STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	5427 GEX ROAD DIAMONDHEAD, MS 39525

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaints, CI MS #15701, CI MS# 15766, and CI MS #15809 from 4/8/19 through 4/11/19. The SA did not substantiate CI MS#15701 Resident/Patient/Client Neglect-injury of unknown origin, CI MS #15766-Quality of Care/Treatment, and CI MS #15809-Resident/Patient/Client Neglect for an injury of unknown origin, and with no citations related to the complaints. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation, The SA cited the regulatory deficiencies of F623, F641, F656, and F693. At the time of the survey the census was 128, and the facility held a license for 132 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		5/15/19

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

Electronically Signed | 05/17/2019

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 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 2 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 3 Based on record review, staff interview, and facility policy review, the facility failed to provide a written notification to the Resident Representative (RR), and to notify the office of Mississippi Long Term Care Ombudsman of a resident's transfer to an acute care facility for three (3) of seven (7) residents reviewed for discharge or transfer to the hospital. Resident #100, Resident #125, and Resident #131. Findings include: Review of the facility's "Transfer or Discharge Notice" policy, dated June 2017, indicated it is the policy of this facility that the facility shall provide a resident and the RR with a written notice of an impending transfer and discharge. The facility policy noted that the facility will send a copy of all acute care transfers based on resident urgent medical needs to the State Long Term Care Area Ombudsman office as soon as practicable, such as in a list of residents on a monthly basis. Resident #100 Review of Resident #100's Physician's Telephone Orders, dated 1/3/2019 and 2/28/2019, revealed an order to send Resident #100 out to the hospital. Review of the document titled, "Departmental Notes", dated 1/03/2019, revealed, at 7:37 AM, a late entry was entered to indicate, on 1/02/2019, Resident #100 was sent out to the Emergency Room (ER) for an evaluation of abnormal vital signs, to include a low oxygen saturation, an increased heart rate, and an elevated temperature. The Departmental Notes indicated, on 1/12/2019, there was a late entry, noted that	F 623	F623 Notice Before Transfer/Discharge " Resident #100, Resident #125 and Resident s Representative were spoken to by the Director of Nursing (DON) regarding prior discharge experience, and will receive Transfer/Discharge Notices for future transfers as of 4/10/2019. Resident #131 no longer resides within the facility. " The facility recognizes that all residents with bowel incontinence and Hemodialysis have the potential to be affected by the deficient practice. The Quality Assurance (QA) Nurse will conduct a random audit of three (3) residents receiving a Notice of Transfer/Discharge weekly for six (6) weeks to ensure this deficient practice does not recur. " The DON and Social Services Coordinator completed an in-service on 4/10/2019 with the Resident Care Managers (RCM), the QA Nurse, and the Administrative Assistant. The in-service included notifying the resident and the Resident s Representative of the transfer or discharge in a language that is understood and Notification to the State Long Term Care Ombudsman. The facility implemented a Notice of Transfer/Discharge letter on 4/10/2019, for residents transferred or discharged. The Administrative Assistant will mail the notice of transfer/discharge to the Resident's Representative and to the resident. A log of the transfers/discharges will be retained by Social Services Coordinator and the State Long Term	

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F 623	Continued From page 4 Resident #100 arrived back from the hospital on 1/11/2019 at approximately 18:45 (6:45 PM). The Departmental Notes also indicated, on 2/28/2019 at 7:55 PM, that Resident #100 was sent to the ER at 1:45 PM related to an altered level of consciousness. The Departmental Notes also indicated that Resident #100 returned to the facility on 3/02/2019. During an interview, on 4/10/2019 at 1:40 PM, with the Social Services Director (SSD), it was revealed that a written notice of transfer to an acute care hospital was not sent to Resident #100's RR for the hospital transfers on 1/03/2019 and 2/28/2019. The SSD stated Resident #100 was listed on the January 2019 transfer log, sent to the State Ombudsman Office, for the 01/03/2019 hospital transfer, but was not listed on the February 2019 transfer log for the 02/28/2019 hospital transfer. The SSD stated she has only been at the facility for approximately four (4) weeks, and she has been unable to locate any notice of transfer letters sent out prior to her employment at the facility. During an interview, on 4/10/2019 at 1:58 PM, the Director of Nursing (DON), it was revealed she was unaware the written notice of transfers had not been sent out to the RR(s) by the previous SSD. The DON stated that she was unaware the log that is sent to the Stated Ombudsman every month, had not been complete. Resident #125 During an interview, on 4/08/19 at 12:15 PM, Resident #125's daughter revealed the facility does not notify her when they send her mother to the hospital. The daughter said the last time	F 623	Care Ombudsman will receive a copy of the log monthly. " The Social Services Coordinator will audit patient transfers and/or discharges every Friday to determine that notification letters have been sent to residents and resident representatives that have been transferred or discharged. The Social Services Coordinator will present the findings of the transfer/discharge audit to the Quality Assurance Committee weekly x six(6) weeks for action and review to determine if the Plan of Correction is effective and sustained.	

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Resident #125 went to the hospital the facility did not notify her. Resident #125's daughter also said the facility told her a week later.

Review of the Minimum Data Set (MDS) dated 1/23/2019, revealed Resident #125 was a discharge assessment-return anticipated.

Review the nurses notes, dated 1/23/2019, revealed the nurse attempted to call the family to report the resident was sent to the hospital. The family did not answer the phone. On 1/30/2019 the Responsible Representative (RR) called and said she was unaware of the resident going to the hospital. The facility noted the RR failed to notify the facility of the change in her number. The new number was given to the facility at that time.

During an interview, on 4/10/2019 at 2:40 PM, the Social Services Director (SSD) revealed that a written notice of transfer to an acute hospital was not sent to Resident #125's family for the hospital transfer on 01/23/2019. The social worker stated a notice to the State Ombudsman Office was sent of the hospital transfers at the end of the month. The social worker stated she has only been at the facility for four (4) weeks. The social worker also stated she has been unable to locate any notice of transfer letters sent out prior to her employment at the facility.

Resident #131

Review of Resident #131's medical record revealed the resident was sent to the hospital, on 1/24/2019, because she was observed unresponsive, no respirations. The facility was unable to obtain an apical or radial pulse. The facility initiated CPR (Cardiopulmonary

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F 623	Continued From page 6 Resuscitation). Record of the Minimum Data Set (MDS) dated 1/24/2019, revealed Resident #131 was a discharged assessment-return not anticipated. During an interview, on 4/10/19 at 2:07 PM, Registered Nurse (RN) #2 revealed the resident was sent to the hospital and was taken via (by) American Medical Response (AMR). Cardiopulmonary Resuscitation (CPR) was continued by the Emergency Medical Technician (EMT) on the way to the hospital. During an interview, on 4/10/2019 at 2:40 PM, the SSD revealed a written notice of transfer to an acute hospital was not sent to Resident #131's family for the hospital transfer on 01/24/2019. The SSD stated a notice to the State Ombudsman Office was sent of the hospital transfers at the end of the month. The SSD also stated she has only been at the facility for four (4) weeks and is unable to locate any notice of transfer letters sent out prior to her employment at the facility.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to accurately code the Comprehensive Minimum Data Set (MDS) Assessment for two (2) of (29) MDS Assessments reviewed. Resident #23 and Resident #50.	F 641	F 641 Accuracy of Assessments On 4/9/2019, the Minimum Data Set (MDS) nurse, corrected the Minimum Data Set (MDS) Assessment, dated 1/31/19, for Resident #23, by changing	5/15/19

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F 641	Continued From page 7 Findings include: A review of the facility policy titled, "Resident Assessment Instrument", dated June 2017, revealed, "the purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. Resident #23 Review of Resident #23 MDS Assessment, dated 1/31/19, revealed Section H of the MDS was coded inaccurately for bowel continence. The MDS was coded as Resident #23 is always continent while previous records indicated Resident #23 is incontinent of bowel. Review of the care plan revealed Resident #23 is incontinent of bowel. An interview, on 4/09/19 at 11:05 AM, with Licensed Practical Nurse (LPN) #2 regarding the MDS Assessment, dated 1/31/19, for Resident #23 revealed, "It's just an error. The MDS assessment should have been coded as always incontinent instead of always continent". An interview, on 4/10/19 at 10:15 AM, with the Director of Nursing (DON) revealed, "Resident #23 should have been coded on the MDS for bowel incontinence, but after reviewing the MDS it was coded for always continent".	F 641	Section H to reflect bowel incontinence. On 4/9/2019, the MDS Nurse, corrected the MDS Assessment,dated 2/15/19,forResident #50,by changing Section Oto reflect Hemodialysis. The facility recognizes that all residents with bowel incontinence and Hemodialysis have the potential to be affected by the deficient practice. All MDS Assessments for residents with bowel incontinence and with Hemodialysis were audited by the Minimum Data Set (MDS) Coordinator for accuracy on 4/9/2019, and no other residents were affected. An MDS audit will be conducted by the Director of Nursing (DON)weekly for six (6)weeks beginning on 4/12/2019 to identify accuracy of MDS assessments. An in-service was conducted by the DON to the MDS Coordinator, MDS Nurse and Care Plan Nurse on 4/9/2019from criteria and examples based from the Resident Assessment Instrument Manual from Section H and Section O. The in-service also included accuracy of assessments to reflect the resident's status. The DON will continue to audit the Minimum Data Set assessments monthly for three (3) months and then quarterly. The DON will present the MDS audit findings quarterly to the Quality Assurance Committee meeting for action and review to determine if the (POC) is effective and sustained.	

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F 641	Continued From page 8 Resident #50 Review of Resident #50's MDS Assessment, dated 2/15/19, revealed the MDS was not coded accurately indicating Resident #50 was receiving Dialysis. Review of the care plan revealed Resident #50 was to attend Hemodialysis. Review of the Physicians Orders, for Resident #50, revealed Resident #50 was to go out for Dialysis on Tuesday/Thursday/Saturday. An interview, on 4/09/19 at 11:05 AM, with Registered Nurse (RN) #1/MDS Director, regarding Resident #50 MDS Assessment revealed, "I just over looked it. The resident's MDS assessment should have been coded for Dialysis and it wasn't". An interview, on 4/10/19 at 10:15 AM, with the Director of Nursing (DON) revealed, "Dialysis should have been coded on the resident's MDS and after viewing the MDS is was not coded for Dialysis".	F 641		
F 656 SS=D	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	F 656		5/15/19

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F 656	Continued From page 9 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 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 staff interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan for Enteral Feedings for one (1) of 29 care plans reviewed, Resident #23.	F 656	F 656 Develop/Implement Comprehensive Care Plan The Minimum Data Set (MDS) Nurse implemented the Comprehensive Care Plan for Enteral Feedings for Resident	

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F 656	Continued From page 10 Findings include: Review of facility's "Care Plans-Comprehensive" policy, dated June 2017, revealed, "An individual comprehensive person centered care plan that includes measurable objectives and timetables to meet the resident's medical, mental, and psychological needs is developed for each resident. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical and psychosocial well-being. Each resident's comprehensive care plan is designed to incorporate identified problem areas". Review of the care plan, for Resident #23, revealed a high risk of Aspiration related to dysphagia, presence of a feeding tube with interventions of elevating the head of the bed to 30-45 degrees, and a tube feeding of Jevity 1.5 at 70cc/hr. An observation, on 4/09/19 at 1:15 PM, revealed Certified Nurse Aide (CNA) #2 and CNA #3 entered Resident #23's room to perform catheter care. Upon entry into the room, Resident #23 was lying in the bed in a supine position. Resident #23's bed was in a flat position with the head of the bed (HOB) also in a flat position. Resident #23's enteral feeding of Jevity 1.5 was being administered via a feeding pump at a rate of 70 cubic-centimeters per hour (cc/hr). An interview, on 4/09/19 at 1:25 PM, with Licensed Practical Nurse (LPN) #3, who came into Resident #23's room verified the feeding was running at 70cc/hr with the resident lying flat in	F 656	#23on 4/9/2019, including elevating the head of bed to at least 30-45 degrees during tube feeding, and at least 1 hour after receiving the tube feeding. Resident #23 was assessed immediately on 4/9/2019 by Licensed Practical Nurse (LPN) #3and Quality Assurance Nurse Registered Nurse for signs and symptoms of aspiration. An in-service was conducted immediately by the Quality Assurance Nurse to Certified Nursing Assistant (CNA) #2 and CNA #3 and LPN #3 to include elevating the head of bed to at least 30-45 degrees during tube feeding, and at least one (1) hour after receiving the tube feeding as indicated on the care plan. The facility recognizes that all residents receiving Enteral Feeding have the potential to be affected by this deficient practice. An audit was conducted on all residents receiving Enteral Feeding by the Director of Nursing (DON) on 4/9/2019 to ensure the head of the bed was elevated at least 30 to 45 degrees and no deficient practice was found according to the care plan. An in-service was conducted beginning immediately on 4/9/2019 and on going, by the Quality Assurance (QA) Nurse and/or Resident Care Manager (RCM) for all Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA) on providing appropriate procedures and services to prevent possible complications for a resident who receives Enteral Feeding and following the residents comprehensive care plan. The RCM, QA	

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F 656	Continued From page 11 bed, and with the HOB in a flat position. LPN #3 stated, "the HOB should be at least 30 degrees while the tube feeding is running. The feeding should be placed on hold before lying the resident flat when performing care". An interview, on 4/11/19 at 12:35 PM, with Registered Nurse (RN) #1/Minimum Data Set (MDS) Director/Care Plan Nurse revealed, "We expect the nurses and Certified Nursing Assistants (CNAs) to follow the care plan for each resident. Based on your observation of Resident #23, the care plan was not followed regarding the tube feeding. I expect staff to follow the facility policy on tube feeding". An interview, on 4/11/19 12:50 PM, with the Director of Nursing (DON) revealed, "I expect the care plan to be followed by all staff. The care plan for Resident #23 was not followed regarding the head of bed (HOB) being flat during a tube feeding". An interview, on 04/11/19 at 1:07 PM, with RN #2/Quality Assurance Nurse (QA) revealed, "I expect the CNAs and nurses to go by the care plan. The care plan was not followed for Resident #23 regarding tube feeding. Policy was not followed on tube feeding".	F 656	Nurse and/or the DON will conduct an Enteral Feeding audit of five (5) residents weekly that are receiving Enteral Feeding, beginning on 4/15/2019 for six (6) weeks then monthly for three (3) months then quarterly to ensure the Comprehensive Care Plan is being followed and to ensure this deficient practice does not recur. The DON will bring the results of the Enteral Feeding Audit to the Quarterly Quality Assurance Committee meeting. If revisions to the Plan of Correction are needed, the revisions will be developed and approved by the Quality Assurance Committee to ensure corrective action is achieved and sustained. The Quality Assurance Committee members includes: Medical Director, Administrator, DON, Infection Preventionist, and at least two other facility staff members.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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	F 693		5/15/19

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	255163	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	5427 GEX ROAD DIAMONDHEAD, MS 39525

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F 693	Continued From page 12 ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to provide appropriate treatment and services to prevent possible complications for a resident who receives Enteral Feeding for one (1) of two (2) resident feeding observations, for Resident #23. Findings include: Review of the facility's policy titled, "Enteral Feedings-Safety Precautions", dated May 2014, revealed, "The purpose of the policy is to ensure the safe administration of enteral nutrition. A Subtitle of the above named policy with the heading. "Preventing Aspiration", stated to elevate the head of the bed (HOB) at least 30-45 degrees during tube feeding, and at least 1 hour after. It further revealed a part of preventing aspiration is to recognize the risk factors for aspiration including supine position and advanced	F 693	F 693 Tube Feeding Mgmt/Restore Eating skills Resident # 23 was assessed on 4/9/2019 by Licensed Practical Nurse (LPN) #3 and Quality Assurance Registered Nurse for signs and symptoms of aspiration. Resident #23 had no signs or symptoms of aspiration. An in-service was conducted immediately by the Quality Assurance Registered Nurse to the Certified Nursing Assistant #2, Certified Nursing Assistant #3 and to Licensed Practical Nurse #3 to include elevating the head of the bed to at least 30 to 45 degrees during tube feeding, and at least one (1) hour after receiving the tube feeding. The facility recognizes that all residents receiving Enteral Feeding have the	

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F 693	Continued From page 13 age. Review of the physician's orders, for Resident #23, revealed an order for Jevity 1.5 at 70 cubic-centimeters per hour (cc/hr) x 20 hours with (water) H2O flush at 55cc/hr x 20 hours. Observation, on 4/09/19 at 1:15 PM, revealed Certified Nurse Aide (CNA) #2 and CNA #3 entered Resident #23's room to perform catheter care. Upon entry into the room, Resident #23 was lying in the bed in a supine position. Resident #23's bed was in a flat position with the head of the bed (HOB) also in a flat position. Resident #23 was receiving an enteral feeding via a feeding pump of Jevity 1.5 at a rate of 70cc/hr. Interview, on 4/09/19 at 1:25 PM, with Licensed Practical Nurse (LPN) #3, who came into Resident #23's room, verified the feeding was running at 70cc/hr with the resident lying flat in bed, and with the head of the bed (HOB) in a flat position. LPN #3 stated "the HOB should be at least 30 degrees while the tube feeding is running. The feeding should be placed on hold before lying the resident flat when performing care". Interview, on 4/09/19 at 1:30 PM, with CNA #2 revealed, "I made rounds about 10 minutes ago (prior to our entering the room to do catheter care) and I let the head of the bed down". Interview, on 4/10/19 at 10:20 AM, with CNA #1 revealed, "to be honest that was the first time I had been in Resident #23's room that day. I was just assisting CNA #2. The HOB being flat should not have happened with the feeding going. We usually get the nurse to turn the feeding off before	F 693	potential to be affected by this deficient practice. An audit of all Enteral Feeding patients was conducted Director of Nursing (DON) on 4/9/2019, to ensure the head of the bed was elevated at least 30 to 45 degrees and no deficient practice was found according to the care plan. An in-service by the Quality Assurance (QA) Nurse and/or Resident Care Manager (RCM) was conducted on 4/9/2019 and ongoing, for all Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) regarding appropriate procedures and services to prevent complications for Enteral Feeding residents and following the resident s comprehensive care plan. The Resident Care Manager (RCM), Quality Assurance (QA) Nurse and/or the Director of Nursing (DON) will conduct an audit of five (5) residents receiving Enteral Feeding weekly, beginning 4/15/2019 for six (6) weeks then monthly for three (3) months, then quarterly to ensure this deficient practice does not recur. The DON will bring the results of the Enteral Feeding audit to the Quarterly Quality Assurance Committee (QAC) meeting. If any revisions to the Plan of Correction are needed, the revisions will be developed and approved by the QAC to ensure corrective action is achieved and sustained. The QAC members include: Medical Director, Administrator, DON, QA nurse, and at least two other facility staff members.	

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	255163	A. BUILDING _____ B. WING _____	04/11/2019

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F 693	Continued From page 14 care, and we allow 30 minutes or so before we flatten the HOB to provide care. When I walked in and saw the HOB flat with the feeding going, I knew it was a big mistake". Interview, on 4/10/19 10:22 AM, with the Director of Nursing (DON) revealed, "the head of the bed should not have been flat. It should be at 30-45 degree level during a tube feeding. Yes, from a nursing stand point, the head of the bed being flat during a tube feeding could cause some complications for Resident #23. I have never had this to happen that I know of. CNA #2 is one of my best CNAs, and I think she just got nervous knowing you were going to watch her do catheter care".	F 693		

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	255163	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/10/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 05/29/2019

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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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/10/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 05/29/2019

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