still upset. S25Weekend Supervisor was unable to recall if the residents were placed on increased supervision. S25Weekend Supervisor further confirmed a physical altercation occurred between Resident #3 and Resident #67 later in the day on 12/01/2019, which resulted in Resident #3's injury.

In an interview on 02/07/2019 at 1:12pm, S1Administrator stated the verbal altercation between Resident #3 and Resident #67 which occurred on 12/01/2019 was not reported to him until after the physical altercation, which resulted in Resident #3's injury on 12/01/2019 at 3:25pm.

Review of Resident #96's record revealed he was admitted to the facility on 05/23/2019 with diagnoses which included, in part, Encounter for

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Attention to Gastrostomy, Hypoxic Ischemic Encephalopathy, Schizophreniform Disorder, Anxiety Disorder, Anoxic Brain Damage.

Review of Resident #96's MDS with an ARD of 12/19/2019 revealed a BIMS score of 7, which indicated he was severely cognitively impaired. Resident #96 had verbal behaviors 1 to 3 days in the prior assessment period.

Review of Resident #96's nurse's notes entry dated 12/14/2019 at 8:10pm revealed, in part, the nurse heard loud talking, was walking toward the voices, then heard a "smack" sound, furniture moving, and the sound of glass breaking. The nurse met Resident #67 walking away from the area. The nurse found Resident #96 on the floor against a broken glass panel, and broken glass on the left side of the room. The nurse assessed Resident #96 for injuries and noted a small laceration to the left index finger, and a laceration to the back of his head.

Record reviews revealed Resident #96 and Resident #67 were both sent to a local hospital for evaluation. Resident #96 had a laceration to the scalp and index finger, which required no sutures. Resident #67 was admitted for treatment of a urinary tract infection, returned to the facility on 12/20/2019. Resident #67 was placed on one to one observation until he was discharged to another facility on 12/30/2019.

Throughout the survey from 02/05/2020 through 02/07/2020, random staff interviews revealed staff received training on the facility's abuse policies and procedures, and were knowledgeable of what to do in the event of any observed resident abuse. In interviews with

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sampled and un-sampled residents, residents revealed they were knew who to report abuse to.

The facility has implemented the following actions to correct the deficient practice effective 12/02/2019 at 3:25pm:

1.) Initiated investigation of 12/01/2019 incident resulting in resident injury to identify any needed improvements in staff addressing resident aggression.

2.) Reeducated Department Heads and Weekend Registered Nurse Supervisor on Abuse and Neglect related to resident altercation and aggression to implement appropriate interventions to ensure resident safety on 12/02/2019. Completion date listed as 12/20/2019. Review of staffing in-service records revealed nurses and CNAs were in-serviced on abuse policies on 11/01/2019, and again on 12/15/2019.

3.) DON/Designee will review resident behaviors with nurses during morning nurse meeting. Any reported resident behaviors will be reviewed in the daily morning QA meeting to ensure appropriate assessments and interventions.

4.) Administrator/Designee will audit Incident and Accident reports to ensure appropriate assessments and interventions were initiated and plan of care followed. Audits will be conducted weekly for 6 weeks and then as deemed necessary by the QAPI Committee. Any identified issue will be addressed with reeducation, revision of plan, and progressive discipline as deemed necessary by the team. Review of the facility's daily nursing reports and

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F 600	Continued From page 9 morning meeting notes revealed documentation of monitoring for incidents, accidents, and resident behaviors. Review of the administrator's daily meeting notes revealed, in part, documentation of reported falls, behaviors, incidents, and other concerns. Review of the facility's Quarterly QA meeting notes dated 01/31/2020 revealed documentation a QAPI was initiated regarding abuse and neglect. The facility began reviewing behaviors in the daily QA, ensuring appropriate assessments and interventions. Monitoring of behaviors became a system change that will be continued and audited monthly until the next quarterly review. 5.) Compliance date 12/30/2019.	F 600		
F 646 SS=E	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to notify the state mental health authority that a PASARR 2 (pre admission screening and resident review) was needed on 2 (#69, #88) of 28 sampled residents with a mental illness. This deficient practice had the potential to affect any of the 113 residents listed on the facility's census list. Findings: Resident #69	F 646	1. OBH PASRR level 2 request for resident review was completed and submitted resident #69 and #88. 2. Chart review of current census has been conducted to determine any other residents that require a level 2 review. Identified residents who need to have a resident review and have not had one done will have one completed. 3.Social Service/admit nurse will be	2/12/20

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F 646	Continued From page 10 Record review revealed Resident #69 was admitted to the facility on 04/07/16 with diagnoses, in part, of Insomnia and Anxiety. Resident #69 was diagnosed with Schizoaffective Disorder on 08/03/17. Further review revealed Resident #69 did not have a mental illness diagnosis when a Level 1 PASARR was completed on 11/12/15. In an interview on 01/13/2020 at 2:45pm, S10Social Worker stated she did not have a Level II PASARR on file for Resident #69. In an interview on 01/17/2020 at 9:33am, S11Social Worker stated the facility's social services department was responsible for notifying the Office of Behavioral Health when a resident has had a significant change mental health diagnosis that required a Level II PASARR. In an interview on 01/17/2020 at 9:41am, S2DON confirmed there was no documentation of a Level II PASARR for Resident #69. S2DON further agreed that Level II PASARR should have been completed when Resident #69 was diagnosed with Schizoaffective Disorder. Resident #88 Record review revealed Resident #88 was admitted to the facility on 11/15/13 with diagnoses, in part, of Hypertension, Depression and back pain. Further review revealed Resident #88 had a Level 1 PASARR completed on 11/11/13. Record review revealed Resident #88 was diagnosed with Bipolar II disorder on 08/27/14 and schizoaffective disorder on 09/29/15. In an interview on 01/13/2020 at 2:45pm, S10Social Worker stated she did not have a Level II PASARR on file for Resident #88. In an interview on 01/17/2020 at 9:33am, S11Social Worker stated the facility's social	F 646	reeducated on the criteria for Resident review and completing and submitting required documents timely. 4. Residents will be monitored by Social services or designee in accordance with the MDS assessment schedule and hospital readmissions for compliance with OBH resident review requirements and a monitoring tool completed weekly. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed. The tool will be reviewed with the Administrator weekly.	

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F 646	Continued From page 11 services department was responsible for notifying the Office of Behavioral Health that a significant change in mental health diagnosis was required for Resident #88 to obtain a Level II PASARR assessment. In an interview on 01/17/2020 at 9:40am, S10Social Worker stated the process for obtaining a Level II PASARR on Resident #88 would have been to complete a level II request and faxed to the Office of Behavioral Health who would then send a representative out to complete an assessment. In an interview on 01/17/2020 at 9:41am, S2DON confirmed there was no documentation of a Level II PASARR for Resident #88. S2DON further agreed that Level II PASARR should have been completed on Resident #88 who later was diagnosed with Schizoaffective and Bipolar disorder.	F 646		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		2/12/20

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F 656	Continued From page 12 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews the facility failed to ensure resident's care plans were revised with measureable interventions and time tables after a fall (Resident #64 and Resident # 81). This deficient practice was identified for 2 (Resident #64 and Resident #81) of 3 residents reviewed for accidents in a total investigation sample of 28 residents and had the potential to affect any of the 113 residents residing in the facility as documented on the Resident Census and Conditions of Residents form (CMS-672). Findings:	F 656	1. Resident #64 and #81 have had the care plan reviewed and revised as indicated to assure measurable goals and time tables related to falls. 2. Chart audit will be conducted to determine residents that have sustained a fall since 1/1/20. Identified residents will have their care plan reviewed and revised as indicated to assure goals and time tables are measurable. 3. Care plan nurses will be reeducated on	

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F 656	Continued From page 13 Resident #64 Review of Resident #64's record revealed an admit date of 10/23/2017 with diagnoses, in part, of Unsteady Gait with History of Falls, History of CVA on Coumadin Therapy, and Delirium. Review of Resident #64's Significant Change Minimum Data set (MDS) with an Assessment Reference Date (ARD) of 10/22/2019 revealed, in part, the Brief Interview for Mental Status not completed due to resident unable to be understood, required a one person assist for transfers, bed mobility, toileting, and activities of daily living, was always incontinent of bowel and bladder and had one fall prior to assessment with no injury noted. Review of Resident #64's fall risk assessment dated 10/22/2019 and 12/12/19 indicated Resident #64 was a high risk for falls. Review of facility's incident/accident log dated October 2019 and November 2019 revealed Resident #64 had a fall on 10/31/2019 and 11/17/2019. Review of Resident #64's care plan revealed no revision to the care plan with a measurable intervention after Resident #64's fall on 11/17/19. In an interview on 01/16/2020 at 12:45pm, S2DON confirmed Resident #64's care plan was not revised after a fall on 11/17/19. Resident #81 Review of Resident #81's record revealed an admit date of 08/29/19 with diagnoses of, in part, Bipolar, Major Depressive Disorder with a fall at	F 656	completing care plans with goals and time tables that are measurable 4. DON/designee will review the care plan for each resident post fall to assure care plans have measurable goals and time tables. Any care plan that does not meet the requirement will be revised upon identification. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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F 656	Continued From page 14 home. Review of Resident #81's MDS with ARD of 10/30/19 revealed, in part, BIMS not assessed due to resident severely impaired; required one person extensive assistance for bed mobility and transfers and had one fall since prior assessment: injury (not major) and no falls with major injury. Review of the facility's incident/accident log revealed in part, Resident #81 had a witnessed fall on 10/17/19 and unwitnessed fall on 10/28/19. Review of Resident #81's care plan revealed no revision to the care plan with measurable interventions with timetables implemented after Resident #81 falls on 10/17/19 and 10/28/19. In an interview on 01/15/20 at 2:54pm, S17LPN/Care plan nurse confirmed the approaches listed on Resident #81's fall care plan after her 10/17/19 and 10/28/19 fall were not measureable interventions with timetables. In an interview on 01/17/2020 at 9:35am, S2DON reviewed the above deficient practice and had no additional documentation to present.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 677	1. Resident # 205 had a shower during	2/12/20

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F 677	Continued From page 15 failed to ensure residents received a shower according to their schedule for 1 (Resident #205) of 3 (#10, #14, #205) residents sampled for activities of daily living in an investigation sample of 28 residents. This deficient practice had the potential affect any of the 113 residents that resided in the facility as documented on the Residents Census and Conditions form (CMS-672). Findings: Review of Resident #205's record revealed an admit date of 11/29/19 with diagnoses of, in part, Left Fracture of Tibia/Fibula status post Open-Reduction Internal Fixation, and Morbid Obesity. Review of Resident #205's Certified Nursing Assistant (CNA) flowsheet dated January 2020 revealed in part, documentation of a shower given on the following dates/times: 6:00am to 2:00pm shift: 01/07/2020, 01/08/2020, 01/09/2020 and on 01/13/2020, 01/14/2020, and 01/15/2020. Further review of the CNA flowsheet revealed documentation Resident #205 received a bed bath on 01/11/2020 and 01/12/2020. Observation on 01/13/2020 at 11:38am revealed Resident #205 was sitting in her wheelchair in her room and her hair appeared very oily, and not combed. Resident #205's stated she had not had a shower or a bed bath since last Tuesday, 01/07/2020. Resident #205 stated she was scheduled to get a shower every other day. Resident #205 stated she was able to get into her wheelchair and sat in the shower chair when the CNA's took her to the shower. Resident #205's family was in the room and confirmed she did not	F 677	the survey 2. All residents have the potential to be affected 3. Nurses aides will be reeducated on the bath schedule, providing services to assure residents are clean and well groomed, and documenting such care. 4. 10% of the residents will be monitored 3 days a week x 4 weeks. by the DON/designee to assure residents are clean and well groomed. This will be monitored using a QA tool. Identified areas will be corrected at time of observations. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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receive a shower since 01/07/2020.

In an interview on 01/13/2020 at 11:38am, Resident #205 stated she spoke with the Occupational Therapist this morning and he told Resident #205 that he would make sure she received a shower today.

In an interview on 01/15/2020 at 9:40am Resident #205 denied receiving a shower today and confirmed she did not receive a shower on Monday, 01/13/2020 after surveyor interviewed her.

In an interview on 01/16/2020 at 10:20am Resident #205 stated she did not receive a shower yesterday.

In an interview on 01/15/2020 at 9:55am S21CNA stated Resident #205 goes to the shower and Resident #205 gets a shower every other day. S21CNA stated Resident #205's shower day varied because she was in a private room. S21CNA stated she would look at the CNA flowsheet to determine if the previous day CNA had taken Resident #205 for her shower. S21CNA stated Resident #205 was a two person assist for bathing in the shower. S21CNA stated Resident #205 did not receive a shower today. Record review of Resident #205's CNA flowsheet dated January 2020 with S21CNA revealed there was documentation that Resident #205 had a shower on 01/13/2020, 01/14/2020 and 01/15/2020 and her documentation for 01/15/2020 was not accurate. S21CNA confirmed Resident #205 did not receive a shower on 01/15/2020.

In an interview on 01/15/2020 at 10:05am,

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Resident #205 stated her CNA told her on Thursday, 01/09/2020 and Saturday, 01/11/2020 that it was too cold outside for her to take a shower and have her hair washed. Resident #205 confirmed she had not received a bed bath or shower since 1/07/2020.

In an interview on 01/16/2020 at 10:25am, S22Occupational Therapist (OT) stated he observed Resident #205 on the morning of Monday, 01/13/2020 and her hair was very oily and she had a strong body odor. S22OT stated Resident #205 told him she had not had a shower since Tuesday, 01/07/2020. S22OT confirmed Resident #205 was a reliable resident to interview and she was cognitively intact. S22OT stated he told Resident #205's CNA to give Resident #205 a shower on Monday, 01/13/2020, and he assumed it would be done.

In an interview on 01/15/2020 at 10:00am, S2DON stated the CNA's on each hall are responsible for bathing/showering their assigned residents. S2DON stated she observed Resident #205 on Monday, 01/13/2020 and her hair looked wet, so she thought Resident #205 had received her shower on 01/13/2020. S2DON was unaware Resident #205 had not received a shower since 01/07/2020 and she did not receive a shower on Monday, 01/13/2020. S2DON confirmed not receiving a shower in seven days was an issue and residents should receive a shower every other day, including the weekends, if that was her preference. Surveyor informed S2DON that the CNA flowsheets were inaccurate and the CNA documented Resident #205 received a shower on 01/08/2020, 01/09/2020, 01/13/2020 and 01/15/2020 and Resident #205 did not receive a shower on those days, and bed baths were

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F 677	Continued From page 18 documented on 01/11/2020 and 01/12/202 and they were not performed. S2DON did not present any additional information.	F 677		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		2/12/20

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F 690	Continued From page 19 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to: 1. Ensure a resident's catheter was changed as ordered (Resident #13); 2. Ensure a urinalysis was collected as ordered after a new catheter was placed (Resident #13); 3. Record urinary output every shift and 24 hour total (Resident #81); 4. Ensure a urine collection leg bag was used only when resident was sitting, standing or walking (Resident #81); 5. Revise a resident's care plan with measureable interventions with timetables after a diagnosis of a urinary tract infection (Resident #81); and 6. Ensure catheter care was performed according to standard infection control practices (Resident #81). This deficient practice was identified for 2 (Resident #13 and Resident #81) of 2 residents sampled for urinary catheter and/or urinary tract infection in an investigation sample of 28 residents. The deficient practice had the potential to affect any of the 15 residents with indwelling catheters as documented on the facility's Residents Census and Conditions Form (CMS-672). Findings: Resident #13 Review of Resident #13's Face Sheet revealed an admit date of 03/02/2010 with diagnoses including neurogenic bladder (injury of the central or peripheral nerves involved in controlling urination) and urinary tract infection.	F 690	1. Resident # 13 had urinary catheter changed. Resident # 13 had physician notified of failure to obtain urinalysis and orders were followed. Resident #81 had urinary output including 24hr total completed 1/18/20. Resident had urinary leg bag added as care planned. Resident #81 had the UTI care plan revised to include measurable interventions and timetables. Resident # 81 had catheter care preformed starting 1/18/20 that meets Infection control standards 2. Residents with catheters and orders for urinalysis were identified through chart audit. Those residents were reviewed to assure a)all orders for urinalysis were followed, b)urinary catheters were changed as ordered (c)outputs were completed including 24hr totals, (d)urine collection bags were appropriate and care planned correctly,)e)care plans were reviewed and revised as indicated for all identified residents to include measurable goals and timetables. 3. MDS, Care plan nurses will be reeducated on following orders and appropriate care plan interventions with measurable goals and timetables and initiating care plans. Aides and floor nurses were reeducated on recording output, collection bags, following care plans, and following physician orders.	

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F 690	Continued From page 20 Review of Resident #13's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/09/2019 revealed Resident #13 had a Brief Interview for Mental Status Score (BIMS) of 15 (cognitively intact). Further review of the MDS revealed Resident #13 had an indwelling catheter with a diagnosis of neurogenic bladder. Review of Resident #13's January 2020 Physician Orders revealed an order to change suprapubic catheter every other weekend and prn (as needed). Further review of Resident #13's Physician Orders revealed an order to obtain a urinalysis when new catheter is inserted. Review of Resident #13's Care Plan revealed Resident #13 had a potential for urinary tract infections related to the presence of a catheter. Further review of Resident #13's care plan included an intervention to change Resident #13's catheter as ordered. Review of Resident #13's December 2019 Medication Administration Record (MAR) revealed documentation of Resident #13's suprapubic catheter was changed on 12/05/19 and 12/18/19. Review of Resident #13's January 2020 (MAR) revealed documentation of Resident #13's suprapubic catheter was changed on 01/13/2020. In interview on 01/15/2020 at 8:16am, S2Director of Nursing (DON) stated she is responsible for changing Resident #13's catheter. She stated she changed Resident's catheter on 01/13/2020. In interview on 01/15/2020 at 9:56am, S2DON stated there was no documentation that Resident	F 690	Aides have had skills checklist completed for catheter care per policy. 4. DON/designee will monitor catheter care plans as developed using a monitoring tool. DON/designee will audit catheter documentation 3 x week for completion x 4 weeks using a monitoring tool DON/designee will make observational rounds 3 x week x 4 weeks for adherence to orders and care plan interventions regarding collection bags using a monitoring tool. DON/designee will monitor catheter changes months using monitoring tool. Identified issues will be corrected at time identified. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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#13's catheter was changed from 12/18/19 to 1/13/20. She stated without documentation, there is no way to prove the catheter was changed.

In interview on 01/15/2020 at 10:35am, Resident #13 stated the last time his suprapubic catheter was changed was on 12/18/19. He stated he kept track of the dates of his catheter changes on his computer.

In interview on 01/16/20 at 3:09pm, S2DON stated she did not obtain a urinalysis with Resident's catheter change on 01/13/2020. S2DON further stated she was unaware Resident #13 had an order to obtain a urinalysis with each new catheter insertion.

In interview on 01/16/20 at 3:10pm, S9Corporate Nurse denied any UAs were collected with the catheter changes in December 2019 or January 2020.

Resident #81
Review of Resident #81's record revealed an admit date of 08/29/19 with diagnoses of, in part, Interstitial Cystitis, Neurogenic Bladder and Urinary Retention.

Review of Resident #81's MDS with ARD of 10/30/19 revealed in part, BIMS not assessed due to severely impaired; required one person extensive assistance for personal hygiene and one person total dependence for toilet use; appliance assessed under bowel and bladder section and was always incontinent of urine and bowels.
Review of Resident #81's Physician Orders dated 11/19/19 revealed an order for a foley catheter. Further review of orders dated November 2019

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revealed in part, an order to record output every shift and 24 hour total.

Review of Resident #81's Physician Orders dated December 2019 revealed, in part, an order for foley catheter.

Review of Resident #81's Physician Orders dated January 2019 revealed an order to record output every shift and 24 hour total.

Review of Resident #81's MAR dated November 2019 revealed no documentation of output recorded for the following dates/times:
6:00am-2:00pm shift: 11/22/19 through 11/25/19, 11/27/19, 11/29/19 and 11/30/19;
2:00pm-10:00pm: 11/30/19.

Further review of Resident #81's November 2019 MAR revealed no documentation of a 24 hour output total for the month of November.

Review of Resident #81's intake and output record dated December 2019 revealed no documentation of output on the following dates/times:
6:00am-2:00pm shift:
12/05/19, 12/06/19, 12/13/19, 12/14/19, 12/15/19, 12/17/19, 12/20/19, and 12/31/19;
2:00pm to 10:00pm shift: 12/29/19; and
10:00pm to 6:00am shift: 12/29/19.

Further review of Resident #81's intake and output record dated December 2019 revealed no documentation of the 24 hour totals of Resident #81's output for the month of December 2019.

Review of Resident #81's MAR dated January 2019 revealed in part, no documentation of 24

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hour output totals for the following dates: 01/03/2020, 01/04/2020, 01/10/2020, 01/11/2020, and 01/12/2020.

Review of Resident #81's care plan with problem onset date of 10/30/19 for foley catheter and is incontinent of bowel with approaches in part, give perineal care when resident is incontinent, use urine collection leg bag only when resident is sitting, standing, or walking, position urine collection bag below level of bladder, position catheter tubing below level of bladder, and position resident so urine will drain from bladder. Further review of Resident #81's care plan revealed in part, infection risk for recent treatment of diagnoses UTI with an approach in part, to ensure correct perianal cleansing with no revision to the care plan after Resident #81 diagnosed with UTI on 09/05/19, 10/23/19 and 01/14/2020.

Observation on 01/15/2020 at 12:55pm, surveyor walked into Resident #81's room and Resident #81 was lying flat in bed on her right side. Surveyor observed S15Certified Nursing Assistant (CNA) perform catheter care on Resident #81 with S16Restorative CNA standing on the side of Resident #81's bed. Resident #81 was lying supine in her bed with foley catheter attached to a leg bag which was secured to Resident #81's thigh with velcro straps to the top and bottom of the leg bag. Resident #81's leg bag was dated 01/15/19. S15CNA donned gloves and went to Resident #81's bathroom and wet a wash cloth and applied shampoo/body wash liquid to the wet wash cloth. S15CNA then took Resident #81's adult brief off and took the wet wash cloth and cleaned Resident #81 from back to front multiple times then took the same wash cloth and wiped the catheter tubing from insertion

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site down the tubing away from insertion site. S15CNA then took a dry wash cloth and wiped Resident #81 from back to front multiple times then applied a clean adult brief. S16CNA informed S15CNA that she did it all wrong and she should know better than to wipe back to front. S16CNA also informed S15CNA she should rinse the soap off of the resident because the soap can irritate her.

In an interview on 01/15/2020 at 1:45pm, S2DON was informed of the break in infection control during Resident #18's catheter care with S15CNA. S2DON stated the CNA should know how to wipe front to back. S2DON stated an inservice on incontinence care was done on 11/21/19, but there was no monitoring or observation of CNA staff after the inservice was given.

In an interview on 01/17/2020 at 9:35am, S2DON reviewed documentation for Resident #81's output and confirmed there was no documentation of urinary output or 24 hour totals for the dates/times mentioned above.

In an interview on 01/15/2020 at 2:35pm, S17CNA stated she was Resident #81's CNA and she was responsible for emptying Resident #81's foley bag. S17CNA stated Resident #81's leg bag stayed attached to her thigh when Resident #81 was sitting up or laying down. S17CNA stated they were told to keep the leg bag attached to Resident #81's thigh at all times.

On 01/15/2020 at 2:40pm, S2DON confirmed with surveyor that Resident #81 was lying flat on her right side in her bed with foley catheter attached to a leg bag secured with velcro straps

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to her upper thigh. S2DON confirmed Resident #81's foley catheter should not be attached to a leg bag while she was lying in bed.

In a joint interview on 01/15/2020 at S18LPN/Care plan (CP) and S19LPN/CP both reviewed Resident #81's CP and stated they assumed the urine collection bag would be changed when Resident #81 was lying in bed. S18/LPN/CP and S19LPN/CP both confirmed the foley attached to the leg bag should not be secured to Resident #81's leg when she was lying in bed and could have contributed to her current Urinary Tract Infection (UTI).

In an interview on 01/16/2020 at 10:10am, S8LPN stated prior to yesterday, Resident #81 had her foley catheter attached to a leg bag to her thigh all the time and S8LPN did not change out Resident #81's collection bag when Resident #81 was placed in her bed.

In an interview on 01/16/2020 at 4:10pm, S20CNA Supervisor confirmed she did not monitor CNA staff with direct observation of catheter care and/or incontinence care and only had inservices with CNA staff. S20CNA Supervisor stated CNA staff should wipe female residents front to back.

In a joint interview on 01/17/2020 at 9:15am, S18LPN/CP and S19LPN/CP stated they are notified of UTI's by receiving a copy of the orders daily and would revise the care plan. S18LPN/CP and S19LPN/CP confirmed there was no revision to Resident #81's care plan with measurable interventions with time tables for Resident #81's UTI diagnosed on 09/05/19 with a change in antibiotic on 09/10/19, UTI on 10/21/19 and a

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F 690	Continued From page 26 change of antibiotic on 10/23/19 and new diagnosis of a UTI on 01/14/2020. In an interview on 01/17/2020 at 9:35am, S2DON reviewed the above deficient practice and had no additional documentation to present.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a resident with significant weight loss received nutritional supplement as ordered. This deficient practice was identified for 1 (Resident #81) of 4 residents reviewed for nutrition, in a investigation sample of 28	F 692	1. Resident # 81 had supplement started as ordered on 1/18/20 2. Other residents affected were identified through end of month chart audit. Those identified residents had documentation	2/12/20

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F 692	Continued From page 27 residents. There were 113 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form (CMS-672). Findings: Review of Resident #81's record revealed an admission date of 08/29/19 with diagnosis of, in part, Bipolar Disorder, Major Depressive Disorder and Protein Calorie Malnutrition. Review of Resident #81's weights revealed the following weights: 08/29/19- 171 pounds; 11/01/19- 168 pounds; 12/01/19- 160 pounds; and 01/01/2020- 155 pounds, which was a significant weight loss of 7.74% in three months. Review of Resident #81's Registered Dietician (RD) Progress Notes dated 10/25/19 revealed a supplement order for Ensure one can twice a day. Further review of the RD's notes revealed no documentation of any new orders since 10/25/19. Review of Resident #81's signed Physician Orders dated November and December 2019 revealed an order for Ensure one can twice a day. Further review of Resident #81's December 2019 Physician orders revealed no documentation of a nurse signature who reviewed Resident #81's December 2019 orders. Further review of Resident #81's Physician Orders revealed no documented evidence of an order to discontinue Resident #81's Ensure twice a day by mouth. Review of Resident #81's Medication Administration Record (MAR) dated December 2019 revealed no documented evidence that	F 692	put into place to assure orders were followed. 3. Nurses were reeducated on following physician orders and reconciling orders. 4. DON/designee will monitor implementation of orders for supplements and documenting supplements weekly x 4 weeks using a monitoring tool. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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Resident #81 received one can of Ensure twice a day by mouth as ordered.

In an interview on 01/15/19 at 11:30am, S8Licensed Practical Nurse (LPN) reviewed Resident #81's Physician orders dated December 2019 and Resident #81's MAR dated December 2019. S8LPN confirmed Resident #81 had an order for Ensure one can twice a day and there was no documentation that Resident #81 received her Ensure for the month of December 2019. S8LPN then reviewed Resident #81's weights with surveyor and confirmed Resident #81 had a 7.74% weight loss in three months.

In an interview on 01/16/19 at 12:25pm, S12Registered Dietician (RD) stated she makes four visits per month at the facility and her last visit at the facility was on 01/09/19. S12RD reviewed her RD progress notes in Resident #81's record and confirmed her last documented progress note was on 10/25/19.

In an interview on 01/16/19 at 1:25pm, S3Assistant Director of Nursing (ADON) stated it was a team effort to reconcile MAR's and Physician orders on a monthly basis. S3ADON stated the nurse reconciled the orders with the MAR's would initial the MAR at the bottom after the reconciliation. S3ADON reviewed Resident #81's December 2019 MAR and confirmed there was no nurse signature or initials at the bottom of the MAR. S3ADON confirmed the Ensure order must have been missed because the orders were not reconciled with Resident #81's MAR for December 2019.

In an interview on 01/17/2020 at 9:35am, S2Director of Nursing (DON) reviewed the above

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F 692	Continued From page 29 deficient practice and had no other documentation to present.	F 692		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to assess for pain and have ordered pain medication available for use for 1 (Resident #154) of 3 (#58, #78, #154) resident's sampled for pain management in an investigation sample of 28 residents. The deficient practice had the potential to affect any of the 113 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form (CMS-672). Findings: Review of Resident #154's record revealed an admit date of 12/09/2019 with a diagnoses of a Fractured Right Clavicle, Chronic Low Back Pain, Arthritis, Spinal Stenosis of Lumbar Region at Multiple Levels. Review of Resident #154's Physician Progress Note dated 12/11/2019 revealed Resident #154 had a Lumbar Laminectomy on 08/19/2019 with a healed incision, and had joint replacement on both hips. Review of Resident #154's Baseline Care Plan	F 697	1. Resident #154 had order and pain medication obtained during survey 2. Other residents with orders for pain medications will be identified through records review and observation to assure pain medication available and pain assessment documented. 3. Nurses will be reeducated on the pain management policy 4. DON/designee will audit using a monitoring tool 3 x week (a) medication cart to assure pain meds are available for residents with orders (b) pain assessment is documented every shift on MAR . Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	2/12/20

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revealed in part, a problem identified for pain with approaches, in part, to administer pain medications as ordered; report ineffectiveness to the physician, and monitor pain levels as appropriate.

Review of Resident #154's Medication Administration Record (MAR) for January 2020 revealed, in part, an order for Percocet (pain medication) 7.5 milligrams (mg)/ 325mg by mouth every four hours as needed for pain. Further review of the MAR revealed Resident #154's last Percocet dose was on 01/08/2020 at 8:30pm.

In an interview on 01/14/20 10:21am, Resident #154 stated she experienced pain in the neck, shoulder and her lower back and had received Percocet since her admit date in December 2019. Resident #154 further stated about a week ago, a nurse told her the facility was out of her Percocet and was waiting for her doctor to respond.

In an interview on 01/15/20 10:28am, S8 Licensed Practical Nurse (LPN) stated Resident #154 was admitted with a fractured right clavicle and was always in pain. S8LPN stated Resident #154 was out of her Percocet and she would give Resident #154 Tylenol for the pain. S8LPN confirmed there was no Percocet on the medication cart for Resident #154 and she was not sure how long Resident #154 had been out of her Percocet.

Observation on 01/15/20 at 12:48pm, Resident #154 was observed in bed guarding her right arm, and stated she was in bed because she was hurting.

In an interview on 01/15/2020 at 12:48pm,

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Resident #154 stated she was in pain this morning and asked for pain medication and was told her Percocet was still not available.

Review of Resident #154's January 2020 MAR with S8LPN revealed Tylenol was not on Resident #154's MAR. S8LPN stated she faxed the doctor on Resident #154 requiring a script for the Percocet and has not received any orders.

Review of a Communication Result Report dated 01/10/2020, 01/13/2020, and 01/14/2020 revealed the doctor was faxed on Resident #154 requiring a script for Percocet.

Review of Resident #154's Daily Skilled Nurse's Note dated 01/08/2020 through 01/14/2020 revealed no documentation of the doctor being notified of Resident #154 being out of Percocet.

In an interview on 01/15/2020 at 3:00pm, S8LPN stated she did not find any notes of contacting the doctor and stated the medication should be available if there was an order for the medication.

In an interview on 01/16/20 09:46am, Resident #154 stated she was in severe pain last night and she had let the nurse know and the nurse informed her she will let the doctor know.

In an interview 01/16/20 10:40am, S2Director of Nursing (DON) stated she was not aware of Resident #154 being out of her Percocet. S2DON stated Resident #154 should have pain medication in the facility and confirmed Resident #154 was out of her Percocet since 01/08/2020. S2DON stated she was not aware Resident #154 was in pain.

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F 726	Continued From page 32	F 726		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to: 1). Ensure neurochecks were performed after a fall (Resident #64 and Resident #81); and	F 726	1. Resident # 64 and #81 were assessed and suffered no ill effects from failure to complete neuro-checks. Resident #102 received medications as ordered during	2/12/20

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F 726	Continued From page 33 2.) Ensure a resident (Resident #102) received medication as ordered. This deficient practice was identified for 3 (Resident #64, Resident #81, and Resident #102) of 28 residents in the investigation sample and had the potential to affect any of the 113 residents residing in the facility as documented on the Resident Census and Conditions of Residents form (CMS-672). Findings: Review of the facility's policy on Assessing Falls and their Causes revealed in part, After a fall: observe for delayed complications of a fall for approximately seventy-two hours after an observed or suspected fall and will document findings in the medical record Resident #64 Review of Resident #64's record revealed an admit date of 10/23/2017 with diagnoses, in part, of Unsteady Gait with History of Falls, History of CVA on Coumadin Therapy, and Delirium. Review of Resident #64's Significant Change Minimum Data set (MDS) with an Assessment Reference Date (ARD) of 10/22/2019 revealed, in part, the Brief Interview for Mental Status not completed due to resident unable to be understood, required a one person assist for transfers, bed mobility, toileting, and activities of daily living, was always incontinent of bowel and bladder and had one fall prior to assessment with no injury noted. Review of facility's incident/accident log dated October 2019 and November 2019 revealed Resident #64 had a fall on 10/31/2019 and 11/17/2019.	F 726	the survey. 2. Residents affected were determined through audit of medication administration records. Medications not documented were corrected starting 1/18/20. Residents requiring neuro checks were determined by review of incident reports since 1/18/20.Identified residents had an assessment completed by nurse to assure no negative outcomes. 3. Nurses were reeducated on administering medications and documenting the administration. Nurses were reeducated on falls management policy. 4. DON/designee will audit medication administration records to assure medications are documented 3 x week x 4 weeks. Identified concerns will be corrected at time of identification. DON/designee will monitor completion of the neuro check per policy and document results using a monitoring tool. Monitoring will be done per incident x 4 weeks. Identified concerns will be corrected at the time of identification. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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Review of Resident #64's clinical record revealed no documented evidence of neurochecks completed for the falls of 10/31/2019 and 11/17/2019.

In an interview on 01/16/2020 at 3:05pm, S7LPN stated neuro checks were suppose to be initiated after an unwitnessed fall or a fall when the head was struck. She further stated there was a neurocheck form that should be completed and placed in the resident's chart.

In an interview on 01/17/20 at 10:13am, S2DON stated there was no documentation that neurochecks were performed for Resident #64 after the falls on 10/31/2019 and 11/17/2019 and confirmed the neurochecks should have been documented.

Resident #81
Review of Resident #81's record revealed an admit date of 08/29/19 with diagnoses of, in part, Bipolar, Major Depressive Disorder with a fall at home.

Review of Resident #81's MDS with ARD of 10/30/19 revealed, in part, BIMS not assessed due to resident severely impaired; required one person extensive assistance for bed mobility and transfers and had one fall since prior assessment: injury (not major) and no falls with major injury.

Review of Resident #81's incident report dated 09/24/19 revealed in part, Resident #81 had an unwitnessed fall and was found on the floor next to a chair laying down.

Review of Resident #81's record revealed no

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documented evidence of neurochecks completed for 72 hours after Resident #81's unwitnessed fall on 09/24/19.

In an interview on 01/15/20 at 2:45pm, S2DON stated neurochecks should be done on all unwitnessed resident falls or falls that involved head injury.

In an interview on 01/17/2020 at 10:05am, S2DON confirmed there was no documentation of neurochecks after Resident #81's unwitnessed fall on 09/24/19. S2DON confirmed the nurses should have documented neuro checks for 72 hours after Resident #81's unwitnessed fall.

In an interview on 01/17/2020 at 9:35am, S2DON reviewed the above deficient practice and had no additional documentation to present.

Resident #102
Review of Resident #102's record revealed an admit date of 06/06/19 with diagnoses, in part, of Down's Syndrome, Alzheimer's and Dementia.

Review of Resident #102's Minimum Data Set (MDS) revealed in part, with an Assessment Reference Date (ARD) of 11/06/2019 revealed: Brief Interview for Mental Status (BIMS) of 3 (severely cognitively impaired). Behaviors of verbal/vocal symptoms such as yelling and shouting noted. Use of antianxiety, antidepressant, and antipsychotic medication used 7 of 7 days prior to assessment.

Review of Resident #102 Care Plan, in part, noted a Problem of Coping Impaired, Individual mild depression symptoms. Risk for depression, sleep troubles, trouble concentrating, easily

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annoyed. Approaches were: Medication as ordered. See MAR (Medication Administration Record).

Review of Resident #102's Physicians orders dated 12/30/2019 revealed Ativan (generic is Lorazepam, an antianxiety medication) 1 milligram (mg.) tablet 3 times a day.

Review of the facility's policy on Medication orders and Receipt Record revealed, in part, Medication should be ordered in advance, based on the dispensing pharmacy's required lead time.

Review of the facility's policy Administering Medications policy revealed, in part, medications must be administered in accordance with the orders, including any required time frames. Medications must be administered within 1 hour of their prescribed time, unless otherwise specified. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

Review of the Facility's policy on Medication Time Schedule revealed TID means three times a day 8AM, 12 NOON, 4 PM or 9AM, 1PM, 5PM.

Review of Resident #102's MAR for November 2019 and December 2019 revealed the following doses for Ativan/Lorazepam 1 mg. were not signed out as ordered:
11/05/2019-6am,
11/09/2019-1pm, 8pm,
11/10/2019-1pm,
11/12/2019-6am,
11/16/2019-8pm,
11/18/2019-6am,

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F 726	Continued From page 37 11/19/2019-6am, 11/23/2019-6am, 1pm, 8pm, 11/25/2019-1pm, 11/26/2019-1pm, 11/27/2019-1pm, 11/30/2019-6am, 8pm, 12/01/2019-10pm, 12/02/2019-2pm, 12/03/2019-6am, 12/14/2019-6am, 12/15/2019-10pm, 12/21/2019-6am, 12/22/2019-10pm, 12/26/2019-2pm, 12/27/2019-2pm, 12/28/2019-2pm, 10pm, 12/30/2019-2pm, and 12/31/2019-2pm. Review of Resident #102's Individual Resident's Controlled Substance Record from November 11, 2019 through December 31, 2019 of Ativan/Lorazapam 1 mg. revealed the following doses were not signed out as ordered: 11/13/2019- 2pm, 11/14/2019- 2pm, 11/18/2019- 6am, 11/23/2019- 8pm, 11/30/2019-10pm, 12/05/2019- 2pm, 12/12/2019-2pm, 12/13/2019-2pm, 10pm, 12/14/2019-6am, 2pm, 12/16/2019-2pm, 12/21/2019-8pm, 12/22/2019-10pm, 12/28/2019-10pm, 12/30/2019-8pm, 12/31/2019-2pm.	F 726		

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F 726	Continued From page 38 In an interview on 01/15/2020 at 10:45am, Resident #102's sitter and cousin stated he had missed doses of his prescribed Ativan in the last 3 months. She further stated she was told by staff his Ativan was out and they were waiting on the doctor to send a prescription. In an interview on 01/15/2020 11:18am, S14License Practical Nurse (LPN), stated when Resident #102 has a 2-3 day supply of his Ativan staff calls the MD for a refill or new prescription. In an interview on 01/15/2020 12:50pm, S2DON and S13Corporate Nurse confirmed Ativan 1 mg. was not given as ordered for Resident #102.	F 726		
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		2/12/20

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professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice

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representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible

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for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.

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F 849	Continued From page 42 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to collaborate with a hospice agency to ensure a resident had a Hospice Plan of Care for 1 resident (Resident #203) sampled for a hospice investigation in a total investigative sample of 28 residents. The deficient practice had the potential to affect any of the 5 residents receiving hospice services as documented on the facility's Resident Census and Conditions form (CMS-672). Findings: Review of Resident #203's January 2020 Physician Orders revealed an order to admit to hospice with a diagnosis of liver cancer. Review of the facility's Hospice Program Policy and Procedure revealed, in part, when a resident participates in the hospice program, a	F 849	1. Resident # 203 has a Hospice care plan. 2. All hospice residents will be audited to assure Hospice care plans are in place. 3. MDS/Care Plan nurses will be reeducated on the policy for having a Hospice care plan on the chart 4. DON/designee will monitor Hospice residents to assure Hospice care plan is in place monthly using a monitoring tool. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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F 849	Continued From page 43	F 849		

coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms.

Review of the facility and hospice agency's Long Term Care Agreement revealed, in part, Hospice Plan of Care means a written care plan established, maintained, reviewed and modified if necessary, at intervals established by the Hospice Interdisciplinary group, which includes; an assessment of each Hospice patient's needs; an identification of the Hospice Services, including Management of discomfort and symptom relief, needed to meet such Hospice patient's needs and the related needs of the patient's family; and details of the scope and frequency of such Hospice services. Further review of the facility and hospice agency's Long Term Care Agreement revealed, in part, Hospice will develop a Plan of Care for each new Residential Hospice Patient, furnishing Nursing Facility with a copy of this Plan of Care.

Review of Resident #203's hospice folder revealed no Hospice Plan of Care.

Review of Resident #203's medical record revealed no Hospice Plan of Care.

In interview on 01/17/2020 at 8:47am, S8Licensed Practical Nurse (LPN) stated the Hospice Agency should have provided the facility with Resident #203's Hospice Plan of Care, but she was unable to locate it. She agreed that without a Hospice Plan of Care, the facility would be unware of how to coordinate Resident #203's care with the hospice agency.

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F 849	Continued From page 44 In interview on 01/17/2020 at 9:11am, S1Director of Nursing (DON) confirmed Resident #203's Hospice Plan of Care was not present on the medical record. She stated Resident #203 should have a Hospice Plan of Care on his chart. She also stated the facility was unable to verify the correct coordination of Resident #203's care was taking place without a Hospice Plan of Care. In interview on 01/17/2020 at 10:02am, S1DON stated Resident #203's Hospice Plan of Care was never received from the Hospice Agency because the Hospice Agency did not have the facility's email address for correspondence. She stated the facility never asked for the Hospice Plan of Care before 01/17/2020.	F 849		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed develop and implement appropriate plans of action to correct identified quality deficiencies during the Quality Assessment and Assurance (QAA) meetings. This deficient practice was identified for the facility, but had the potential to affect any of the 113 residents who resided in the facility as documented on the facilities Resident Census and Conditions of Residents form (CMS-672).	F 867	1. The facility has conducted an in depth QAPI meeting with documentation of data 2. All residents have the potential to be affected. In depth QAPI meeting was held with documentation of data. 3. QAPI committee members have been reeducated on the QAPI policy	2/12/20

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F 867	Continued From page 45 Findings: Review of the facility's Quality Assurance and Performance Improvement (QAPI) Committee policy revealed in part, the primary goals of the QAPI Committee are to coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals. Further review of the QAPI committee policy revealed in part, the QAPI committee shall help various departments/committees/disciplines/individuals develop and implement plans of correction and monitoring approaches. These plans should include specific time frames for implementation and follow-up. The committee shall track the progress of any active plans of corrections. Review of facilities quarterly Quality Assurance Meeting dated 03/27/19 revealed no quarterly data documented for the months of January 2019 and February 2019. Review of facilities quarterly Quality Assurance Meeting dated 06/28/19 revealed no quarterly data documented for the months of April 2019 and May 2019. Review of facilities quarterly Quality Assurance Meeting dated 09/27/19 revealed no quarterly data documented for the months of July 2019 and August 2019. Review of facilities quarterly Quality Assurance Meeting dated 12/30/19 revealed no quarterly data documented for the months of October 2019 and November 2019.	F 867	4. Administrator will monitor quarterly QAPI meeting to assure requirements are met. Identified issues will be corrected at the time identified.	

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F 867	Continued From page 46 Review of the facilities identified QAPI plans in place, prior to the annual survey, revealed no documentation of any monitoring, follow-ups or goal dates in place for any of the projects. In an interview on 1/17/2020 at 2:36pm, S2DON confirmed the QA Committee met on a quarterly basis and she was the QAPI Coordinator. S2DON reviewed the quarterly QA meeting information for the year 2019 and confirmed there was incomplete and missing quarterly data for each of the quarterly meetings mentioned above. S2DON also reviewed the current QA plans that were in place, prior to the survey, and S2DON confirmed there was no documentation of monitoring, follow-ups and goal dates and signatures on the QA forms reviewed. S2DON did not provide any additional documentation.	F 867		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are	F 868		2/12/20

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F 868	Continued From page 47 necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure quality assessment and assurance committee included the medical director or his/her designee. This failed practice had the potential to affect the 113 residents residing in the facility as documented on the facility's Resident Census and Conditions of Residents form (CMS-672) Findings: Review of the facility's Quality Assurance (QA) Meeting sign in sheet for the year of 2019 revealed no documented evidence of the medical director and/or his designee having attended the meetings for the second, third and fourth quarters of 2019. Review of Quality Assurance and Performance Improvement (QAPI) Committee policy revealed the medical director listed as an individual who will serve on the committee. In an interview on 01/17/2020 at 3:15pm, S2 Director of Nursing (DON) stated the medical director usually attended the QA meetings, and wasn't sure if he was present at the 3 meetings. S2DON confirmed the quality meeting documentation for second, third and fourth quarter did not contain the Medical Director's signature.	F 868	1. The Medical Director has been included in the QA committee 2. All residents have potential to be affected. the Medical Director has been included in the QA committee. 3. Administrator and DON have been reeducated on the QA policy 4. Administrator will monitor quarterly QA committee to assure Medical Director included. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		2/12/20

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F 880	Continued From page 48	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 49 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to: 1. Ensure a toothbrush was labeled and contained in a sanitary manner (Bathroom "a"); and 2. Ensure respiratory equipment was changed weekly, dated and contained in a sanitary manner (Resident #87, Resident #203 and Resident #204). This deficient practice had the potential affect any of the 113 residents that resided in the facility as documented on the Residents Census and Conditions form (CMS-672). Findings:	F 880	1. Infection control rounds were made to assure all personal items were labelled and contained in a sanitary manner. Resident # 87, 203, 204 had their respiratory equipment changed during survey 2. Infection control rounds were made to assure all personal items were labelled and stored in sanitary manner. Residents with respiratory equipment were identified through chart audit. Those residents had their respiratory equipment changed and dated as need.	

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F 880	Continued From page 50 Bathroom "a" Observation on 01/13/2020 at 9:59am revealed an unlabeled and uncontained toothbrush on the bathroom sink in Bathroom "a." Observation on 01/14/2020 at 9:28am revealed an unlabeled and uncontained toothbrush on bathroom sink in Bathroom "a." Observation on 01/15/2020 at 12:05pm revealed an unlabeled and uncontained toothbrush on the bathroom sink in Bathroom "a." In an interview on 01/15/2020 at 1:29pm, S5Certifed Nursing Assistant (CNA) stated toothbrushes should be contained and stored in the resident's bedside drawer. She stated an unlabeled and uncontained toothbrush could cause a problem with multiple residents sharing a bathroom because any resident could use the toothbrush. In an interview on 01/15/2020 at 1:30pm, S3Assistant Director of Nursing (ADON) stated the unlabeled and uncontained toothbrush on the bathroom sink in Bathroom "a" should not have been there. She stated the toothbrush should have been labeled and contained. Resident #87 Review of Resident #87's face sheet revealed Resident #87 had a diagnosis of acute and chronic respiratory failure. Review of Resident #87's Physician Orders dated January 2020 revealed, in part, an order for oxygen at two liters per minute per nasal cannula.	F 880	3. Nurses will be reeducated on policy for changing respiratory equipment. Aides were reeducated on labelling and storing personal items in sanitary manner. 4. DON/designee will make infection control rounds to check labelling and storing of personal items and changing and documenting change of respiratory equipment per policy using a monitoring tool 3 x week x 4week. Any identified issues will be corrected through education, progressive discipline, and plan revision as needed.	

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Observation on 01/13/20 at 9:55am revealed Resident #87's oxygen tubing was not dated. Further observation revealed Resident #87's humidifier bottle was dated 01/04/2020.

Observation on 01/14/2020 at 10:45am revealed Resident #87's oxygen tubing was not dated. Further observation revealed Resident #87's humidifier bottle was dated 01/04/2020.

In interview on 01/14/20 at 10:50am, S4Licensed Practical Nurse (LPN) stated it was night shift's responsibility to change oxygen tubing and humidifier bottle. She confirmed the date on Resident #87's humidifier bottle was 01/04/2020. She confirmed Resident #87's oxygen tubing was not dated.

In interview on 01/14/2020 at 10:58am, S3ADON stated it was night shift's responsibility to change and date oxygen tubing and humidifier bottle every week. She acknowledged humidifier bottle was dated 01/04/2020 and the oxygen tubing was not dated. She agreed the oxygen tubing and humidifier bottle needed to be changed.

Resident #203
Review of Resident #203's record revealed an admit date of 11/22/19 with diagnoses, in part, Liver Cancer.

Review of Resident #203's January 2020 Physician orders revealed in part, an order for oxygen at three liters per nasal cannula as needed.

Observation on 01/13/2020 at 10:21am, Resident #203 had a nasal cannula in his bilateral nostrils and the cannula was connected to a humidifier

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bottle located next to his bed with the oxygen tubing dated 01/01/2020 and no date on the humidifier bottle.

In an interview on 01/13/2020 at 10:25am, Resident #203 was cognitively intact and stated he keeps his oxygen on at all times. Resident #203 confirmed with surveyor his oxygen tubing was dated 01/01/2020.

In an interview on 01/14/2020 at 10:15am, S3ADON stated oxygen tubing and respiratory equipment should be changed every Thursday on the night shift. S3ADON stated the nurse should document on the Medication Administration Record when the oxygen tubing, humidifier bottle and respiratory equipment was changed. S3ADON reviewed Resident #203's MAR's dated November and December 2019 and January 2020 and confirmed there was no documented evidence that Resident #203's oxygen tubing or humidifier bottle or nebulizer mask was changed once a week.

Resident #204
Review of Resident #204's record revealed an admit date of 12/31/19 with diagnoses, in part, of Chronic Iron Deficiency Anemia, Heart failure, and Cardiomyopathy.

Review of Resident #204's January 2020 orders revealed, in part, an order for oxygen at one liter per nasal cannula and Duoneb (combination medication used to treat chronic obstructive pulmonary disease) one vial via nebulizer every six hours as needed.

Review of Resident #204's MAR dated January 2020 revealed in part, documentation of Resident

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#204 receiving continuous oxygen and no documented evidence of Resident #204's oxygen tubing or humidifier bottle being changed once per week. Further review of Resident #204's MAR dated January 2020 revealed she received a nebulizer treatment on 01/01/2020, 01/02/2020, 01/03/2020, and 01/08/2020.

Observation on 01/13/2020 at 10:41am revealed Resident #204's nasal cannula was lying on top of the oxygen condenser located next to Resident #204's bed with no date on the oxygen tubing or humidifier bottle and nasal cannula was not contained. Further observation revealed Resident #204's respiratory nebulizer mask lying on top of Resident #204's bedside table not dated and not contained.

In an interview on 01/14/2020 at 10:20am, S3ADON reviewed Resident #204's MAR dated January 2020 and confirmed there was no documented evidence of Resident #204's oxygen tubing, humidifier bottle and respiratory nebulizer mask being changed once a week. S3ADON confirmed oxygen tubing and respiratory nebulizer masks should be contained in a plastic bag when not in use.

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{F 000}	INITIAL COMMENTS A desk review was conducted for the previous deficiencies cited on 02/07/2020. All deficiencies were cleared. Recertification Survey and Complaint #LA00054077. Tag F600 cited as a result of Complaint #LA00054077.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS Complaint # LA00054950-CV, A COVID-19 Focused Infection Control Survey was conducted on 05/11/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 112	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		6/22/20

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

Electronically Signed | 06/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195307	A. BUILDING _____ B. WING _____	C 05/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

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F 880	Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: 1. Ensure residents were supervised and/or encouraged to maintain social distancing of a t least 6 feet in order to help prevent the spread of COVID-19 for 5 residents observed on Patio A (Resident #R2, Resident #R3, Resident #R5, Resident #R6, and Resident #R7); 2. Ensure staff maintained CDC (Centers for Disease Control) recommended guidelines for COVID-19 (corona virus disease 19) prevention by failing to ensure staff wore a mask during care or services and maintaining social distancing (6 feet) for 2 of 2 laundry staff observed (S8Laundry and S9Laundry) and 1 of 2 CNAs (Certified Nursing Assistant) observed providing care (S7CNA); and 3. Ensure laundry staff was not eating on a table with clean linen present for 1 of 2 laundry staff observed (S8Laundry). This deficient practice was identified for 5 random residents observed on Patio A and 3 staff members but had the potential to affect any of the 112 residents residing in the facility as documented on the facility's Census List. Findings: Review of the Louisiana Department of Health's Preventing the Spread of Coronavirus 2019 in Homes and Residential Communities- Providers revealed, in part: the resident should wear a face mask when around other people; and staff were to wear a disposable face mask when you have contact with a resident.	F 880	Step I: 1. Residents 2, 3, 5, 6, 7 have been instructed to maintain social distancing on Patio A. 2. All staff are required to wear masks while in the facility 3. Laundry is no longer allowed to eat in the laundry Step II: 1. All residents who use patio A have the potential to be affected. Patio A has been sectioned off using 6 feet increments. Residents have been issued a mask. 2. All staff identified through payroll. Staff have been issued masks. 3. All residents have the potential to be affected. Step III: 1. Residents have been re-educated on maintaining 6 feet of social distancing. Patio A has been sectioned off in 6-foot areas. Residents have been educated on wearing mask. 2. Staff have been re-educated on the necessity of wearing masks at all times in the facility. 3. Laundry has been re-educated on not eating or drinking in the laundry room. Step IV: 1. Patio A will be monitored twice daily through observation for compliance with	

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F 880	Continued From page 3 1. Observation on 05/06/2020 at 9:45am revealed Resident #R2 was on Patio A with his mask off approximately 3-4 feet away from Resident #R3. Observation further revealed the only staff on Patio A was S4CNA (Certified Nursing Assistant) who was sitting at the edge of Patio A with her back to the residents and typing on her phone. Observation on 05/06/2020 at 12:55pm on Patio A revealed Resident #R5, Resident #R6, and Resident #R7 were sitting at a metal table approximately 2.5 feet by 2.5 feet round. Resident #R5 and Resident #R6 were sitting approximately 3 feet apart, and Resident #R6 and Resident #R7 were sitting approximately 1 foot apart. Further observation revealed none of the three residents were wearing masks. Further observation revealed S5Housekeeping and S6Housekeeping were present on Patio A. Surveyor never witnessed either S5Housekeeping or S6Housekeeping intervening, requesting the residents move apart, or for the residents to wear their masks. In an interview on 05/06/2020 at 1:00pm, S5Housekeeping and S6Housekeeping stated we can ask them to stay apart but no matter how many times we tell them to stay 6 feet apart they don't listen. Observation on 05/06/2020 at 2:15pm revealed three random residents were on Patio A sitting at one table approximately 2 feet apart from each other without any facial covering. Further observation revealed no staff members were present on Patio A. 2. Observation on 05/06/2020 at 9:55am	F 880	social distancing and the results documented on monitoring tool X 2 weeks then daily for 2 weeks. Noncompliance will be addressed at the time of discovery. Monitoring will be completed by Administrator or designee. 2. Staff compliance with wearing masks will be monitored daily using a monitoring tool X 4 weeks. Noncompliance will result in person in-service up to termination. Results will be discussed in morning QA weekly. Monitoring will be completed by DON or designee. 3. Laundry compliance will be monitored through observation on each shift daily X 2 weeks then daily X 2 weeks. Findings will be documented on monitoring tool. Noncompliance will be addressed at the time of discovery. Continued noncompliance will result in personal in-service up to termination. Results of observation will be discussed weekly in the morning QA meeting.	

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F 880	Continued From page 4	F 880		

revealed S7CNA was providing care to Resident #R4. S7CNA was talking to Resident #R4 approximately 2 foot away from the resident's face and S7CNA had a surgical mask tied around her neck, hanging from her neck, not covering her mouth or nose. Further observation revealed S7CNA did not have any type of covering over her mouth or nose during the observation and Resident #R4 did not have a facial covering either.

Observation on 05/06/2020 at 10:10am, of the laundry room, revealed S8Laundry and S9Laundry were sitting in the laundry room 3 feet away from each other with neither staff wearing a face covering.

In an interview on 05/06/2020 at 10:12am, S3ADON (Assistant Director of Nursing) stated the staff should have been wearing masks and social distancing of at least 6 feet apart from each other.

3. Observation on 05/06/2020 at 10:10am of the laundry room revealed S8Laundry was eating food on the clean linen table with the clean folded resident bed sheets present.

In an interview on 05/06/2020 at 10:12am, S3ADON stated the staff should have not been eating in the laundry area.

In an interview on 05/11/2020 at 1:26pm, S2DON (Director of Nursing) stated the above mentioned observations were not in compliance with CDC recommendations for COVID-19 prevention and infection control measures for social distancing and infection control measures followed by the facility.

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{F 000}	INITIAL COMMENTS A desk review was conducted for previous deficiencies cited on 05/11/2020. The deficiency was cleared. Complaint # LA00054950-CV, A COVID-19 Focused Infection Control Survey was conducted on 05/11/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 112	{F 000}		

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Electronically Signed | 09/04/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 08/05/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: (112). F885 was cited as a result of this survey. Complaint #LA00054976-CV. No deficiencies cited as a result of this survey.	F 000		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a	F 885		8/6/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 885	Continued From page 1 confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to update a recorded telephone message to inform residents and their representatives of the facility's COVID-19 status. This deficient practice had the potential to affect any of the 112 residents who resided in the facility as identified on the facility's census list. Findings: In an interview on 08/05/2020 at 10:14am, S1Administrator stated residents and families were provided a telephone number they could call to listen to a recorded telephone message regarding the facility's COVID-19 status. S1Administrator provided the surveyor with the telephone number and the surveyor dialed the number, via speakerphone, in the presence of S1Adminstrator. The recorded message revealed, in part, a COVID-19 facility status update as of 06/12/2020 with a total of 5 positive staff and 9 positive residents with 2 deaths. S1Adminstrator confirmed the recorded message was not accurate. S1Administrator further confirmed the current COVID-19 facility status was 28 positive staff and 15 positive residents with 2 deaths. In an interview on 08/05/2020 at 10:27am, S1Adminstrator stated he was responsible for a weekly update of the recorded message and stated he updated the message via an electronic fax number; however, he did not confirm the update was on the recorded message.	F 885	1. The telephone message was updated on 8/5/20 by the administrator to reflect current Covid status. 2. All residents have the potential to be affected. Corrective action was obtained for them by updating the telephone message on 08/08/20. 3. The Administrator was reeducated on F885. New admits and or Responsible Party will be provided with the information line phone number. 4. The Administrator will update the telephonic information line at least weekly or by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours and maintain a log of these updates. The Assistant Administrator or designee will verify the updates by calling the information line as outlined above to verify message is current and will initial the log as evidence for 6 weeks. Issues will be corrected as identified.	

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{F 000}	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 08/05/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: (112). F885 was cited as a result of this survey. Complaint #LA00054976-CV. No deficiencies cited as a result of this survey. A desk review was conducted for previous deficiency citred on 08/05/2020. The deficiency was cleared.	{F 000}		

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F 000	INITIAL COMMENTS Complaint #LA00056685. No deficiencies cited as a result of this survey. A COVID-19 Focused Infection Control Survey was conducted on 12/22/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 111	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		12/25/20

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

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F 880	Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a COVID-19 positive staff member (S4Licensed Practical Nurse) did not return to work until after the COVID-19 positive staff member's ten day quarantine period was completed. This deficient practice had the potential to affect any of the 111 residents residing in the facility as per the facility's census. Findings: In interview on 12/18/2020 at 11:26am, S1Administrator denied utilizing any emergency staffing at this time. S1Administrator additionally stated he was not having any issues with staffing the facility. Review of the positive employee list provided by the facility revealed S4Licensed Practical Nurse (LPN) tested positive for COVID-19 on 12/14/2020. Review of S4LPN's laboratory report, with a specimen collection date of 12/14/2020, revealed SARS CoV-2 (COVID-19) was detected. Review of the Centers for Disease Control and Prevention's recommendations, Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection, updated August 10, 2020, revealed "health care personnel who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test" or "are negative from at least two	F 880	1. On 12/21/2020 LPN S4 was sent home. On 12/22/2020 administrator and administrative staff were in-serviced by [redacted] Corporate Clinical Consultant on the proper return to work criteria for healthcare providers with SARS-Cov-2 infection. 2. All 111 residents in the facility could be affected. A baseline review of all COVID-19 test results for staff from 12/06/2020 to 12/23/2020 was completed by administrative staff to determine if any employee returned to work prior to meeting return to work criteria. Any issues identified were corrected at the time of discovery. 3. The facility conducted a root cause analysis to develop and implement training and any other measures needed to address the deficient practice as outlined in the submitted DPOC. 4. The Administrator or designee will complete the staffing sample as stated in the DPOC once per week to monitor employees for compliance with return to work criteria for healthcare providers with SARS-Cov-2 infection. Observations of findings will be recorded on monitoring tools. Monitoring will be completed for 8 weeks and then as deemed necessary by the QAPI team. Any issues noted will be corrected at the time of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195307	A. BUILDING _____ B. WING _____	C 12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 3 consecutive respiratory specimens collected ?24 hours apart (total of two negative specimens) tested using an Food and Drug Administration-authorized molecular viral assay to detect SARS-CoV-2 RNA." In an interview on 12/21/2020 at 11:20am, S4LPN, stated she was directed by S2Director of Nursing (DON) and S3Assistant Director of Nursing (ADON) that she could return to work on 12/21/2020 after her positive COVID test on 12/14/2020. S4LPN stated S2DON conducted a rapid test on 12/21/2020 and the test result was negative. In an interview on 12/21/2020 at 11:39am, S2DON stated she referred to the Louisiana Department of Health memorandum, dated 12/07/2020, for S4LPN to return to work on 12/21/2020. S2DON stated she thought S4LPN could return to work after seven days of quarantine and a negative COVID-19 test. S2DON stated she did not realize the memorandum was giving guidance regarding a close contact of an infected person and not a positive COVID-19 staff member. In an interview on 12/21/2020 at 11:54am, S1Administrator stated he had to allow S4LPN back to work on 12/21/2020, following her positive COVID-19 result on 12/14/2020, because the facility was in a staffing crisis. S1Administrator stated he was unable to pull from his administrative staff to cover S4LPN's position because the state agency was in the building, and it was three days before Christmas. Review of the facility's Coronavirus Disease (COVID-19) - Surge Capacity Staffing policy,	F 880	RCA Committee weekly to track and trend progress towards projected goal and to identify opportunities for improvement. Revisions to the plan of correction will be developed/implemented as deemed necessary based on results of monitoring.	

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F 880	Continued From page 4 revealed, "The administrator communicates with the health department, emergency planning agencies and healthcare coalitions (state and local) to identify available options for additional staffing." In interview on 12/21/2020 at 1:00pm, S1Administrator confirmed S4LPN tested positive for COVID-19 on 12/14/2020 and returned to work on 12/21/2020 prior to her recommended ten day quarantine or two negative COVID-19 tests greater than or equal to twenty-four hours apart. He stated S2DON and S3ADON are able to staff the halls, but he could not pull from his administrative staff due to the state agency being at his facility. He additionally stated he had not contacted the health department or emergency planning agency to notify them of his current staffing crisis.	F 880		