STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00248796. Complaint IN00248796 - Substantiated. No deficiencies related to the allegation were cited. Survey dates: December 13, 14, 15, 18, 19, and 20, 2017 Facility number: 000553 Provider number: 155660 AIM number: 100267430 Census bed type: SNF: 3 SNF/NF: 52 Total: 55 Census payor type: Medicare: 8 Medicaid: 34 Other: 13 Total: 55 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/21/17.	F 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensure of the long term care facility and this Plan of Correction in its entirety, constitutes this provider's credible allegation of compliance. Completion dates are provided for procedural purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is of the opinion that it was in compliance with the requirements of participation. We are respectfully requesting a desk review to clear any and all proposed or implemented remedies	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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			that have been presented to date.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required 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			

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	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 record review and interview, the facility failed to develop a care plan related to a PRN (when necessary) hypnotic (sleeping medication) for 1 of 5 residents reviewed for unnecessary medications. (Resident 40) Finding includes: Record review for Resident 40 was completed on 12/15/17 at 12:25 a.m. Diagnoses included, but were not limited to hypertension, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, completed on 11/10/17, indicated the resident was cognitively intact and received a hypnotic medication. The December 2017 Physician Order Summary indicated an order for zolpidem (hypnotic/ sleeping medication) 5 mg (milligrams) at bedtime as needed for insomnia. The December 2017 PRN Psychotropic or Sedative/Hypnotic Medications flow sheet indicated the resident received the medication on the following dates and times: 12/1/17 at 8:30 p.m. 12/4/17 at 8:00 p.m. 12/6/17 at 8:00 p.m. 12/7/17 at 8:00 p.m.	F 0656	**ISSUE: F656 Develop/Implement Comprehensive Care Plans** **1. WHAT** corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A care plan related to a PRN hypnotic for Resident #40 has been developed and implemented. **2.HOW** other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with an order for a PRN hypnotic have the potential to be affected by the alleged deficient practice. Residents with an order for a PRN hypnotic have been reviewed to ensure that a care plan has been developed and implemented. Care plans will be reviewed with each MDS assessment to ensure all needed care plans are in place for residents with a prn hypnotic. Care plans will be updated following a PRN hypnotic medication change and/or a new order received. Addendum: Care plans will be	01/19/2018

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	12/9/17 at 8:00 p.m. 12/10/17 at 8:00 p.m. 12/11/17 at 8:00 p.m. 12/12/17 at 8:00 p.m. 12/13/17 at 8:00 p.m. 12/14/17 at 8:00 p.m. The record lacked any documentation that a care plan for the hypnotic medication had been put into the resident's plan of care. Interview with the Social Service Designee on 12/15/17 at 2:48 p.m., indicated the resident did not have a care plan in place for the hypnotic medication but should have had one completed. 3.1-35(a)		reviewed with each MDS assessment to ensure all needed care plans are in place for residents. Care plans will be updated when receiving any new physician orders. **3. WHAT** measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All new orders are reviewed each business day in the morning meeting. Any new orders for PRN hypnotics are addressed by the Interdisciplinary Team and a care plan is developed and implemented. The Interdisciplinary Team will be re-educated by January 19, 2018 on the requirement that all residents receiving a PRN hypnotic medication must have a care plan developed and implemented. Addendum: All new orders are reviewed each business day in the morning meeting. Any new orders are addressed by the Interdisciplinary Team and a care plan is developed and implemented. **4. HOW** the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A QAPI audit tool titled "PRN Medication Tool" will be completed	

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			weekly times four weeks, monthly times three months and quarterly times three. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Social Service Director or her designee will be responsible for follow up. **5. BY WHAT DATE** the systemic changes will be completed? January 19, 2018	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to provide treatment to maintain vision related to not administering eye drops as ordered for 1 of 1 sampled residents reviewed for vision. (Resident 42) Finding includes: Interview with Resident 42 on 12/14/17 at 1:48 p.m. indicated she had gone to the eye doctor yesterday to follow up from eye surgery she had a	F 0685	**ISSUE: F685 Treatment/Devices to Maintain Hearing/Vision** **1. WHAT** corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The physician's order for Resident #42's eye drops has been clarified and the eye drops have been	01/19/2018

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	few months ago and he had wanted her to restart her eye drops. She was concerned because she had not received any eye drops yesterday or today yet. Resident 42's record was reviewed on 12/20/17 at 10:25 a.m. Diagnoses included, but were not limited to, corneal decompensation and hypertension. The resident had a care plan for impaired vision related to corneal decompensation and corneal transplant. The resident had a corneal transplant to her right eye on 7/29/15 and to her left eye on 6/14/17. The interventions included, "...eye drops as ordered..." An Appointment Transfer Sheet, dated 12/13/17, indicated the resident had gone to the eye doctor for a cornea graft check and received a new order to "restart pred forte (steroid eye drops) OS (left eye) QID (four times a day), RTC (return to clinic) in one month." A Progress Note, dated 12/13/17 at 8:30 p.m., indicated the resident had returned from her appointment and had a new order to start pred forte eye drops to the left eye four times a day, in one month. Review of the December 2017 Medication Administration Record (MAR) on 12/20/17 at 11:50 a.m. indicated the pred forte order had been written on the MAR but was dated to start 1/13/17. No eye drops had been signed off as administered. Interview with the Unit Manager on 12/20/17 at 11:50 a.m. indicated the eye drops should have been restarted following the resident's eye doctor		administered according to the physician's order. **2.HOW** other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents returning with a new physician order from a physician's appointment have the potential to be affected by the alleged deficient practice. Progress notes from the last 30 days of physician's appointments will be reviewed to ensure that all new orders are being followed. **1.WHAT** measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Two licensed nurses will review all progress notes and corresponding orders following a physician's appointment. The licensed nurse responsible for the resident will sign off on all progress notes from the physician appointments to verify if there are orders once they return to the facility. The Director of Nursing or her designee will review all progress notes and verify orders within 24 business hours. Nurse staff will be re-educated on the procedures to follow related to progress notes and physician	

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	appointment on 12/13/17. She would notify the eye doctor and clarify the order. 3.1-39(a)(b)		orders resulting from a physician's appointment by January 19, 2018. **2.HOW** the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A QAPI audit tool titled "Physician Visit Audit Tool" will be completed weekly times four weeks, monthly times three months and quarterly times three. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Director of Nursing or her designee will be responsible for follow up. **1. BY WHAT DATE** the systemic changes will be completed? January 19, 2018	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as			

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	usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure the Registered Dietitian's (RD) recommendations were addressed in a timely manner related to a nutritional supplement not ordered and a resident not receiving a nutritional supplement as ordered for 2 of 3 residents reviewed for nutrition. (Residents 34 & 50) Findings include: 1. On 12/18/17 at 12:14 p.m., Resident 34 was observed to receive his lunch tray. On the tray was 2 pieces of chicken, noodles, a vegetable, and a roll. No fortified foods or house supplement was observed. Interview with LPN 1 who delivered the resident his meal tray, indicated she was unsure if any of the food on the tray was a fortified food. Record review for Resident 34 was completed on 12/15/17 at 3:03 p.m. Diagnoses included, but were not limited to, hypertension and anxiety. The resident was admitted to the facility on 10/24/17. The Admission Minimum Data Set (MDS) assessment completed on 10/31/17, indicated the	F 0692	**ISSUE: 692 Nutrition/Hydration Status Maintenance** **1. WHAT** corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Registered Dietitian's recommendation for Resident #34 has been addressed. Resident #34 is now receiving fortified foods and a nutritional supplement. Resident #50 is receiving a Magic Cup daily and ice cream at lunch and supper daily. **2.HOW** other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents receiving Registered Dietician recommendations have the potential to be affected by the alleged deficient practice. All residents receiving a supplement	01/19/2018

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	resident was cognitively impaired. A Nutrition Care Plan, updated on 12/12/17, indicated the resident was to have super (fortified) potatoes at lunch and yogurt at breakfast and supper. A Dietary Progress Note, dated 11/30/17, indicated the resident had weight loss. The RD recommended to add fortified foods and a house supplement at each meal. A Physician Order, dated 12/15/17, indicated Med Pass (nutritional supplement) 120 cc (cubic centimeter) TID (three times a day). There was nothing in the resident's record to indicate a nutritional supplemental had been started since 12/15/17. Interview with the Director of Nursing (DON) on 12/18/17 at 4:20 p.m., indicated she was unsure why the house supplement had not been ordered until 12/15/17, and should have been put into place on 11/30/17. The resident was receiving the Med Pass but not at meal times. They had tried adding fortified foods, but the resident had refused them. She was unsure if the RD had been made aware. 2. On 12/18/17 at 12:19 p.m., Resident 50 was observed to receive her lunch tray. On the tray was 2 pieces of chicken, noodles, and a vegetable. No ice cream was observed on the tray. On 12/18/17 at 2:24 p.m., and again at 4:00 p.m., the resident was observed in her room without an ice cream supplement. Interview at both times indicated she had not received her ice cream yet.		have the potential to be affected by the alleged deficient practice. Registered Dietician recommendations for the last 30 days have been reviewed to ensure they have been followed up on. MAR's will be reviewed weekly by the Director of Nursing or her designee to ensure supplements are given. **1.WHAT** measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Nursing or her designee will review the Registered Dietician's recommendations upon receipt and then 72 hours after request has been made to verify order or declination has been received from the physician. The Dietary Manager will audit the Registered Dietician's recommendations weekly at SNAR and follow up on any issues noted. She will report findings monthly to the QAPI committee. When a resident is placed on isolation, a disposable copy of their diet card will be made and provided on each meal tray to ensure accuracy of diet and supplement compliance.	

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	Record review for Resident 50 was completed on 12/18/17 at 2:03 p.m. Diagnoses included, but were not limited to, heart failure, coronary artery disease and hypertension. The resident was admitted on 10/25/17. The Admission MDS completed on 11/1/17, indicated the resident was cognitively intact.. A Nutrition Care Plan, updated on 12/12/17, indicated the resident was to have a magic cup (nutritional supplement) BID (twice a day), provide her with ice cream at lunch and supper. A Physician Order, dated 12/12/17, indicated a new order for ice cream/magic cup at 9:00 a.m., and 2:00 p.m. Interview with the Unit Manager on 12/18/17 at 4:05 p.m., indicated the kitchen had not sent the resident's magic cup down, but someone should have gotten it from the kitchen. Interview with Dietary Assistant 1 on 12/18/17 at 4:08 p.m., indicated she forgot to put the resident's magic cup on the cart to send down to the unit. A policy titled, "Nutritional Supplements", received as current from the DON on 12/19/17, indicated, "Policy: The food service manager will ensure that individuals receive the nutritional supplements that have been ordered by the physician and / or recommended by the registered dietician (RD). Nursing staff will deliver the nutritional supplements and assist individuals to consume nutritional supplements...." 3.1-46(a)(1)		MAR's will be reviewed weekly by the Director of Nursing or her designee to ensure supplements are given. Residents will be interviewed weekly times four, monthly times three and quarterly thereafter to ensure they are receiving their supplements. Dietary and Nursing staff will be re-educated by January 19, 2018 on how to read diet cards and ensure residents receive the correct diets and supplements. A list of all residents on supplements at meals and between meals is now being posted in the pantry snack book. Dietary and Nursing staff will be re-educated by January 19, 2018 on the location of the supplement list. The supplement list will be updated as changes occur. **1.HOW** the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A QAPI audit tool titled "Nourishment Pass Audit Form" will be completed three days a week for four weeks, monthly times three months and quarterly times three. A QAPI audit tool titled "Dietary Tray Line Accuracy Checklist" will be completed three days a week for four weeks, monthly times three months and quarterly times three	

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			and meeting 100% accuracy at various meals to ensure accuracy. The Dietary Manager will audit the Registered Dietician's recommendations weekly at SNAR and follow up on any issues noted. She will report findings monthly to the QAPI committee. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Food Service Manager or her designee will be responsible for follow up. **1.BY WHAT DATE** the systemic changes will be completed? January 19, 2018	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(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 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			

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	unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications, related to the lack of non-pharmacological interventions attempted prior to the administration of PRN (when necessary) hypnotics (sleeping medication) and the increase of an antidepressant medication without justification for 2 of 5 residents reviewed for unnecessary medications. (Residents 40 & 28)	F 0758	**ISSUE: F758 Free from Unnecessary Psychotropic Meds/PRN Use** **1. WHAT** corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	01/19/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: 1. Record review for Resident 40 was completed on 12/15/17 at 12:25 a.m. Diagnoses included, but were not limited to hypertension, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment completed on 11/10/17 indicated the resident was cognitively intact and received a hypnotic medication. The December 2017 Physician Order Summary indicated an order for zolpidem (hypnotic/ sleeping medication) 5 mg (milligrams) at bedtime as needed for insomnia. The December 2017 PRN Psychotropic or Sedative/Hypnotic Medications flow sheet indicated the resident received the medication on the following dates and times: 12/1/17 at 8:30 p.m. 12/4/17 at 8:00 p.m. 12/6/17 at 8:00 p.m. 12/7/17 at 8:00 p.m. 12/9/17 at 8:00 p.m. 12/10/17 at 8:00 p.m. 12/11/17 at 8:00 p.m. 12/12/17 at 8:00 p.m. 12/13/17 at 8:00 p.m. 12/14/17 at 8:00 p.m. The record lacked any documentation that non-pharmacological interventions had been attempted prior to the administration of the PRN hypnotic medication. Interview with the Director of Nursing (DON) on		Resident #40 receives non-pharmacological intervention attempts before administering any PRN hypnotic medication. We have requested Resident 28's physician to come in and review her medication. **2.HOW** other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents receiving a PRN hypnotic medication have the potential to be affected by the alleged deficient practice. All residents receiving a PRN hypnotic medication are offered non-pharmacological interventions before administering the medication. An audit will be conducted for all residents receiving a psychotropic medication to ensure that there is appropriate justification in the medical record by January 19, 2018. We will request physician visits and review for any resident that is receiving a psychotropic medication without appropriate justification. **1.WHAT** measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurse staff will be re-educated on	

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	12/15/17 at 1:38 p.m., indicated staff should have been completing non -pharmacological interventions before administering the PRN hypnotic medication to the resident. A policy titled, "Antipsychotic Medication Use", provided as current from the DON on 12/20/17, indicated, "...13. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record...."2. The record for Resident 28 was reviewed on 12/19/17 at 11:01 a.m. Diagnoses included, but were not limited to, sleep disturbance, dysthymic disorder, and insomnia. The December 2017 Physician Order Summary indicated an order for Trazodone (an antidepressant medication used for insomnia) 50 milligrams (mg) at bedtime for insomnia, started on 9/16/17. The December 2017 Medication Administration Record (MAR) indicated the resident received Trazodone 50 mg at bedtime daily. A Progress Note, dated 9/8/17, indicated the resident's Physician had been in to see her and increased the Trazodone to 50 mg at bedtime. The Progress Notes, dated 8/22/17 through 9/8/17 lacked documentation of any episodes of the resident having trouble sleeping or insomnia. A Physician's Progress Note, dated 9/8/17, indicated the Physician was in to see the resident. There was lack of documentation regarding any episodes of insomnia or why the Trazodone medication had been increased. The September 2017 and August 2017 Behavior		the procedures for offering non-pharmacological interventions before administering PRN hypnotic medication and documenting on the PRN medication flow sheets by January 19, 2018 All PRN medication flow sheets will be audited weekly by the Unit Manager or her designee to ensure compliance. All new orders are reviewed each business day in the morning meeting. Any new orders for psychotropic medication will be addressed by the Interdisciplinary Team and a review of the medical record will be done to ensure there is appropriate justification. The Interdisciplinary Team will be re-educated on the procedure to ensure any resident that is receiving a psychotropic medication has appropriate justification in the medical record by January 19, 2018. Addendum: Nurse staff will be re-educated on the procedures for offering non-pharmacological interventions before administering PRN psychotropic medication and documenting on the PRN medication flow sheets by January 19, 2018. All PRN medication flow sheets will be audited weekly by the Unit Manager or her designee to ensure non-pharmacological interventions are attempted before any PRN psychotropic medication is administered. **1.HOW** the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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	Monitoring Flowsheets indicated the resident was monitored for difficulty going to sleep and difficulty staying asleep. There were no episodes documented. Interview with the Social Service Designee on 12/19/17 at 3:01 p.m. indicated she had not been working at the facility back in September so she was not sure why the resident's medication had been increased. She was unable to find any documentation regarding why the medication had been increased or any documented episodes of the resident having difficulty sleeping. 3.1-48(a)(6)		i.e. what quality assurance program will be put into place? All PRN medication flow sheets will be audited weekly by the Unit Manager or her designee to ensure compliance. A QAPI audit tool titled "PRN Medication Tool" will be completed weekly times four weeks, monthly times three months and quarterly times three. A QAPI audit tool titled " Psychotropic medication audit tool " will be completed weekly times four weeks, monthly times three months and quarterly times three. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Director of Nursing or her designee will be responsible for follow up **1.BY WHAT DATE** the systemic changes will be completed? January 19, 2018	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure an infection control program was followed related to staff not following contact isolation precautions, a lack of a water management policy and plan to protect high risk residents in the facility, and not wearing gloves during a glucometer (blood sugar) testing. (Residents 34 & 41) Findings include: 1. On 12/13/17 at 12:25 p.m., Resident 34 was observed sitting in a wheelchair in his room. The room door had contact precaution equipment in a container hanging on the door. The equipment consisted of gowns and gloves. Housekeeper 1	F 0880	**ISSUE: F880 Infection Prevention and Control** **1. WHAT** corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #34 is no longer in contact isolation. Licensed nurses always wear gloves when doing glucometer checks for Resident #41. The facility has implemented a water	01/19/2018

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	was observed coming out of the resident's bathroom, wearing only gloves and no gown. Interview at the time of the observation, indicated she only needed to put a gown on if she was cleaning the resident's whole room. On 12/14/17 at 4:27 p.m., CNA 1 was observed coming out of the resident's bathroom, wearing only gloves and no gown. Interview at the time of the observation, indicated she had just removed her gown and threw it away in the bathroom before coming out, and she only needed to wear a gown if she was assisting in incontinence care. She then proceeded to go back into the bathroom with the resident but did not don another gown before entering. On 12/18/17 at 12:14 p.m., LPN 1 was observed to bring the resident's lunch tray into his room. The LPN did not put on gloves or a gown before going in and setting up the resident's lunch tray. Record review for Resident 34 was completed on 12/15/17 at 3:03 p.m. Diagnoses included, but were not limited to, hypertension and anxiety. The resident was admitted to the facility on 10/24/17. The Admission Minimum Data Set (MDS) assessment, completed on 10/31/17, indicated the resident was cognitively impaired. A Physician Order, dated 12/6/17, indicated the resident was to have contact isolation related to c. diff (Clostridium difficile) (infection) positive. Interview with the Director of Nursing (DON) on 12/18/17 at 12:32 p.m., indicated the resident was under contact precautions because of c. diff infection. Staff should be putting on gloves and a		management program, completed a risk assessment and developed a plan to protect high risk residents in the facility. **1.HOW** other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Facility staff will be re-educated on the isolation policy and procedure and utilizing the CDC guidelines. Nurse staff have been re-education on the policy and procedure for blood sugar/glucometer checks. A skills validation for nurses will be completed by January 19, 2018. The facility has implemented a water management program, completed a risk assessment and developed a plan to protect high risk residents in the facility. **1.WHAT** measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility staff will be re-educated on the isolation policy and procedure	

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	gown any time they walk into his room. A policy titled, "Procedure for Isolation: Initiation of Isolation", and received as current from the DON on 12/19/17 indicated, "...3. Contact Precautions: In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items..." "...Gather all equipment and supplies needed before going into the room...." 2. Interview with the Environment Services Director on 12/20/17 at 9:50 a.m., indicated he was just informed last month about the water management program and the facility did not have a water management policy or plan in place to monitor for Legionella (bacteria) in the water at the current time. Observation during the survey indicated there were no decorative fountains or hot tubs at the facility. The Resident Census and Condition report indicated 12 of the 55 residents received respiratory treatments. Facility records indicated none of the residents smoked cigarettes or received chemotherapy. Interview with the Administrator on 12/20/17 at 10:15 a.m., indicated they do not have a policy in place or any documentation a risk assessment had been completed for possible places where waterborne pathogens can grow. She indicated they have one resident who was younger than 50 years old and they do not have any whirlpool tubs in the facility.3. During a blood sugar		and utilizing the CDC guidelines. The Infection Control Preventionist will monitor facility infections and address any patterns of possible cross-contamination by staff. If needed, individual staff will be re-educated and/or disciplined to ensure compliance. Nurse staff have been re-education on the policy and procedure for blood sugar/glucometer checks. A skills validation for all nurse will be completed by January 19, 2018. The facility has implemented a water management program, completed a risk assessment and developed a plan to protect high risk residents in the facility. Facility staff will be educated on the Water Management program by January 19, 2018. **1.HOW** the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Infection Control Preventionist will report her findings monthly to the QAPI committee. Random skills validations for nurse staff will be completed weekly times four weeks, monthly times three months and semi-annually thereafter to ensure compliance with blood sugar/glucometer checks. The	

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	glucometer test observation on 12/14/17 at 2:34 p.m., RN 2 gathered supplies and went into Resident 41's room. RN 2 completed the following: - cleansed Resident 41's skin with an alcohol wipe - used a lancet, - drew blood - placed a drop of blood on to the test strip - cleansed the skin with an alcohol wipe - placed the lancet and alcohol wipe with blood on it, into the sharp's container in the resident's bathroom. RN 2 did not use gloves during the entire process. Interview with RN 2 at that time, indicated she did not use gloves during blood sugar tests. Interview with the Director of Nursing on 12/14/17 a 4:20 p.m., indicated the nurse should have worn gloves when performing a blood sugar test. A policy titled, "Policy/procedure Checklist, Checking Fingerstick Blood Glucose Levels," was provided by Director of Nursing on 12/14/17 at 4:20 p.m. This current policy indicated, "...5. Don gloves...." 3.1-18(a)(j)		Maintenance Supervisor will audit the Water Management Program monthly and report any findings to the QAPI committee. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Administrator or her designee will be responsible for follow up. **1.BY WHAT DATE** the systemic changes will be completed? January 19, 2018	