STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 00 B. WING	07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction to the Investigation of Complaint IN00235042. Complaint IN00235042 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F464. Survey dates: July 10, 11, 12, 13, 14 and 17, 2017 Facility number: 002982 Provider number: 155700 AIM number: 200382090 Census bed type: SNF/NF: 56 SNF: 14 Total: 70 Census payor type: Medicare: 14 Medicaid: 26 Other: 30 Total: 70 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality Review was completed on July 24, 2017.			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under			

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	paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on interview and record review, the facility failed to notify the physician when a resident had uncontrolled pain (Resident #134) and when a resident had an abnormal pulse rate (Resident #73). Findings include: 1. During an interview on 7/10/17 at 2:39 P.M., Resident #134 indicated she was in horrible pain when she first got to the facility and she did not get relief from it until the Fourth of July weekend was over when changes were made to her medications. A clinical record review was completed	F 0157	1.The physician was updated on pain for resident #134 Resident discharge. The physician was updated on pulse rates for resident #73 on 7/24/2017. 2.A pain assessment will completed on all residents to assure pain goals are being achieved. Physician will be notified of uncontrolled pain. MARs will be reviewed to assure physician notification of pulse rate per order. 3.Nurses will be re-educated on updating physician with uncontrolled pain, and according to orders for reporting pulse rates. 4.The DON or designee will review shift report 2 times per	08/16/2017

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	on 7/12/2017 at 3:41 P.M., and indicated Resident #134 was admitted to the facility on 6/30/17. Her diagnoses included, but were not limited to spinal stenosis, dorsalgia (pain in the upper back), difficulty in walking, polyneuropathy, anxiety disorder, and muscle spasms. An admission MDS (Minimum Data Set) assessment, dated 7/7/17, indicated Resident #134 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. The section for pain assessment was not completed. Review of the "Admission Care Plan," undated, indicated it was not completed, including a problem area for pain. Review of the resident's comprehensive care plan indicated she did not have a care plan for pain. A "Discharge Medication List," dated 6/30/17 from the hospital the resident was discharged from included the following medications: Fentanyl (a pain medication) 12 mcg/hr (micrograms per hour) every 3 days, Percocet (a pain medication) 5/325 mg (milligrams) 1-2 tabs every 6 hours as needed for pain and diazepam (an anti-anxiety medication) 5 mg (milligrams) 3 times a day as needed		week for 4 weeks to assure physician updated on complaints of uncontrolled pain and per order for abnormal pulse rate and documentation of the update present. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	for spasms. A "PAIN ASSESSMENT FLOW SHEET FOR PRN [AS NEEDED] INTERVENTIONS," dated, 6/30/17 through 7/5/17, indicated the resident received as needed Percocet 5/325 two tablets on the following dates and times: 6/30/17 at 11:15 P.M., 7/1/17 at 6:30 A.M., 1:00 P.M. and 7:30 P.M., 7/2/17 at 7:30 A.M., 12:30 P.M. and 6:30 P.M., 7/3/17 at 12:40 A.M., 12:45 P.M. and 6:00 P.M., 7/4/17 at 12:00 A.M., 4:00 A.M. and 8:00 A.M. and 7/5/17 at 10:15 A.M. and 3:00 P.M.. A "Nurses Note," dated 7/2/17 indicated, "...c/o [complains of] pain in back prn pain rx [prescription] ordered...." A "Nurses Note," dated 7/3/17 indicated, "...resident did complain of pain and states Percocet every 6 hours is not enough resident is requesting percocet every four hours. [Name of Physician] emailed about increasing meds. No response at this time...." A "Physician's Order," dated 7/3/17 indicated, "...Change Percocet 5/325 mg 1 tab p.o. [by mouth] to every 4 hours PRN/pain...." A "Physician's Order," dated 7/4/17			

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	indicated, "...Clarify Percocet 5/325 mg to be 1-2 tabs q [every] 4 [hours] PRN/pain...." A "Nurses Note," dated 7/4/17 indicated, "...resident requested prn pain medication at 12am for back pain. Resident has nonverbal s.s [signs and symptoms] of pain as well. Resident sleeping in recliner for comfort...." A "Therapy Note," dated 7/4/17 indicated, "...pt [patient] very fatigued this date and required increased time to complete transfers. pt very anxious with transfers and c/o pain though unable to get more pain meds at that time...." A "Therapy Note," dated 7/4/17 indicated, "...pt very fatigued this date and required min [minimum] encouragement to complete therapy secondary to fatigue...." A "Therapy Note," dated 7/5/17 indicated, "...Patient reports increased pain requiring frequent rest periods with treatment session on this date...." A "Social Services Note," dated 7/5/17 indicated, "...discussed pain medication and pain management... [Name of Physician] saw resident and reviewed medications...."			

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A "Nurses Note," dated 7/5/17 indicated, "...Does have continuous pain in her lower back if she does not get her PRN pain medications routinely. She did receive Percocet 5/325mg (2 tabs) at 10:15am during day shift. It does fully alleviate her pain if she gets this routinely... [Name of Physician] was in house today and saw resident. New orders are as follows: Increase Fentanyl 25mg every 72 hours. Start percocet 10/325mg q6h [every six hours] routinely and may have percocet 10/325mg q4h [every four hours] as needed for breakthrough pain in between scheduled doses...."

A "Nurses Note," dated 7/6/17 indicated, "...resident continues with changes in medication dosing, with no adverse effects noted. resident states that she feels 'it really is helping' resident has no c/o pain or discomfort at this time...."

During an interview on 7/14/17 at 9:50 A.M., LPN (Licensed Practical Nurse) #5 indicated the resident was in a lot of pain when she was admitted and the nurses were trying to figure out her percocet because it was not routine and she was not getting relief from her pain. She indicated the resident was offered ice and heat, but it did not help and the resident

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	was only getting temporary relief from the percocet. She could not recall if she had contacted the physician prior to 7/3/17. Review of the resident's clinical record indicated the physician was not notified prior to 7/3/17. During an interview on 7/14/17 at 1:22 P.M., the DON (Director of Nursing) indicated if a resident was in pain and the pain could not get under control, the physician should be notified right away. 2. A clinical record review completed on 7/13/17 at 2:55 P.M., indicated Resident #73 was admitted on 6/27/17. Her diagnosis included, but were not limited to hypertension, insomnia, hypothyroidism, anxiety, dementia,falls, acute renal impairment, thrombocytopenia and hematoma. A MDS (Minimum Data Set) assessment, dated 7/4/17, indicated Resident #73 had a BIMS (Brief Mental Interview for Mental Status) score of 99, indicating the resident was unable to complete the interview. Review of nurses' notes dated, 7/1/17 indicated the resident had a pulse rate of 55, on 7/2 pulse rate was 65, on 7/4 rate			

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	was 66, on 7/5 rate was 60, on 7/6 rate was 55, on 7/7 rate increased to 97, on 7/10 rate decreased to 57 and on 7/11 the pulse rate was listed at 61. Review of a Neurological Assessment flow sheet indicated Resident #73 had pulse rates documented of 51 on 6/22/17 and complained of dizziness and pulse rate of 45 documented on 6/23/17 . A review of the nursing documentation indicated the physician was not notified. Care plans for Resident #73 were reviewed and indicated that she was at risk for falling. During an interview, on 7/13/17 at 4:29 P.M., LPN #2 indicated the physician should have been notified of the abnormal values of high or low pulse rates. During an interview, on 7/17/17 at 12:45 P.M., the DON indicated that the physician should have been notified of the abnormal pulse rates for Resident #73. A policy was provided by the DON on 7/17/17 at 10:25 A.M. titled "Physician and Family Notification Policy", which was undated, indicated this was the current policy used by the facility. The			

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	policy indicated "...The physician, resident, and or family are notified when the resident's physical, communicative, psychosocial, or function status changes unexpectedly, the resident is injured or if treatment is significantly altered. 1. The charge nurse will keep the resident's physician informed of the residents' status. 2. If a change occurs in the resident's condition, the charge nurse will notify the appropriate physician at the time of the change. 6. The residents' condition, the family/significant other, and the physician notified, will be documented in the nurses' noted...." 3.1-5(a)(2)			
F 0167 SS=B Bldg. 00	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3			

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	preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. Based on observation and interview, the facility failed to ensure 3 of 3 residents were aware of where the survey results/book was located without having to ask staff. (Resident #4, Resident #68 and Resident # 76.) Findings include: During an interview,on 7/17/17 at 8:25 A.M., the resident council president indicated that she was unaware of where the survey book was located. A clinical record review completed on 7/14/17 at 3:04 P.M., indicated Resident #4 was admitted on 9/18/15. A MDS (Minimum Data Set) assessment, dated 5/17/17, indicated Resident #4 had a BIMS (Brief Mental Interview for Mental Status) score of 15, cognitively intact.	F 0167	1.Residents #4, #68 and #76 were re-educated on where the survey results book is located. 2.Residents were re-educated on where the survey results book is located in the resident council meeting on _8/2/17_____. 3.Residents will be educated on where the survey results book is located periodically in resident council meetings. 4.The SSD or designee will perform random resident interviews 2 times a week for 4 weeks to assure residents are aware of where the survey results book is located. Results of interviews will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	During an interview, on 7/17/17 at 8:37 A.M., Resident #68 indicated she did not know where the survey book was located in the facility. A clinical record review completed on 7/17/17 at 10:19 P.M., indicated Resident #68 was admitted on 11/22/15. A MDS assessment dated 5/12/17, indicated Resident #68 had a BIMS score of 15, cognitively intact. During an interview, on 7/17/17 at 8:38 A.M., Resident #76 indicated she did not know where the survey book was located. A clinical record review was completed on 7/17/17 at 10:30 A.M., indicated Resident #76 was admitted on 9/4/14. A MDS assessment dated 6/8/17, indicated Resident #76 had a BIMS score of 15, cognitively intact. A policy was requested and one was not provided by the facility. A paper was provided by the Administrator on 7/17/17 at 10:10 A.M., that indicated "staffing patterns and ISDH survey results are located at the receptionist desk."			

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	3.1-3(b)(1)			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on interview and record review the facility failed to ensure one randomly observed resident was treated with respect and dignity. (Resident #103) Findings include A clinical record review was conducted on 07/13/2017 at 3:47 P.M., and indicated Resident #103 was admitted on 2/23/2016. Her diagnosis included but were not limited to: Chronic kidney disease Stage 5, low back pain, primary osteoarthritis right shoulder, macular degeneration, major depressive disorder, gerd, hypercholesterolemia, heart failure, hyperparathyroidism, sciatica, type II diabetes, dementia. During an interview, on 7/11/2017 at 9:38A.M., the resident indicated the staff did not treat her with respect and dignity. The resident indicated "some are nasty, terminology, staff talking about their	F 0241	1.Resident #103 is being treated with dignity and respect. The IDT reviewed/revised the resident care plan to reflect the terminology preference. 2.All residents are being treated with dignity and respect. 3.Staff was re-educated on treating residents with dignity and respect; not speaking about personal life while caring for residents; not using potentially offensive words while caring for residents on _8/10,11,14,15/2017, 4.The SSD or designee will do random resident interviews 2 times a week for 4 weeks to assure residents feel they are being treated with dignity and respect. Results of interviews will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	personal life, more on evenings and night shift." Staff saying the word butt and she prefers posterior side. On 7/13/2017 at 1:30P.M., A (MDS), Minimum Data Set dated 5/9/2017 indicated Resident #103 had a BIM score of 11. During an interview, on 07/14/2017 at 11:10 A.M.,with Licensed Practical Nurse (LPN) #3, indicated he would intervene with staff if he heard them talking about personal information where residents could here and then report to his supervisor. During an interview, on 07/14/2017 at 11:20 A.M., Certified Nursing Assistant #4, indicated that it is not appropriate to talk about personal information where residents could hear. She would ask them to go to the breakroom. On 7/14/2017 at 2:30 P.M., a policy for dignity was requested from the Director of Nursing and one was not provided. During an interview, on 7/14/2017 at 2:35 P.M., the Director of Nursing indicated that staff talking inappropriately where residents can hear is not acceptable.			

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	A Care plan provided on 7/17/2017 indicated all statements by resident would be investigated. 3.1-3(t)			
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on interview and record review, the facility failed to bathe a resident as frequently as preferred for 1 of 4 residents reviewed for choices (Resident #35).	F 0242	1.Resident #35 is being bathed on a schedule per her choice. 2.Bathing schedules will be audited to assure residents receiving bathing per choice. 3.Nursing staff will be	08/16/2017

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	Finding includes: During an interview, on 7/11/17 at 9:35 A.M., Resident #35 indicated she would like a shower daily in the mornings but because the facility was so short handed they can't do it that often and sometimes its 2-3 days between showers and she was upset about it. A clinical record review was completed on 7/11/17 at 11:48 A.M., and indicated Resident #35 was admitted to the facility on 7/19/14. Her diagnoses included, but were not limited to right hemiparesis, depression and muscle spasms . A significant change MDS (Minimum Data Set) assessment, dated 4/18/17, indicated Resident #35 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact and was totally dependent on staff for bathing. A current, 5/28/17, care plan related to the resident's preferences indicated she preferred to shower daily around 4:30 - 5:00 in the morning. A "Hygiene, Bath, Skin Check Roster," dated 5/14/17 through 7/14/17 indicated the resident did not receive a shower on the following days: 5/15/17, 5/18/17,		re-educated to ask residents upon admission/readmission about their preferred schedule for bathing and following bathing schedules per resident choice. 4.The DON or designee will do random resident interviews 2 times per week for 4 weeks to assure residents are being bathed per their choice of schedule. Results of interviews will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	5/19/17, 5/20/17, 5/21/17, 5/23/17, 5/25/17, 5/28/17, 5/29/17, 6/2/17, 6/3/17, 6/4/17, 6/6/17, 6/15/17, 6/20/17, 6/24/17, 6/25/17, 6/26/17, 6/29/17, 6/30/17, 7/3/17 and 7/8/17. During an interview, on 7/17/17 at 9:57 A.M., the Social Service Director indicated they continue to work with staff on getting showers done daily for the resident. A policy for choices was requested and none was provided as of exit on 7/17/17. 3.1-3(u)(3)			
F 0273 SS=D Bldg. 00	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)			

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	Based on interview and record review, the facility failed to have an admission MDS (Minimum Data Set) assessment completed in a timely manner for 1 of 3 residents reviewed for pain (Resident #134). Finding includes: A clinical record review was completed on 7/12/2017 at 3:41 P.M., and indicated Resident #134 was admitted to the facility on 6/30/17. Her diagnoses included, but were not limited to spinal stenosis, dorsalgia (pain in the upper back), difficulty in walking, polyneuropathy, anxiety disorder and muscle spasms. An admission MDS (Minimum Data Set) assessment, dated 7/7/17, indicated Resident #134 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. The section for pain assessment was not completed. During an interview on 7/14/17 at 2:18 P.M., the MDS coordinator indicated the pain section of the MDS assessment was not completed and should have been completed by 7/13/17. A policy was requested but none was provided as of exit on 7/17/17.	F 0273	1.Resident #134 had an admission MDS completed. 2.All MDS assessments completed after 8/1/17 to 8/8/17 were reviewed for to ensure the pain section was completed timely. 3.The MDS nurse was re-educated on completing the admission MDS within 14 days. A tool has been developed to assist the MDS nurse in tracking due dates for MDSs. 4.The DON or designee will do a random audit of admission MDSs to assure they are completed within 14 days 2 times a week for 4 weeks. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	3.1-31(d)(1)			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute			

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	a material and false statement. Based on interview and record review, the facility failed to include the use of an anti-anxiety medication (Resident #35) and diagnoses of depression (Residents #4) on an MDS (Minimum Data Set) assessment for 2 of 5 residents reviewed for unnecessary medications. Findings include: 1. A clinical record review was completed on 7/11/17 at 11:48 A.M., and indicated Resident #35 was admitted to the facility on 7/19/14. Her diagnoses included, but were not limited to muscle spasms and depression. A significant change MDS (Minimum Data Set) assessment, dated 4/18/17, indicated Resident #35 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact and received an anti-anxiety medication 0 of 7 days during the assessment period. A current, 3/26/16, care plan problem indicated the resident had a diagnosis of spasticity for which an anti-anxiety medication had been ordered. An intervention for this problem was to give medications as ordered. A current, 3/2/17, physician's order	F 0278	1.Corrections for MDS assessments to include the use of an anti-anxiety medication for resident #35 and a diagnosis of depression for resident #4 were completed. 2.MDSs completed between 8/1/17 and 8/8/17 will be reviewed for accuracy before submission by the DON or designee. 3.The MDS nurse will be re-educated on validating the accuracy of MDSs before submission. 4.The DON or designee will randomly review MDSs for accuracy 2 times a week for 4 weeks. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	indicated the resident received diazepam (an anti-anxiety medication) 2 mg (milligrams) by mouth at bedtime for muscle spasms. During an interview on 7/14/17 at 2:19 P.M., the MDS coordinator indicated the MDS assessment did not include the use of an anti-anxiety medication. 2. A clinical record review completed on 7/12/17 at 2:57 P.M., indicated Resident #4 was admitted on 9/18/15. Her diagnosis included, but were not limited to: congestive heart failure, hypertension, breast cancer with right mastectomy, edema, diverticulosis, depression and insomnia. A current physician order, dated 7/1/17, indicated the resident received Escitalopram, an (anti depressant) medication daily for depression. A MDS (Minimum Data Set), dated 3/20/17 and 5/17/17 section I for diagnosis indicated there was no diagnosis of depression documented on the MDS. During an interview,on 7/14/17 at 11:05 A.M., MDS staff #2 indicated that the diagnosis should be documented on the MDS especially if they were receiving a			

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	medication for the diagnosis. A pollicy was requested but none was provided. 3.1-31(g)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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			

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	(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.			
	Based on interview and record review, the facility failed to initiate a pain care plan for 1 of 32 residents whose care plans were reviewed (Resident #134). Finding includes: A clinical record review was completed	F 0279	1.The care plan for resident #134 was updated to include pain. 2.Care plans of all residents with pain concerns as identified by pain assessment will be reviewed to assure appropriate care plan in place for pain. 3.The MDS nurse was re-educated on assuring	08/16/2017

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	on 7/12/2017 at 3:41 P.M., and indicated Resident #134 was admitted to the facility on 6/30/17. Her diagnoses included, but were not limited to spinal stenosis, dorsalgia (pain in the upper back), difficulty in walking, polyneuropathy, anxiety disorder and muscle spasms. An admission MDS (Minimum Data Set) assessment, dated 7/7/17, indicated Resident #134 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. The section for pain assessment was not completed. Review of the "Admission Care Plan," undated, indicated it was not completed, including a problem area for pain. Review of the resident's comprehensive care plan indicated she did not have a care plan for pain. During an interview, on 7/14/17 at 2:18 P.M., the MDS coordinator indicated the resident did not have an initial or comprehensive care plan related to pain. On 7/17/17 at 9:12 A.M., the Director of Nursing provided the policy titled "CARE PLAN POLICY," dated 8/1/16, and indicated the policy was the one currently used by the facility. The policy		comprehensiveness of resident care plans and reviewing these care plans according to the RAI schedule. 4.The DON or designee will do a random audit of care plans post RAI scheduled care plan review meetings weekly x 4 weeks to assure comprehensiveness. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	indicated "...POLICY: This facility will have a written care plan for each resident that is at a NF [Nursing Facility] or SNF [Skilled Nursing Facility] level of care... PROCEDURES: 1. Each resident must have a care plan, within 24 hr [hours] of admit... 4. Problems will be identified through completion of interdisciplinary assessments, interviews and observations, and the Resident Assessment Instrument... 9. MDS Coordinator/designee has the overall responsibility of coordinating care among all disciplines to achieve established goals...." 3.1-35(a)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the			

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	effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.			

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	(D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based or observation, record review and interview, the facility failed to update a care plan after a fall for 1 of 2 residents reviewd for falls. (Resident #73) Finding includes: A clinical record review completed on 7/14/17 at 9:22 A.M., indicated Resident #73 was admitted on 6/27/17. Her diagnosis included, but were not limited to: hypertension, insomnia, hypothyroidism, anxiety, dementia, history of falls, acute renal impairment, thrombocytopenia and hematoma.	F 0280	1.The care plan for resident #73 was updated to reflect the fall and new intervention implemented. 2.Care plans for residents with a documented fall in the last 30 days were reviewed to assure the fall is reflected. 3.The nurses will be re-educated on updating the care plan post fall with new intervention initiated. 4.The DON or designee will randomly audit care plans post fall 2 times/week x4 weeks to assure the care plan has been updated to reflect the fall. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	A nurses note, dated 6/22/17 at 8:00 A.M.,indicated Resident #73 was observed on the floor at 7:00 A.M., stating she got dizzy as she stood up and fell beside her bed. Resident #73 received a hematoma and laceration to her head. A MDS (Minimum Data Set), dated 5/17/17, indicated Resident # 73 requires extensive assist with transfers and limited assist for walking and bed mobility. A care plan related to fall risk, initiated on 11/20/2014, indicated Resident #73 was at risk for falling related to dizziness. There were no interventions implemented to prevent further falls after the resident fell on 6/22/17. A fall assessment form,completed on 5/15/17 and revised on 6/22/17, indicated the resident had intermittent confusion, gait issues and systolic blood pressure fluctuations. During an interview on 7/14/17 at 11:05 A.M., MDS staff indicated that the care plan was not updated. A policy was provided by the Wound Nurse on 7/17/17 at 10:25 A.M. titled " Care Plan Policy" dated 8/1/16, indicated this was the current policy used by the facility. The policy indicated "...The			

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	facility will have a written care plan for each resident that is in a NF or SNF level of care. All such care plans will be reviewed for appropriateness by the Care plan Committee. c. Each discipline is to initiate or revise his/her portion of the care plan...." 3.1-35(d)(2)(B)			
F 0281 SS=D Bldg. 00	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review the facility failed to appropriately assess for, assess, and treat pressure ulcer areas for 3 of 5 residents reviewed. (Resident #16, #93 and #55) Findings include: 1. A clinical record review was completed on 7/12/17 at 2:28 P.M., and indicated Resident #16 was admitted to the facility on 5/5/17. Her diagnoses included, but were not limited to heart failure, multiple sclerosis, seizure disorder, depression, insomnia and pain.	F 0281	1.Pressure areas have been assessed and are being treated for residents #16, #93 and #55. 2.Pressure areas for all residents have been assessed and are being treated. A skin check was completed on all residents to assure all pressure areas were identified, assessed and treatment ordered. 3.Nurses were re-educated on facility policies on assessment and treatment for pressure areas. 4.The wound nurse or designee will perform a random audit 2x/week x 4 weeks to assure pressure areas are being assessed and treated and routine skin checks are being	08/16/2017

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	An admission MDS (Minimum Data Set) assessment, dated 5/16/17, indicated Resident #16 had a BIMS (Brief Interview for Mental Status) of 10, moderate cognitive impairment, had a stage 3 pressure ulcer and received hospice care. A current, 5/19/17, care plan problem indicated the resident had a stage 3 pressure ulcer to her left heel. Interventions for this problem included, assess skin daily with routine care, assess wound healing weekly, encourage/assist to turn and reposition every 2 hours, monitor ulcer for signs of infection, provide pressure reducing surfaces on bed, keep linens clean, dry and wrinkle free, notify MD as needed and treatment as ordered. A "Nursing Admission Assessment," dated 5/5/17, indicated, "...Left heel has 4 cm area of pink boggy skin [with] 2 cm [centimeter] scabbed area open in center...." A "Weekly Pressure Ulcer Progress Report," dated 5/17/17 through 7/12/17, indicated, "...L [left] heel... date identified 5/5/17... Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or		documented. Results of audits will be taken to QAPI for review until facility is in 100% compliance. 5.Date of compliance: 8/16/17	

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	muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss... Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined... 5/17/17... Length Width cm... 2x2... Depth... 0.5... Color... pink... Stage III... 5/24/17... 1.9x0.6... <0.1... Color... pink... Stage II... 5/31/17... 1.9x0.6... <0.1... Color... pink... Stage III... 6/7/17... 1.8x0.5... 0.3... Color... pink... Stage III... 6/14/17... 1.8x0.5... 0.3... Color... pink... Stage III... 6/21/17... 0.8x0.8... Depth [no depth]... Color... thin yellow scab... Stage III... 6/28/17...1.8x0.5... 0.2... Color... pink... Stage III... 7/6/17... 0.8x0.7... Depth [no depth]... Color... thin yellow scab... Stage III 7/12/17... 0.8x2.0... Depth [no depth]... Presence/Absence/Drainage/Type... scant yellow... Color... thick yellow slough... Stage U [unstageable]...." The resident's admission orders indicated, "...Wound Dressing - Hydrogel [a			

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	treatment for pressure ulcers] apply topically to wound on left heel daily until healed...." A physician's order, dated 5/9/17, indicated, "...DC [discontinue] Hydrogel topically QOD [every other day]...." A physician's order, dated 5/9/17, indicated, "...apply medihoney [a treatment for pressure ulcers] after cleaning with non-sterile saline wrap loosely with kerlix q [every] day...." A hospice physician's order, dated 6/13/17, indicated, "...Discontinue Wound Dressings (Medihoney Wound/Burn Dressing)... Clean Left Heel Wound With Sterile Normal Saline Daily, Apply Sterile Dressing, Wrap Loosely With Kerlix Dressing...." A physician's order, dated 6/13/17, indicated, "...D/C [discontinue] old L [left] heel tx [treatment]; start: cleanse [with] NS [normal saline], pat dry, cover [with] non adherent drsg [dressing], wrap [with] kerlix...." During an observation of wound care on 7/12/17 at 4:03 P.M., LPN (Licensed Practical Nurse) #13 washed her hands, put on gloves and removed a dressing from Resident #16's left heel. There was			

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	a nickel-sized area to the back of the left heel with scant yellow drainage on the dressing and the area was tan-yellow in color. During an interview on 7/12/17 at 4:12 P.M., the Wound Nurse indicated she charted the wound on 6/21/17 and 7/6/17 as a stage III because "it was crusty" and because she did not like to change stages to make them worse. During an interview on 7/14/17 at 9:57 A.M., the Wound Nurse indicated hospice made the choice for the current treatment. During an interview on 7/14/17 at 1:06 P.M., the Hospice Nurse indicated the facility was using Medihoney as a treatment and the resident's skin was getting too moist so they discussed it at a hospice care plan meeting and decided to just start cleaning the wound and covering with a sterile dressing to dry it out. She indicated she did not speak with the Wound Nurse but informed a floor nurse of the new order. She indicated she was unaware of the wound bed becoming a "thin yellow scab" and if she would have been made aware, it would have been addressed at the hospice care plan meeting.			

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	During an interview on 7/14/17 at 1:17 P.M., the Wound Nurse indicated a non-adherent dressing was not a "drying" dressing and that was what was currently being used for treatments. She indicated she did not contact hospice when the wound first had a "thin yellow scab" because it was "thin not like this last time". She indicated she did contact hospice on 7/12/17 but had not heard back from them. 2. A clinical record review was conducted on 7/13/2017 at 1:50 P.M., for Resident #93 and indicated she was admitted on 4/20/2017. Her diagnoses included but was not limited to: Alzheimer's, dementia, overactive bladder, depression, lower leg contractures, and lumbar stenosis. A treatment sheet, dated 7/12/2017, indicated Resident #93 had an unstageable pressure ulcer to her left side of her left foot documented as 0.9 cm(centimeters) x 0.9 cm x 0.5 cm, without tunneling. During an observation on 7/13/2017 at 3:17 P.M., the wound was observed to have no dressing in place, and the facility wound nurse indicated the wound now had tunneling at 6 oclock. A bandaid was observed to be on top of the foot. Wound			

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	nurse removed the bandaid from the top of the foot and an area was found to the second toe. Wound nurse indicated the found area was an unstageable pressure ulcer. She indicated the facility was unaware Resident #93 had two pressure ulcers and the bandaid was put on the toe in an error, with staff thinking they were dressing the original pressure ulcer. Wound nurse indicated she believed the pressure ulcer was formed due to Resident #93's positioning. A physician order dated 4/20/2017 indicated Resident #93 was to have her heels floated for pressure reduction. A physician order dated 5/11/2017 indicated a weekly skin assessment was to be completed every Wednesday. A review of Resident #93's medical record indicated no documentation related to the pressure ulcer located on her toe. During an observation on 7/13/2017 at 3:00 P.M., Resident #93 was observed to have her feet pushed down into each other, putting pressure on her toes. During an observation on 7/13/2017 at 5:00 P.M., Resident #93 was observed lying in her bed with her feet on a pillow,			

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	pressure ulcer area buried deep within the pillow. 3. A clinical record review was conducted on 07/12/2017 at 4:33 P.M., and indicated Resident #58 was admitted on 1/12/2016. Her diagnoses included but were not limited to: gastromostomy, muscle weakness, lack of cooordination, dementia , alzheimer's disease, dysphagia, major depressive disorder, malaise, fatigue, and altered mental status. A nurses note dated 7/12/2017 indicated Resident #58 had an area to her left pinky toe with a pink bridge in the center. During an observation on 7/12/2017 at 3:35 P.M., Resident #58 was observed with an unstageable pressure ulcer to her left pinky toe close to the tip, on the side. An additional unstageable pressure ulcer was observed closer to her toe joint. The second pressure ulcer was observed to be round and dark in color. Resident's feet were observed with her pressure ulcerated toe lying directly on a flat pillow, with the pressure point not elevated. A review was completed on Resident #58's medical record and contained no documentation related to the second			

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	pressure ulcer. During an interview on 7/12/2017 at 4:00 P.M., the Wound nurse indicated Resident #58's toes should be positioned up off a pillow to off load the pressure point. During an observation on 7/13/2017 at 9:02 A.M., Resident #58 was observed to be lying on her right side with her toes lying on a pillow, with the pressure point not elevated. During an observation on 7/13/2017 at 5:12 P.M., Resident #58 was observed lying on her back with her legs contracted up and her left foot directly on the pillow, with the pressure point not elevated. During an observation on 7/13/2017 at 11:16 A.M., Resident #58 was observed sitting in a broda chair in her room, with her left toe pushed down into a pillow on the foot of the broda chair. Her affected toe was observed reddened and twisted appliying pressure to the existing pressure areas. 4. A clinical record review was conducted on 07/13/2017 9:22:21 AM and indiated Resident #55 was admitted on 1/12/2015. Her diagnoses included but was not limited to: cervical vertebrae 7th			

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	D, fracture first thorvertebra, aftercare, muscle weakness, need for assistance with personal care, and cervical disc degeneration. During an observation on 7/13/2017 at 4:00 P.M., Resident #55 was observed to have a dark purple, blister like area to her right foot second toe tip, a little bigger than a pencil eraser. Her shoes were observed to be a tight fit, with indent marks being left following removal. During an observation on 7/14/2017 at 9:50 A.M., Resident #55 was observed sitting in her recliner with her feet up and her shoes on. During an interview on 7/14/2017 at 9:59 A.M., the Wound nurse indicated the area found was a callous. A nurses note dated 6/20/2017 indicated Resident #55 had received new shoes with cushions to the toes and bottom of her foot and indicated "...resident is trying them out for comfort and decreased pressure to areas...." A review of Resident #55's medical record showed no documentation of the deep purple blister area to her right second toe or any documentation of monitoring the fit and wear of her new			

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	shoes. A policy was requested and one was not provided. 3.1-35(g)(1)			
F 0282 SS=E Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow resident care plan for 3 of 35 residents reviewed. (Resident #93, #58 and #55) Findings include: 1. A clinical record review was conducted on 7/13/2017 at 1:50 P.M., for Resident #93 and indicated she was admitted on 4/20/2017. Her diagnoses included but was not limited to:	F 0282	1.Care plans were reviewed by the IDT and are being followed in care for residents #93, #58 and #55. 2.Rounds completed to assure care planned interventions are in place for all residents. 3.Nursing staff will be re-educated on assuring care plans followed. 4.The DON or designee will do rounds with care sheets 2 times per week for 4 weeks to assure all care planned interventions are in place. Results of audits will be	08/16/2017

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	Alzheimer's, dementia, overactive bladder, depression, lower leg contractures, and lumbar stenosis. A treatment sheet, dated 7/12/2017 indicated Resident #93 had an unstageable pressure ulcer to her left side of her left foot documented as 0.9x0.9x0.5 without tunneling. During an observation on 7/13/2017 at 3:17 P.M., the wound was observed to have no dressing in place, and the facility wound nurse indicated the wound now had tunneling at 6 oclock. A bandaid was observed to be on top of the foot. Wound nurse removed the bandaid from the top of the foot and an area was found to the second toe. Wound nurse indicated the found area was an unstageable pressure ulcer. She indicated the facility was unaware Resident #93 had two pressure ulcers and the bandaid was put on the toe in an error, with staff thinking they were dressing the original pressure ulcer. Wound nurse indicated she believed the pressure ulcer was formed due to Resident #93's positioning. A nurses note, dated 7/13/2017, indicated Resident #93 had an "area covered with slough" to the top of her second toe. A physician order, dated 4/20/2017,		taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	indicated Resident #93 was to have her heels floated for pressure reduction. A physician order, dated 5/11/2017, indicated a weekly skin assessment was to be completed every Wednesday. A review of Resident #93's medical record indicated no documentation related to the pressure ulcer located on her toe. During an observation on 7/13/2017 at 3:00 P.M., Resident #93 was observed to have her feet pushed down into each other, putting pressure on her toes. During an observation on 7/13/2017 at 5:00 P.M., Resident #93 was observed lying in her bed with her feet on a pillow, pressure ulcer area buried deep within the pillow. 2. A clinical record review was conducted on 07/12/2017 at 4:33 P.M., and indicated Resident #58 was admitted on 1/12/2016. Her diagnoses included but were not limited to: gastromostomy, muscle weakness, lack of cooordination, dementia , alzheimer's disease, dysphagia, major depressive disorder, malaise, fatigue, and altered mental status.			

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	A nurses note, dated 7/12/2017 indicated Resident #58 had an area to her left pinky toe with a pink bridge in the center. During an observation on 7/12/2017 at 3:35 P.M., Resident #58 was observed with an unstageable pressure ulcer to her left pinky toe close to the tip, on the side. An additional unstageable pressure ulcer was observed closer to her toe joint. The second pressure ulcer was observed to be round and dark in color. Resident's feet were observed with her pressure ulcerated toe lying directly on a flat pillow, with the pressure point not elevated. A review was completed on Resident #58's medical record and contained no documentation related to the second pressure ulcer. During an interview on 7/12/2017 at 4:00 P.M., the Wound nurse indicated Resident #58's toes should be positioned up off a pillow to off load the pressure point. During an observation on 7/13/2017 at 9:02 A.M., Resident #58 was observed to be lying on her right side with her toes lying on a pillow, with the pressure point not elevated.			

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	During an observation on 7/13/2017 at 5:12 P.M., Resident #58 was observed lying on her back with her legs contracted up and her left foot directly on the pillow, with the pressure point not elevated. During an observation on 7/13/2017 at 11:16 A.M., Resident #58 was observed sitting in a broda chair in her room, with her left toe pushed down into a pillow on the foot of the broda chair. Her affected toe was observed reddened and twisted appliying pressure to the existing pressure areas. 3. A clinical record review was conducted on 07/13/2017 9:22:21 AM and indiated Resident #55 was admitted on 1/12/2015. Her diagnoses included but was not limited to: cervical vertebrae 7th D, fracture first thorvertebra, aftercare, muscle weakness, need for assistance with personal care, and cervical disc degeneration. During an observation on 7/13/2017 at 4:00 P.M., Resident #55 was observed to have a dark purple, blister like area to her right foot second toe tip, a little bigger than a pencil eraser. Her shoes were observed to be a tight fit, with indent marks being left following removal. During an observation on 7/14/2017 at			

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	9:50 A.M., Resident #55 was observed sitting in her recliner with her feet up and her shoes on. During an interview on 7/14/2017 at 9:59 A.M., the Wound nurse indicated the area found was a callous. A nurses note dated 6/20/2017 indicated Resident #55 had received new shoes with cushions to the toes and bottom of her foot and indicated "...resident is trying them out for comfort and decreased pressure to areas...." A review of Resident #55's medical record showed no documentation of the deep purple blister area to her right second toe or any documentation of monitoring the fit and wear of her new shoes. A policy was requested and one was not recieved. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to			

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	facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on interview and record review, the facility failed to ensure a resident received adequate pain relief following a back surgery for 1 of 35 residents reviewed for pain (Resident #134) and failed to coordinate care with hospice	F 0309	1.Resident #134 was assessed and is receiving adequate pain relief. Care has been coordinated with Hospice for wound treatment for resident #16. Resident has been discharged. 2.All residents with pain are	08/16/2017

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	related to wound care for 1 of 4 residents reviewed with pressure ulcers (Resident #16). Findings include: 1. During an interview on 7/10/17 at 2:39 P.M., Resident #134 indicated she was in horrible pain when she first got to the facility and she did not get relief from it until the Fourth of July weekend was over when changes were made to her medications. A clinical record review was completed on 7/12/2017 at 3:41 P.M., and indicated Resident #134 was admitted to the facility on 6/30/17. Her diagnoses included, but were not limited to spinal stenosis, dorsalgia (pain in the upper back), difficulty in walking, polyneuropathy, anxiety disorder, and muscle spasms. An admission MDS (Minimum Data Set) assessment, dated 7/7/17, indicated Resident #134 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. The section for pain assessment was not completed. Review of the "Admission Care Plan," undated, indicated it was not completed, including a problem area for pain.		being assessed to assure adequate pain relief. Treatment plans for residents on Hospice will be reviewed with the Hospice nurse to assure coordination in care. 3.Nurses will be re-educated on pain assessments and assuring pain relief in residents as well as coordinating with Hospice for care and change of condition in residents receiving Hospice Services. 4.The DON or designee will do random interviews of residents with pain 2x/week for 4 weeks to assure adequate pain control. The DON or designee will do a random audit of Hospice residents 2x/week for 4 weeks to assure coordination of care with Hospice. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	Review of the resident's comprehensive care plan indicated she did not have a care plan for pain. A "Discharge Medication List," dated 6/30/17 from the hospital the resident was discharged from included the following medications: Fentanyl (a pain medication) 12 mcg/hr (micrograms per hour) every 3 days, Percocet (a pain medication) 5/325 mg (milligrams) 1-2 tabs every 6 hours as needed for pain and diazepam (an anti-anxiety medication) 5 mg (milligrams) 3 times a day as needed for spasms. A "PAIN ASSESSMENT FLOW SHEET FOR PRN [AS NEEDED] INTERVENTIONS," dated, 6/30/17 through 7/5/17, indicated the resident received as needed Percocet 5/325 two tablets on the following dates and times: 6/30/17 at 11:15 P.M., 7/1/17 at 6:30 A.M., 1:00 P.M. and 7:30 P.M., 7/2/17 at 7:30 A.M., 12:30 P.M. and 6:30 P.M., 7/3/17 at 12:40 A.M., 12:45 P.M. and 6:00 P.M., 7/4/17 at 12:00 A.M., 4:00 A.M. and 8:00 A.M. and 7/5/17 at 10:15 A.M. and 3:00 P.M.. A "Nurses Note," dated 7/2/17 indicated, "...c/o [complains of] pain in back prn pain rx [prescription] ordered...."			

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A "Nurses Note," dated 7/3/17 indicated, "...resident did complain of pain and states Percocet every 6 hours is not enough resident is requesting percocet every four hours. [Name of Physician] emailed about increasing meds. No response at this time...."

A "Physician's Order," dated 7/3/17 indicated, "...Change Percocet 5/325 mg 1 tab p.o. [by mouth] to every 4 hours PRN/pain...."

A "Physician's Order," dated 7/4/17 indicated, "...Clarify Percocet 5/325 mg to be 1-2 tabs q [every] 4 [hours] PRN/pain...."

A "Nurses Note," dated 7/4/17 indicated, "...resident requested prn pain medication at 12am for back pain. Resident has nonverbal s.s [signs and symptoms] of pain as well. Resident sleeping in recliner for comfort...."

A "Therapy Note," dated 7/4/17 indicated, "...pt [patient] very fatigued this date and required increased time to complete transfers. pt very anxious with transfers and c/o pain though unable to get more pain meds at that time...."

A "Therapy Note," dated 7/4/17

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	indicated, "...pt very fatigued this date and required min [minimum] encouragement to complete therapy secondary to fatigue...." A "Therapy Note," dated 7/5/17 indicated, "...Patient reports increased pain requring frequent rest periods with treatment session on this date...." A "Social Services Note," dated 7/5/17 indicated, "...discussed pain medication and pain management... [Name of Physician] saw resident and reviewed medications...." A "Nurses Note," dated 7/5/17 indicated, "...Does have continuous pain in her lower back if she does not get her PRN pain medications routinely. She did receive Percocet 5/325mg (2 tabs) at 10:15am during day shift. It does fully alleviate her pain if she gets this routinely... [Name of Physician] was in house today and saw resident. New orders are as follows: Increase Fentanyl 25mg every 72 hours. Start percocet 10/325mg q6h [every six hours] routinely and may have percocet 10/325mg q4h [every four hours] as needed for breakthrough pain in between scheduled doses...." A "Nurses Note," dated 7/6/17 indicated,			

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	"...resident continues with changes in medication dosing, with no adverse effects noted. resident states that she feels 'it really is helping' resident has no c/o pain or discomfort at this time...." During an interview on 7/14/17 at 9:50 A.M., LPN (Licensed Practical Nurse) #5 indicated the resident was in a lot of pain when she was admitted and the nurses were trying to figure out her percocet because it was not routine and she was not getting relief from her pain. She indicated the resident was offered ice and heat, but it did not help and the resident was only getting temporary relief from the percocet. She could not recall if she had contacted the physician prior to 7/3/17. During an interview on 7/14/17 at 1:22 P.M., the DON (Director of Nursing) indicated if a resident was in pain and the pain could not get under control, the physician should be notified right away. 2. A clinical record review was completed on 7/12/17 at 2:28 P.M., and indicated Resident #16 was admitted to the facility on 5/5/17. Her diagnoses included, but were not limited to heart failure, multiple sclerosis, seizure disorder, depression, insomnia and pain.			

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	An admission MDS (Minimum Data Set) assessment, dated 5/16/17, indicated Resident #16 had a BIMS (Brief Interview for Mental Status) of 10, moderate cognitive impairment, had a stage 3 pressure ulcer and received hospice care. A current, 5/19/17, care plan problem indicated the resident had a stage 3 pressure ulcer to her left heel. Interventions for this problem included, assess skin daily with routine care, assess wound healing weekly, encourage/assist to turn and reposition every 2 hours, monitor ulcer for signs of infection, provide pressure reducing surfaces on bed, keep linens clean, dry and wrinkle free, notify MD as needed and treatment as ordered. A "Nursing Admission Assesssment," dated 5/5/17, indicated, "...Left heel has 4 cm area of pink boggy skin [with] 2 cm [centimeter] scabbed area open in center...." A "Weekly Pressure Ulcer Progress Report," dated 5/17/17 through 7/12/17, indicated, "...L [left] heel... date identified 5/5/17... 5/17/17... Length Width cm... 2x2... Depth... 0.5... Color... pink... Stage III...			

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	5/24/17... 1.9x0.6... <0.1... Color... pink... Stage II... 5/31/17... 1.9x0.6... <0.1... Color... pink... Stage III... 6/7/17... 1.8x0.5... 0.3... Color... pink... Stage III... 6/14/17... 1.8x0.5... 0.3... Color... pink... Stage III... 6/21/17... 0.8x0.8... Depth [no depth]... Color... thin yellow scab... Stage III... 6/28/17...1.8x0.5... 0.2... Color... pink... Stage III... 7/6/17... 0.8x0.7... Depth [no depth]... Color... thin yellow scab... Stage III 7/12/17... 0.8x2.0... Depth [no depth]... Presence/Absence/Drainage/Type... scant yellow... Color... thick yellow slough... Stage U [unstageable]...." The resident's admission orders indicated, "...Wound Dressing - Hydrogel [a treatment for pressure ulcers] apply topically to wound on left heel daily until healed...." A physician's order, dated 5/9/17, indicated, "...DC [discontinue] Hydrogel topically QOD [every other day]...." A physician's order, dated 5/9/17, indicated, "...apply medihoney [a treatment for pressure ulcers] after cleaning with non-sterile saline wrap loosely with kerlix q [every] day...."			

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A hospice physician's order, dated 6/13/17, indicated, "...Discontinue Wound Dressings (Medihoney Wound/Burn Dressing)... Clean Left Heel Wound With Sterile Normal Saline Daily, Apply Sterile Dressing, Wrap Loosely With Kerlix Dressing...."

A physician's order, dated 6/13/17, indicated, "...D/C [discontinue] old L [left] heel tx [treatment]; start: cleanse [with] NS [normal saline], pat dry, cover [with] non adherent drsg [dressing], wrap [with] kerlix...."

During an observation of wound care on 7/12/17 at 4:03 P.M., LPN (Licensed Practical Nurse) #13 washed her hands, put on gloves and removed a dressing from Resident #16's left heel. There was a nickel-sized area to the back of the left heel with scant yellow drainage on the dressing and the area was tan-yellow in color.

During an interview on 7/12/17 at 4:12 P.M., the Wound Nurse indicated she charted the wound on 6/21/17 and 7/6/17 as a stage III because "it was crusty" and because she did not like to change stages to make them worse.

During an interview on 7/14/17 at 9:57

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	A.M., the Wound Nurse indicated hospice made the choice for the current treatment. During an interview on 7/14/17 at 1:06 P.M., the Hospice Nurse indicated the facility was using Medihoney as a treatment and the resident's skin was getting too moist so they discussed it at a hospice care plan meeting and decided to just start cleaning the wound and covering with a sterile dressing to dry it out. She indicated she did not speak with the Wound Nurse but informed a floor nurse of the new order. She indicated she was unaware of the wound bed becoming a "thin yellow scab" and if she would have been made aware, it would have been addressed at the hospice care plan meeting. During an interview on 7/14/17 at 1:17 P.M., the Wound Nurse indicated a non-adherent dressing was not a "drying" dressing and that was what was currently being used for treatments. She indicated she did not contact hospice when the wound first had a "thin yellow scab" because it was "thin not like this last time". She indicated she did contact hospice on 7/12/17 but had not heard back from them. During an interview on 7/17/17 at 10:13			

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	A.M., The Director of Nursing indicated there should be coordination of care between hospice and the facility wound nurse related to the resident's pressure ulcer. On 7/17/17 at 10:25 A.M., the Wound Nurse provided the policy titled "ONE-TIME RESIDENTIAL SERVICES AGREEMENT," dated 2/2015, and indicated the policy was the one currently used by the facility and the hospice company. The policy indicated "...AGREEMENT... FACILITY shall meet the following requirements... 5. Coordination of Care. FACILITY shall participate in any meetings, when requested, for the coordination, supervision and evaluation by HOSPICE of the provision of Residential Services. HOSPICE and FACILITY shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day... HOSPICE shall meet the following requirements... 8.1... HOSPICE shall promote open and frequent communication with FACILITY..." 3.1-37(a)			

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F 0314 SS=G Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, interview, and record review the facility failed to prevent the development of an unstageable pressure ulcer for 2 of 4 residents (Resident #58 and #93), failed to prevent the development of a deep tissue injury for 1 resident (Resident #55), and failed to prevent a pressure from worsening for 1 resident (Resident #16). This deficient practice had the ability to affect 4 of the 4 residents reviewed for pressure ulcers. Findings include: 1. A clinical record review was	F 0314	1.Interventions have been put in place for residents #58, #93 and #55 to prevent pressure injury/ulcers. Resident #16 has a treatment and interventions in place to promote healing of the pressure area. 2.All residents at risk were audited to assure interventions in place to prevent pressure and promote healing of existing areas. 3.Nursing staff will be re-educated on interventions to prevent pressure areas and heal existing areas. 4.The wound nurse or designee will do a random audit 2x/week for 4 weeks to assure interventions to prevent pressure area development and promote	08/16/2017

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	conducted on 7/13/2017 at 1:50 P.M., for Resident #93 and indicated she was admitted on 4/20/2017. Her diagnoses included but was not limited to: Alzheimer's, dementia, overactive bladder, depression, lower leg contractures, and lumbar stenosis. A treatment sheet, dated 7/12/2017 indicated Resident #93 had an unstageable pressure ulcer to her left side of her left foot documented as 0.9x0.9x0.5 without tunneling. During an observation on 7/13/2017 at 3:17 P.M., the wound was observed to have no dressing in place, and the facility wound nurse indicated the wound now had tunneling at 6 oclock. A bandaid was observed to be on top of the foot. Wound nurse removed the bandaid from the top of the foot and an area was found to the second toe. Wound nurse indicated the found area was an unstageable pressure ulcer. She indicated the facility was unaware Resident #93 had two pressure ulcers and the bandaid was put on the toe in an error, with staff thinking they were dressing the original pressure ulcer. Wound nurse indicated she believed the pressure ulcer was formed due to Resident #93's positioning. A physician order, dated 4/20/2017,		healing of existing pressure areas. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	indicated Resident #93 was to have her heels floated for pressure reduction. A physician order, dated 5/11/2017, indicated a weekly skin assessment was to be completed every Wednesday. A review of Resident #93's medical record indicated no documentation related to the pressure ulcer located on her toe. During an observation on 7/13/2017 at 3:00 P.M., Resident #93 was observed to have her feet pushed down into each other, putting pressure on her toes. During an observation on 7/13/2017 at 5:00 P.M., Resident #93 was observed lying in her bed with her feet on a pillow, pressure ulcer area buried deep within the pillow. 2. A clinical record review was completed on 7/12/17 at 2:28 P.M., and indicated Resident #16 was admitted to the facility on 5/5/17. Her diagnoses included, but were not limited to heart failure, multiple sclerosis, seizure disorder, depression, insomnia and pain. An admission MDS (Minimum Data Set) assessment, dated 5/16/17, indicated Resident #16 had a BIMS (Brief			

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	Interview for Mental Status) of 10, moderate cognitive impairment, had a stage 3 pressure ulcer and received hospice care. A current, 5/19/17, care plan problem indicated the resident had a stage 3 pressure ulcer to her left heel. Interventions for this problem included, assess skin daily with routine care, assess wound healing weekly, encourage/assist to turn and reposition every 2 hours, monitor ulcer for signs of infection, provide pressure reducing surfaces on bed, keep linens clean, dry and wrinkle free, notify MD as needed and treatment as ordered. A "Nursing Admission Assessment," dated 5/5/17, indicated, "...Left heel has 4 cm area of pink boggy skin [with] 2 cm [centimeter] scabbed area open in center...." A "Weekly Pressure Ulcer Progress Report," dated 5/17/17 through 7/12/17, indicated, "...L [left] heel... date identified 5/5/17... Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss... Unstageable: Full thickness tissue loss in which the base of the ulcer			

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	is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined... 5/17/17... Length Width cm... 2x2... Depth... 0.5... Color... pink... Stage III... 5/24/17... 1.9x0.6... <0.1... Color... pink... Stage II... 5/31/17... 1.9x0.6... <0.1... Color... pink... Stage III... 6/7/17... 1.8x0.5... 0.3... Color... pink... Stage III... 6/14/17... 1.8x0.5... 0.3... Color... pink... Stage III... 6/21/17... 0.8x0.8... Depth [no depth]... Color... thin yellow scab... Stage III... 6/28/17...1.8x0.5... 0.2... Color... pink... Stage III... 7/6/17... 0.8x0.7... Depth [no depth]... Color... thin yellow scab... Stage III 7/12/17... 0.8x2.0... Depth [no depth]... Presence/Absence/Drainage/Type... scant yellow... Color... thick yellow slough... Stage U [unstageable]...." The resident's admission orders indicated, "...Wound Dressing - Hydrogel [a treatment for pressure ulcers] apply topically to wound on left heel daily until healed...."			

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	A physician's order, dated 5/9/17, indicated, "...DC [discontinue] Hydrogel topically QOD [every other day]...." A physician's order, dated 5/9/17, indicated, "...apply medihoney [a treatment for pressure ulcers] after cleaning with non-sterile saline wrap loosely with kerlix q [every] day...." A hospice physician's order, dated 6/13/17, indicated, "...Discontinue Wound Dressings (Medihoney Wound/Burn Dressing)... Clean Left Heel Wound With Sterile Normal Saline Daily, Apply Sterile Dressing, Wrap Loosely With Kerlix Dressing...." A physician's order, dated 6/13/17, indicated, "...D/C [discontinue] old L [left] heel tx [treatment]; start: cleanse [with] NS [normal saline], pat dry, cover [with] non adherent drsg [dressing], wrap [with] kerlix...." During an observation of wound care on 7/12/17 at 4:03 P.M., LPN (Licensed Practical Nurse) #13 washed her hands, put on gloves and removed a dressing from Resident #16's left heel. There was a nickel-sized area to the back of the left heel with scant yellow drainage on the dressing and the area was tan-yellow in color.			

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	During an interview on 7/12/17 at 4:12 P.M., the Wound Nurse indicated she charted the wound on 6/21/17 and 7/6/17 as a stage III because "it was crusty" and because she did not like to change stages to make them worse. During an interview on 7/14/17 at 9:57 A.M., the Wound Nurse indicated hospice made the choice for the current treatment. During an interview on 7/14/17 at 1:06 P.M., the Hospice Nurse indicated the facility was using Medihoney as a treatment and the resident's skin was getting too moist so they discussed it at a hospice care plan meeting and decided to just start cleaning the wound and covering with a sterile dressing to dry it out. She indicated she did not speak with the Wound Nurse but informed a floor nurse of the new order. She indicated she was unaware of the wound bed becoming a "thin yellow scab" and if she would have been made aware, it would have been addressed at the hospice care plan meeting. During an interview on 7/14/17 at 1:17 P.M., the Wound Nurse indicated a non-adherent dressing was not a "drying" dressing and that was what was currently			

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	being used for treatments. She indicated she did not contact hospice when the wound first had a "thin yellow scab" because it was "thin not like this last time". She indicated she did contact hospice on 7/12/17 but had not heard back from them. 3. A clinical record review was conducted on 07/12/2017 at 4:33 P.M., and indicated Resident #58 was admitted on 1/12/2016. Her diagnoses included but were not limited to: gastromostomy, muscle weakness, lack of cooordination, dementia , alzheimer's disease, dysphagia, major depressive disorder, malaise, fatigue, and altered mental status. A nurses note, dated 7/12/2017, indicated Resident #58 had an area to her left pinky toe with a pink bridge in the center. During an observation on 7/12/2017 at 3:35 P.M., Resident #58 was observed with an unstageable pressure ulcer to her left pinky toe close to the tip, on the side. An additional unstageable pressure ulcer was observed closer to her toe joint. The second pressure ulcer was observed to be round and dark in color. Resident's feet were observed with her pressure ulcerated toe lying directly on a flat pillow, with the pressure point not			

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	elevated. A review was completed on Resident #58's medical record and contained no documentation related to the second pressure ulcer. During an interview on 7/12/2017 at 4:00 P.M., the Wound nurse indicated Resident #58's toes should be positioned up off a pillow to off load the pressure point. During an observation on 7/13/2017 at 9:02 A.M., Resident #58 was observed to be lying on her right side with her toes lying on a pillow, with the pressure point not elevated. During an observation on 7/13/2017 at 5:12 P.M., Resident #58 was observed lying on her back with her legs contracted up and her left foot directly on the pillow, with the pressure point not elevated. During an observation on 7/13/2017 at 11:16 A.M., Resident #58 was observed sitting in a broda chair in her room, with her left toe pushed down into a pillow on the foot of the broda chair. Her affected toe was observed reddened and twisted appliying pressure to the existing pressure areas.			

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	4. A clinical record review was conducted on 07/13/2017 9:22:21 AM and indiated Resident #55 was admitted on 1/12/2015. Her diagnoses included but was not limited to: cervical vertebrae 7th D, fracture first thorvertebra, aftercare, muscle weakness, need for assistance with personal care, and cervical disc degeneration. During an observation on 7/13/2017 at 4:00 P.M., Resident #55 was observed to have a dark purple, blister like area to her right foot second toe tip, a little bigger than a pencil eraser. Her shoes were observed to be a tight fit, with indent marks being left following removal. During an observation on 7/14/2017 at 9:50 A.M., Resident #55 was observed sitting in her recliner with her feet up and her shoes on. During an interview on 7/14/2017 at 9:59 A.M., the Wound nurse indicated the area found was a callous. A nurses note, dated 6/20/2017, indicated Resident #55 had recieved new shoes with cushions to the toes and bottom of her foot and indicated "...resident is trying them out for comfort and decreased pressure to areas...."			

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	A review of Resident #55's medical record showed no documentation of the deep purple blister area to her right second toe or any documentation of monitoring the fit and wear of her new shoes. On 7/12/17 at 4:00 P.M., the DON provided the policy titled "PRESSURE SORES: ULCER - NURSING INTERVENTIONS AND TRACKING POLICY," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...STANDARD: This policy has been established to outline and maintain the facility's procedure as it relates to recognizing the importance of prevention in resident who is at high risk for developing pressure sores, classifying pressure sores as to their pathological involvement, employing a systematic approach to management of pressure sores, being aware of pressure sores, and the reporting of the seven essentials of describing pressure sores to insure [sic] proper documentation... General Information: 1. Prevention of pressure sores is the responsibility of all nursing personnel... 3. Areas of the body that require special attention... heels... Skin surfaces coming together... between toes... 6. There is no single method of treatment for all pressure sores. Nursing			

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	interventions based on systematic approach and continuity of care are necessary for any treatment to be effective. 7. Accurate and consistent documentation on the Pressure Sore/Ulcer Report form on a weekly basis, and more often if necessary, must contain the following essentials: a) accurate description of the area... 9. Stage III and IV pressure sores are to be photographed monthly or more frequently if deemed appropriate... PROCEDURES... c) Ulcer Care: Care of the pressure ulcer will follow the Wound Care/Ulcer Procedure...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed			

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	rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview, and record review the facility failed to monitor the use of a hot water bottle for 1 of 35 residents (Resident #52) and failed to ensure proper storage of a physician ordered gel. (Resident #35). Findings include: 1. A clinical record review was conducted on 7/3/2017 at 4:30 P.M., and indicated Resident #52 was admitted on 7/12/2011. Her diagnoses included but were not limited to: left breast cancer, multiple malignancies in remission, pontine stroke and right vertebral artery stenosis, venous insufficiency, and knee pain. On 7/3/2017 at 3:30 P.M., CNA (certified nurses aide) #12 was observed to bring a full hot water bottle to Resident #52.	F 0323	1.The use of a hot water bottle by resident #52 is being monitored per policy. 2.No other residents currently use a hot water bottle. Any resident that may use a hot water bottle will be monitored per policy. 3.Nursing staff will be re-educated on the policy for monitoring the use of a hot water bottle. 4.The DON or designee will audit to assure proper monitoring of resident's use of a hot water bottle 2x/week for 4 weeks. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	Resident #52 placed the hot water bottle on her shoulder/arm area. During an interview, on 7/3/2017 at 3:40 P.M., CNA #12 indicated she fills up the water bottle using the hot water dispenser in the nutrition kitchen. During an observation, on 7/3/2017 at 3:50 P.M., Maintenance director checked the water temperature from the hot water dispenser in the nutrition kitchen. He indicated the temperature of the water was 164.8 degrees. During an interview on 7/3/2017 at 3:45 P.M., Employee #15 indicated the facility was not supposed to be using water bottles due to the risks. During an interview on 7/3/2017 at 4:00 P.M., the facility administrator indicated the facility was not to be using hot water bottles for pain relief. During an interview on 7/3/2017 at 4:15 P.M., two of the five CNA's interviewed, indicated they had also used the hot water dispenser in the nutrition kitchen to fill up the hot water bottle for Resident #52 use. A review of Resident #52's medical record indicated no documentation for			

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	the use of a hot water bottle. On 7/3/2017 at 4:45 P.M., request was made for the facility policy on hot water bottle use, facility administrator indicted the faclity did not have a policy related to the use of a hot water bottle. 2. During the initial tour on 7/10/17 at 10:27 A.M., a bottle of Vicks vapor rub and a plastic cup with a blue gel substance was observed on the night stand in Resident #35's room. During an environmental tour conducted on 7/17/17 at 11:00 A.M., the following was observed: A bottle of Vicks vapor rub and a blue gel substance in a plastic medication cup on the night stand. During and interview, on 7/17/17 at 11:15 A.M., Resident #35 indicated the "nurse puts it on my shoulder three times a day." During an interview, on 7/17/17 at 1:43 P.M., LPN (Licensed Practical Nurse) # 12 indicated that the "bottle of vapor rub was almost empty and the blue gel stuff should not be in the room and should be thrown out". A policy provided by the wound nurse on 7/17/17 at 1:15 P.M., titled "Bedside			

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	Medication Storage" dated 6/1/15 indicated this was the current policy used by the facility. The policy indicated "...Bedside medication storage is permitted for residents who wish to self administer medication, upon the written order of the prescriber ...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0329 SS=E Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs.			

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	Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on interview and record review, the facility failed to attempt a GDR (gradual dose reduction) on an anti-anxiety medication (Resident #35) and failed to have a proper indication for the use of an anti-anxiety medication (Resident #48) and the use of an antidepressant medication (Resident #68) for 3 of 5 residents reviewed for unnecessary medications. Findings include: 1. A clinical record review was completed on 7/11/17 at 11:48 A.M., and indicated Resident #35 was admitted to the facility on 7/19/14. Her diagnoses included, but were not limited to muscle spasms and depression. A significant change MDS (Minimum Data Set) assessment, dated 4/18/17,	F 0329	1.A dose reduction was requested for the anti-anxiety medication for residents #35 . Indication for use of an anti-anxiety for resident #48 was clarified. Indication for use of an anti-depressant was clarified for resident #68. 2.All psychotropic medications were reviewed to assure proper indications for use and gradual dose reduction requests completed as indicated. 3.Nurses will be re-educated on assuring proper indications for use of psychotropic medications and gradual dose reduction requirements. A spread sheet has been developed to assist in tracking gradual dose reduction requests. 4.The DON or designee will do a random audit 2x/week for 4 weeks to assure proper indications in place for use of psychotropic medications and gradual dose reduction attempts	08/16/2017

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	indicated Resident #35 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. A current, 3/26/16, care plan problem indicated the resident had a diagnosis of spasticity for which an anti-anxiety medication had been ordered. Interventions for this problem included, give medications as ordered, notify physician as needed and observe for side effects related to the medication. A current physician's order indicated the resident received diazepam (an anti-anxiety medication) 2 mg (milligrams) by mouth at bedtime for muscle spasms. During an interview on 7/13/17 at 1:33 P.M., the SSD (Social Service Director) indicated that a GDR (gradual dose reduction) had not been attempted on the diazepam because the medication was being used for muscle spasms and not for anxiety. During an interview on 7/17/17 at 9:56 A.M., the SSD indicated there were no GDR attempts or discussions related to the diazepam because, "we had no idea we were supposed to be doing that. 2. A clinical record review was		have been completed per guidelines. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	

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	conducted on 07/13/2017 9:53:30 AM and indicated Resident #68 was admitted on 11/22/2015. Her diagnoses included diverticulosis, dyspnea, depression, chronic abdominal pain, vascular dementia, frontal lobe disorder, htn, type 2 diabetes, arthritis, seizures, edema, venous insufficiency, pneumonia, and anxiety. A physician order, dated 6/9/2017, indicated Resident #68 was ordered to have clonazepam 1 tablet twice a day for restless leg syndrome. A review of Resident #68's clinical record indicated no indication of any symptoms of restless leg syndrome. During an interview on 7/13/2017 at 1:36 P.M., social services indicated she was unable to locate any information related to signs or symptoms of restless leg syndrome for Resident #68. 3. A clinical record reiew was conducted on 7/13/2017 at 10:30 A.M., and indicated Resident #48 was admitted on 1/8/2017. Her diagnoses included but were not limited to: pacemaker, knee replacement, mitral valve disorder, congestive heart failure, vertigo, dementia, and anxiety.			

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	A physician order, dated 9/17/2016, indicated Resident #48 was ordered to have mirtazapine (an antidepressant medication) daily for an appetite stimulant. A physician order, dated 1/9/2017, indicated Resident #48 was ordered to have mirazapine daily for depression. A review of Resident #48's medical record indicated no adequate indication for the use of an antidepressant prior to ordering it for depression. During an interview on 7/13/2017 at 1:36 P.M., social services indicated she was unable to locate any information related to signs or symptoms of depression for Resident #48. A policy was requested for psychotropic medication use and no policy was provided. 3.1-48(a)(6)			
F 0428 SS=D Bldg. 00	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review			

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	(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should			

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	document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, record review and interviews, the facility failed to ensure pharmacy recommendations regarding psychoactive, PPI's (protein pump inhibitor) and muscle relaxant medications were addressed timely by the physician for 3 of 3 residents reviewed for unnecessary medications. (Resident #3, Resident #4 and Resident #35) Findings include: 1. A clinical record review completed on 7/12/17 at 4:12 P.M., indicated Resident # 3 was admitted on 1/30/17. Diagnosis included, but were not limited to: congestive heart failure, altered mental status, hypothyroidism, depression, anxiety and tremors. A MDS (Minimum Data Set) dated 6/13/17 indicated Resident #3 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact.	F 0428	1.Pharmacy recommendations for residents #3, #4 and #35 have been addressed by the physician. 2.All pharmacy recommendations will be tracked by the DON or designee to assure they are addressed by the physician. 3.Nurses will be re-educated on assuring pharmacy recommendations are addressed by the physician and following up with the physician when no response received timely, 4.The DON or designee will randomly audit resident records 2x/week for 4 weeks to assure physician response to pharmacy recommendations. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	A physician's order, dated 7/1/17, indicated Resident #3 was prescribed Aprazolam 0.25 mg (milligrams) PRN (as needed) every 8 hours, an antianxiety agent. The MARS (Medication Administration Records) for March, April and May of 2017 indicated Resident #3 had not received the Apralozam medication. Behavior Intervention Monthly flow records for March, April and May indicated the resident had not experienced any anxious episodes. A pharmacy recommendation, dated 3/3/17, indicated the Aprazolam "had not been used in several months and was due for a dose reduction." Nurses notes from 3/13/17 to 7/13/17 indicated the pharmacy recommendation had not been addressed. During an interview with the Director of Nursing on 7/17/17, at 10:55 A.M., she indicated that the pharmacy recommendation was not completed. 2. A clinical record review completed on 7/12/17 at 2:57 P.M., indicated Resident #4 was admitted on 9/18/2015. Diagnosis included, but were not limited			

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	to:congestive heart failure, hypertension, breast cancer with right mastectomy. depression, insomnia and peripheral vascular disease. Review of a "Consultant Pharmacy Communication to Physician" form, dated 3/8/17 indicated Resident #4 was receiving Protonix 40 mg (milligrams) daily. The recommendation indicated Resident #4 ..."had HX (history of) significant constipation/IBS/Diverticulosis. She may be at risk for falls or osteoporosis. Decrease Protonix 20 mg daily x 4 weeks, then decrease to Protonix 20 mg every other day...." On 7/12/17, physician orders for Resident #4 were reviewed and indicated a new order dated 6/22/17 at 1 P.M. to d/c (discontinue) Protonix 40 mg every 6 A.M. 3. A clinical record review was completed on 07/11/2017 11:48:11 AM, and indicated Resident #35 was admitted to the facility on 7/19/14. Her diagnoses included, but were not limited to right hemiparesis, hypertension and muscle spasms. A significant change MDS (Minimum Data Set) assessment, dated 4/18/17,			

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	indicated Resident #35 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. A current, 3/26/16, care plan problem indicated the resident had a diagnosis of spasticity for which an anti-anxiety medication had been ordered. Interventions for this problem included, give medications as ordered, notify physician as needed and observe for side effects related to the medication. A current physician's order indicated the resident received tizanidine (a muscle relaxant medication) 8 mg (milligrams) four times daily. A current physician's order indicated the resident received diazepam (an anti-anxiety medication) 2 mg at bedtime for muscle spasms. A current physician's order indicated the resident received baclofen (a muscle relaxant medication) 20 mg four times daily. A document titled, "Consultant Pharmacist Communication to Physician," dated 4/19/17, indicated, "...HIGH DOSE FOR ELDERLY: increased risk of fall... Resident prescribed three agents for muscle			

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	spasms tizanidine 8 mg Four times daily = 32 mg daily baclofen 20 mg Four times daily = 80 mg daily Diazepam 2 mg HS [at bedtime] OTHER Drugs that contribute to fall risk: tessalon Perrles 100 mg BID [twice daily] scheduled carvedilol 12.5 mg BID htn [for hypertension] hydralazine 25 mg BID htn These are high dose for elderly population and may increase risk of CNS [central nervous system] side effects leading to falls. Recommend trial taper down and monitor: decrease tizanidine 8 mg TID [three times daily]... PHYSICIAN RESPONSE TO RECOMMENDATION/FINDING: I AGREE: Please write order(s) OTHER: (Please write a brief statement below concerning the rationale for your response to this recommendation)...." The document was not completed by the physician. During an interview on 7/17/17 at 10:11 A.M., the Director of Nursing indicated the pharmacy recommendation had not been acknowledged by the physician.			

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	On 7/17/17 at 10:38 A.M., the Social Service Director provided the policy titled "MEDICATION REGIMEN REVIEW," dated 6/1/15, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy... Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medical director and/or the administrator. Procedures... E. The consultant pharmacist identifies irregularities through a variety of sources... The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following... 2) As needed (PRN) orders include indications for use... 8) Duplication of medication orders includes a written rationale for the duplication and evidence of monitoring for both efficacy and cumulative adverse medication effects. 9) Resident is monitored for cumulative effects of multiple medications with anticholinergic side effects... 18) Side effects, adverse reactions, and interactions... are evaluated, and modifcations or alternatives are considered... F. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's active			

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	record and reported to the Director of Nursing, and/or prescriber as appropriate. 1) Notification mode is dependent on severity of irregularity and is determined through consultation between consultant pharmacist and the director of nursing... 3) If a continuing irregularity is deemed to be clinically insignificant, or evidence of a valid clinical reason for rejecting the recommendation is provided, the consultant pharmacist will reconsider whether to repor the irregularity again or make a new recommendation on an annual basis. G. Recommendations are acted upon and documented by the facility staff and or the prescriber. a. Physician accepts and acts upon suggestion or rejects and provided an explanation for disagreeing...." 3.1-25(j)			
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and			

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	other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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			

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	followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and record review, the facility failed to ensure one randomly observed residents catheter tubings was off the floor. (Resident #38). Findings include A clinical record review was conducted on 7/14/2017 at 2:00P.M., and indicated resident #38 was admitted on 9/1/2016. His diagnoses included but were not limited to: Hypertension, Dementia, Leucocytosis, Neurogenic bladder, Chronic kidney disease stage 3, Obstruction, Uropathy requiring foley catheter, Benign prostate hyperplasia. During random observations on 7/10/2017 at 12:16P.M., and 7/12/2017 at 2:19P.M., foley catheter tubing was seen on floor.	F 0441	1.Catheter tubing for resident #38 is being positioned so that is does not come into contact with the floor. 2.Catheter tubing for all residents with catheters were audited to assure they are positioned so as to not come into contact with the floor. 3.Nursing staff will be re-educated on proper placement of catheter tubing so that it does not rest on the floor. 4.The DON or designee will do a random audit 2x/week for 4 weeks to assure proper placement of catheter tubing off of the floor. Results of audits will be taken to QAPI for review until facility is in compliance. 5.Date of compliance: 8/16/17	08/16/2017

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	A Careplan dated 6/20/2017 indicated Resident #38 tubing or any part of the drainage system was not to touch the floor. A policy provided by the Director of Nursing titled "Catheter Care-Closed Urinary Drainage", undated, and indicated this was the policy currently being used by the facility. The policy indicated "...Never allow drainage bag to touch the floor...." 3.1-18(b)(1)			