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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey Dates: July 18, 19, 20, 21, 25, and 26, 2016. Census bed type: SNF: 21 SNF/NF: 49 Total: 70 Census payor type: Medicare: 20 Medicaid: 31 Other: 19 Total: 70 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on July 31, 2016.	F 0000	By submitting the Plan of Correction, the facility is not admitting to the truth or accuracy of the cited deficiencies or allegations. The facility reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance, effective on or before August 15, 2016, to the cited deficiencies of the Recertification and State Licensure Survey, ID F4WL11, with an exit date of July 26th, 2016.	
F 0223 SS=D Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.			

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

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	The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 abuse allegations reviewed. A resident was verbally abused which caused the resident to cry and to be scared. (Resident #140) Findings include: On 7/19/16 at 9:46 a.m., Resident #41 indicated she had witnessed another resident being verbally abused. Resident #41 indicated staff was aware of the situation. Resident #41 indicated she would not provide any additional details. On 7/20/16 at 1:39 p.m., Resident #41 indicated it was alright to discuss the alleged verbal abuse with the facility's administration. On 7/20/16 at 1:45 p.m., the Administrator was notified an allegation of verbal abuse had been made. The Administrator indicated he would follow up regarding an investigation. On 7/25/16 at 10:16 a.m., the Administrator provided a State	F 0223	The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident # 140 has not had any additional allegations of abuse. The staff member identified as CNA # 3 was terminated based upon the outcome of the facility investigation which was completed at the time that the allegation was reported to facility management. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that based upon the timely suspension and termination of CNA # 3 no other residents were affected by CNA # 3's behavior. Upon interview of all alert and oriented residents no other allegations of abuse have been reported. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its practices related to screening new employees and educating new hires as well as all employees on a semi-annual basis on the facility's policy and procedure on abuse prevention and reporting. A mandatory in-service on the facility abuse prevention and reporting policies have been conducted for all	08/15/2016

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	Reportable and Investigation regarding Resident #41's roommate on 11/6/15. The incident indicated CNA #3 was in Resident #140's room. CNA #4 was in the hallway and heard Resident #140 state she did not want to go to bed. CNA #4 heard CNA #3 tell Resident #140 "she was not having this [explitive] tonight". Resident #140 told CNA #3 she would like to look for her glasses. CNA #4 heard CNA #3 state she would look for them later. CNA #4 reported she saw CNA #3 reach to take Resident #140's glasses off and the resident jerked their face away. CNA #4 entered the room and asked Resident #140 if she would like to go to bed. Resident #140 answered no and was reportedly crying. CNA #4 removed the resident and took the resident to RN #1. CNA #3 was suspended immediately and left the facility. A transcription, from the text message statement to the facility administration from RN #1 indicated: "CNA [name of CNA] asked me to come to south immediately at 7:25 p.m. I responded at that time and found CNA in a room across the hall from Resident #140, caring for another resident. CNA told this nurse that she just witnessed from the hallway another CNA [name of CNA], raising her voice and cursing at Resident		facility employees. The corrective action taken to monitor and assure compliance is that the facility will review all investigations into allegations of abuse at the regularly scheduled Quality Assurance meetings to ensure that all components of the facility abuse policies have been completed. This review will be conducted at each Quality Assurance meetings for the next twelve months. Any concerns will be promptly addressed by the Quality Assurance committee. The facility would also like to bring the following perspective to the attention of the ISDH. The opening sentence of this citation states that “the facility failed to ensure residents were free from abuse for 1 of 3 abuse allegations reviewed”. The facility contends that, in the real world, it is impossible for any health care facility to be able to ensure (i.e., to completely guarantee) that there will never be an instance of abuse (of some kind) against one of its residents. Health care facilities (and all other health care businesses, for that matter) are dependent upon fallible human beings to provide the services necessary for the care of their residents/patients, and no pre-employment interview and/or post-employment screening and/or training programs can provide employers with absolute confirmation/evidence that there will never be a circumstance in	

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	#140 across the hall. [Name of CNA] entered room and witnessed [name of CNA] grabbing glasses off of residents face. Resident allegedly jerked away. CNA removed resident from situation after resident saying she did not want to go to bed yet. This nurse spoke with resident who stated that 'that mean black girl tried to force me to go to bed'. residents demeanor changed from tearful to sobbing as she described the CNA 'yanking her covers down' to make her go to bed. She then described CNA grabbing glasses off of her face, stating 'it scared me'. She then held her arms out and thanked this nurse saying that 'everyone else here is an angel except for that hateful girl' Resident asked if I or QMA would put her to bed. Assured resident that the CNA in question would not be putting her to bed. Head to toe assessment negative for injuries." A signed statement from the Administrator at the time of the incident indicated the CNA was no longer employed with the facility. The statement further indicated the management considered the incident verbal abuse. On 7/25/16 at 11:00 a.m., the Administrator provided the "Abuse Prohibition" policy, undated. The policy		which a prospective (or current) employee will not react in an unprofessional, and perhaps“abusive”, manner. That obvious fact being stated, when such a situation does arise, it clearly becomes incumbent upon the facility to act promptly to remove the allegedly offending employee, to conduct a thorough investigation of the alleged incident, and then to take the actions that are deemed appropriate based on the facts that are revealed/established as a result of the investigation. With respect to the incident involving Resident #140, the second entry under the Finding section of the survey report indicates that the facility’s State Reportables binder contained no evidence that an allegation of verbal abuse had been reported to the ISDH within the prior six months. Pine Haven believes that the clear implication of this wording is that the facility failed to provide the required notification to the Department of the incident involving Resident #140. What the entry fails to state is that it was soon brought to the survey team’s attention that the incident in question had occurred in November, 2015 (i.e., prior to the six-month period initially reviewed by the surveyors), and that the incident, in fact, had been reported to the Department in a complete and timely manner. Likewise, the fourth entry under the Finding states that the	

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	indicated, "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish..... 3.1-27(b)		Administrator indicated "he would begin an investigation". Again, Pine Haven believes the clear implication of this wording is that there had not been a previous investigation of the incident itself, rather than that the Administrator, in fact, intended to begin an investigation as to why the surveyors had been unable to locate a record of the incident having been previously reported to ISDH, as required. The facility clearly acknowledges that, in the judgment of its own management staff, the behavior of CNA #3 in November, 2015 constituted an incidence of verbal abuse against Resident # 140, and that such behavior was completely unacceptable. As a result of the incident, CNA # 3 was immediately suspended from duty, and once the subsequent investigation was completed, her employment was terminated, and the required report was submitted to the Department on a timely basis. As a result of this "self-reporting" on the part of the facility, ISDH records now appear to indicate that CNA #3's certification to provide nursing assistance has been rescinded. The facility's prompt corrective action taken in response to the specific verbal abuse of Resident #140 has been described above. With respect to the potential for other residents to be affected by the type of abusive behavior demonstrated by CNA #3, that	

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			employee's immediate suspension and subsequent termination effectively eliminated that potential.The facility contends that the manner in which this incident was handled indicates that the measures and policies currently in place at Pine Haven are effective, and adequate to enable the facility to respond in a timely and appropriate manner to any future incident of this nature. As noted in the report made to ISDH in November, 2015, staff received further in-service training at the time regarding the proper handling of these types of abuse allegations. Any incidents of alleged abuse (of whatever type) are routinely being reviewed and monitored during the facility's regular quarterly Quality Assurance meetings. The facility hereby respectfully requests the ISDH to schedule an Informal Dispute Resolution meeting, at which time Pine Haven's representatives intend to challenge the Scope and Severity (i.e., level G) assigned to the specific deficiency cited under F-223.	
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.			

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	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and record review, the facility failed to ensure 2 of 4 residents in a total sample of 23 resident reviewed, participated in their care planning conferences and 1 of 30 residents whose care plan was not revised.. (Resident #75, Resident #68, Resident #1) Findings include: 1. During an observation on 7/18/16 at 3:28 p.m., Resident #75 was observed to be in a wheelchair in his room. Resident #75 indicated the staff had not included him in decisions about his daily care, nor had he been to a care conference in a long while. The clinical record for Resident #75 was reviewed on 7/21/16 at 8:22 a.m. Resident #75 had diagnoses including,	F 0280	1). The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #75 is now being invited to each care conference and there is documentation to support this invitation. In addition, it is documented if the resident declines the offer to participate in the care conferences. Upon interview of resident #75 he indicates that he is very satisfied with his current plan of care and has been satisfied with his plan of care since admission. 2). The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #1 is now being invited to each care conference and there is documentation to support this invitation. In addition, it is documented if the resident declines the offer to participate in the care conferences. Upon	08/15/2016

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	but not limited to atrial fibrillation, ischemic heart disease, and liver disease with hepatitis. The annual MDS (Minimum Data Set) assessment, dated 5/16/16, indicated Resident #75 had a BIMS (Brief Interview for Mental Status) assessment score of 15, which indicated no cognitive impairment. A care plan, initiated 2/16/16 and revised on 5/16/16, indicated the resident should be involved in daily decisions regarding his care and to provide services to the resident in an "effort to enhance his optimal well-being." The clinical record indicated Resident #75's son had refused to attend the care conferences for the resident, but the record indicated the resident had not been invited to attend. During an interview with the SW (Social Worker) on 7/25/16 at 9:59 a.m., the SW indicated she was not aware she needed to have a care conference with the resident on a routine basis. The SW further indicated she would invite the resident to their care conference but did not document their refusal to attend. 2. On 7/19/16 at 9:10 a.m., Resident #1 indicated the staff had not included her in		interview of resident # 1 she indicates that she is satisfied with her current plan of care and has been satisfied with her plan of care since admission 3).The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #68 has had their care plan reviewed and up-dated to include current and accurate information concerning their urinary continence. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been completed related to resident participation in their care plan conferences and the accuracy of their care plans. There is documentation to support that each resident and/or their responsible party is being invited to participate in their care plan conferences and there is documentation to support this invitation as well as their response. In addition all care plans have been reviewed and up-dated to ensure that they reflect the residents current needs including appropriate interventions. The measures that have been put into place to ensure that the deficient practice does not recur is that the Director of Social Services has been counseled concerning her responsibility to ensure that each	

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	decisions about her care, nor did they invite her to attend her care planning conferences. On 7/20/16 at 8:35 a.m., Resident #1 was observed eating breakfast in bed. Resident #1 indicated she was doing well on that day. On 7/20/16 at 3:38 p.m., Resident #1's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) Assessment, dated 5/13/16, indicated Resident #1 had no cognitive impairment. On 7/25/16 at 9:00 a.m., the SW (Social Worker) indicated Resident #1 had refused to attend their care planning conferences. The SW further indicated she usually documents if a resident refused to attend the care planning conferences. On 7/25/16 at 9:22 a.m., the SW indicated she was unable to locate documentation of Resident #1's refusal to attend care planning conferences. A policy, obtained from the ADON on 7/26/16 at 1:41 p.m., indicated residents would be informed and invited by the nursing staff to the care conferences.		resident and/or their responsible party is invited to their care plan conference as well as her responsibility in documenting their response to each invitation. In addition the interdisciplinary team has attended a mandatory in-service on their responsibility to ensure that each resident's care plan is current and contains accurate information based on the resident's current needs. The corrective action taken to monitor to assure compliance is that the clinical documentation of (5) five random residents will be conducted to ensure that they are being invited to their care plan conference and that there is documentation to support this invitation along with the resident's response to this invitation. The review will also include a review of the resident's care plan to ensure that it is current and reflects the resident's current needs along with appropriate interventions. These reviews will be completed by the Administration and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of these audits will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted. The facility would also like to note that in regards to the opening sentence of this citation, the facility takes exception to the	

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	3. On 7/20/16 at 9:07 a.m., Resident #68's clinical record was reviewed. Resident #68's diagnoses included, but were not limited to: urge incontinence. An Admission MDS (Minimum Data Set) Assessment, dated 3/5/16, indicated Resident #68 was frequently incontinent. A Significant Change MDS Assessment, dated 5/8/16, indicated Resident #68 was always incontinent. The Care Plans included, but were not limited to: She has some incontinent episodes and is at risk for complications, revised on 3/16/16. On 7/25/16 at 10:09 a.m., the MDS Coordinator indicated care plans should be updated following a Significant Change MDS Assessment. On 7/25/16 at 10:37 a.m., LPN #1 indicated Resident #68 was always incontinent. On 7/25/16 at 10:41 a.m., Resident #68 was observed sleeping in a common area. On 7/26/16 at 1:49 p.m., the ADON provided the "Interdisciplinary Care Plan Policy and Procedure", dated 8/2008. The policy included, but was not limited		statement that "…the facility failed to ensure 2 of the 4 residents in a total sample of 23 residents reviewed, participated in their care planning conferences…" Clearly, no facility can be expected to "ensure" (i.e., in the sense of requiring something to happen) that any particular resident will necessarily participate in the "care conference" that the facility must conduct periodically regarding that resident's plan of care. What a facility is obligated to "ensure" is that residents who are cognitively able to participate in such care conferences are routinely offered the opportunity to do so. Facilities are obliged also to make sure that family members and/or other parties interested in and/or responsible for a resident's care and well being are informed that care conferences are taking place on a regular and routine basis, and that they are invited (and welcomed) to attend and participate. According to Finding #1, Resident #75 apparently indicated to the surveyor that "the staff had not included him in decisions about his daily care, nor had he been to a care conference in a long while". Though perhaps unintended, the facility believes that the clear implication of this wording to an uninformed reader may well be that "the staff" had somehow chosen to "not include" the resident in decisions about his daily care, and that as a result, he	

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	to:.....Assessments are made and revisions of the plan are completed as necessary to maintain a current profile of the resident..... 3.1-35 (d)(2)(B)		had not been to a care conference in a long while. There is no indication in the survey report, as written, that Resident #75 was ever asked if he wished to be involved, or more involved, in the decisions being made about his daily care, or if he was upset or unhappy about not having attended a care conference in a “long while”. The survey report does not indicate that the resident himself expressed dissatisfaction with the nature or quality of his daily care, nor does it state that the resident expressed frustration with the fact that he had not attended a care conference in some time. As noted in the finding, Resident #75 is alert and cognitively unimpaired. As a matter of fact, he is routinely invited to participate in his periodic care conferences, and just as routinely declines such invitations. If he has concerns about the quality of the care and/or services he is receiving, he is more than capable of bringing those concerns to the attention of “management” – and he would not feel compelled to wait until a scheduled “care conference” to do so. While the wording in the care plan indicates that the resident “should” be involved in decisions regarding his care, the facility would contend that the fact he apparently has not found it necessary to actively participate in recent care conferences is	

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			more likely an indication that he is currently satisfied with his care than an indication that he has been prevented or discouraged from such participation. The survey report does not state, or allege, that Resident # 75 has not routinely been invited to attend conferences regarding his care; rather, the report concludes that such invitations could not be verified based on a lack of documentation by the Social Services Director that such invitations had been extended – but declined. The facility acknowledges that such documentation was not included in the Director's notes within the plan of care for Resident #75. The Director has been counseled regarding the need to consistently document her efforts to include residents in their care planning conferences (as well as their refusal to participate, should that be the case). With respect to Finding # 2 concerning Resident #1, the facility acknowledges that the care plan for this resident did not contain the documentation necessary to support/confirm the Social Service Director's contention that Resident #1 had been invited to her recent care planning conferences. The Director has been counseled regarding the need to consistently document her efforts to include residents in their care planning conferences (as well as their refusal to participate, should that	

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			be the case). Regarding Finding #3 concerning Resident # 68, the facility acknowledges that there was an inconsistency between the information contained in the care plan dated 3/16/2016 and the Significant Change MDS Assessment dated 5/8/2016, in that the resident's condition with respect to incontinence had deteriorated from episodic to constant – and the care plan had not been updated to reflect the significant change with respect to incontinency. The plan of care for Resident #68 has now been updated to reflect current conditions, and is consistent with the information contained within the latest MDS assessment. The facility's MDS coordinator has discussed this apparent inconsistency with nursing management, emphasizing the requirement that the nursing component of a resident's care plan should reflect the resident's actual condition as established by the latest MDS assessment. The facility anticipates that as more and more of the residents' care plans are gradually transitioned to an electronic format under the facility's Point/Click/Care system, it will become progressively easier to ensure care plans are updated on a timely basis to reflect the information contained within the latest MDS assessments.	
F 0312	483.25(a)(3)			

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	155621	A. BUILDING 00 B. WING	07/26/2016

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SS=D Bldg. 00	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to provide ADL care to 1 of 7 residents reviewed for choices in a total sample of 23, who met the criteria for choices. Showers were not provided to a resident. (Resident #17) Findings include: On 7/19/16 at 10:36 a.m., Resident #17 was observed to be sitting in her room in a wheelchair. Resident #17 indicated she was supposed to receive 2 (two) showers a week but had not been receiving showers as she should. On 7/20/16 at 8:38 a.m., Resident #17 was observed to be propelling herself in the hall in a wheelchair. Resident #17"s hair was uncombed. The clinical record for Resident #17 was reviewed on 7/20/16 at 2:55 p.m. Resident #17 had clinical diagnoses including, but not limited to, dementia without behavioral disturbances and lack	F 0312	The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #17 is being offered showers twice a week in accordance with her personal preference. The facility continues to follow their protocol if the resident refuses a shower. If the resident continues to refuse showers then a plan of care will be established to address this concern. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was conducted on the documentation of showers being given/offered. No other residents were identified during this audit. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the facility policy related to the required documentation of showers/bed bath administration documentation to ensure staff knowledge of this policy as well as their responsibility in complying with this policy. The corrective action taken to monitor	08/15/2016

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	of coordination. A significant change MDS (Minimum Data Set) assessment indicated the resident had a BIMS (Brief Interview for Mental Status) assessment score of 15, which indicated no cognitive impairment. The MDS indicated Resident #17 required 1 person assist for bathing. A care plan, dated 10/16/15, indicated Resident #17 was to be provided a shower per preference twice a week. A "Shower Schedule", obtained from the ADON on 7/20/16 at 9:03 a.m., indicated Resident #17 was to receive a shower every Tuesday and Friday on the evening shift. During review of the ADLs (activities of daily living), the list indicated Resident #17 had received a shower on 6/22/16, 6/26/16, 7/3/16, 7/6/16, and 7/22/16. The resident should have received a total of 9 (nine) showers from 6/21/16 through 7/22/16. During an interview on 7/25/16 at 8:26 a.m., the ADON (Assistant Director of Nursing) indicated the resident should have received a shower twice a week, every Tuesday and Friday on the evening shift . A procedure titled "Bath - Shower," dated		to assure compliance is that the Director of Nursing and/or her designee will interview and review the clinical documentation of (5) five random residents to ensure that they are receiving their showers/bed baths in accordance with their personal preference. These reviews will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of these interviews will be reviewed at the Quality Assurance meetings for the next year to determine if any additional action is warranted.Additionally, the facility acknowledges that during the period from 6/21/2016 through 7/22/2016, the ADL record indicates that Resident #17 received only five showers, rather than the nine showers called for during that period by the resident's plan of care. CNA documentation contained within the"point of care" component of the facility's electronic medical records system indicates that the resident declined to take showers on the other four occasions, but the clinical record lacked confirmation that the professional nurse on the resident's unit actively followed up with the resident on those occasions. It is the facility's policy that if a resident initially declines an opportunity to be assisted with his or her shower, the resident will be offered an alternative time for bathing, or the option of receiving	

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	1997 and obtained from the ADON on 7/26/6 at 1:41 p.m., indicated each resident would receive a bath or a shower two times per week and as needed. 3.1-38(b)(2)		a bed bath. If those offerings are also declined, a second CNA will later approach the resident seeking agreement/cooperation to complete the scheduled bathing. If that attempt is also refused, the nurse on duty will get involved, making a third attempt to obtain the resident's approval to be assisted with a shower or bed bath. If that final attempt is also unsuccessful, the nurse is required to document the resident's ongoing refusal in the clinical record. The facility believes that the "showering system" currently in place is generally effective in ensuring that residents are bathed in accordance with a regular schedule –which contention appears to be supported by the fact that the recent survey found only one instance in which appropriate facility documentation was not found. In response to this single finding, nursing management has conducted additional in-servicing for all nursing staff, reviewing the facility policy outlined above, and re-emphasizing the importance of adhering to the established shower schedules.	
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and			

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	assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents were free from accident hazards for 1 of 3 reviewed for falls and 3 of 31 rooms observed for hot water temperatures. A resident was left while ambulating unassisted which resulted in a fracture to the left arm and hot water temperatures were above 120 degrees Fahrenheit. Findings include: 1. On 7/20/16 at 10:40 a.m., Resident #37's clinical record was reviewed. Resident #37's diagnoses included, but were not limited to: senile dementia, personal history of fall, difficulty walking, and lack of coordination. A Quarterly MDS (Minimum Data Set) Assessment, dated 4/12/16, indicated the resident had moderately impaired cognition. The MDS Assessment, further indicated the resident required extensive assistance of one person for locomotion on the unit. The Care Plans included, but were not limited to: [Name of Resident] has alteration in mobility regarding: transfers, ambulation, and positioning. The interventions	F 0323	1). The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident # 37 is no longer a resident at the facility. The event was handled by the facility in accordance with facility policy and the CNA involved in the incident was counseled with a final warning. In addition all nursing staff was re-inserviced on fall prevention and gait belt utilization. 2).The corrective action taken for those residents found to have been affected by the deficient practice is that the resident rooms identified as rooms # 222, 218 and 219 now have water temperatures maintained at the appropriate temperature levels not exceeding 115 degrees Fahrenheit. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been conducted on all residents at fall risk. Each resident has appropriate interventions in place to ensure that the resident is free of accident hazards. In addition, a house wide audit has been completed on all residents' rooms and the water temperatures have been maintained at the appropriate temperature level. The measures that have been put into place to ensure that the deficient practice does not recur	08/15/2016

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	included, but were not limited to: ambulates with walker and assist of one. The Progress Notes included, but were not limited to: On 4/23/16 at 10:02 a.m., a late entry for 9:15 a.m., indicated: The nurse was notified by the housekeeper that the resident was lying on the floor on their back and the CNA was cradling the resident's head. The note further indicated the resident indicated she was having numbness and tingling in the left arm and the arm was observed to be lying in an abnormal position. The collar bone appeared to be protruding out with bruising noted on the skin, but not broken. A skin tear was also noted on the left hand The note further indicated that the CNA reported she was ambulating the resident with a walker, when another resident was in a wheelchair leaning forward. The CNA reported she stepped away from the ambulating resident to assist the resident in the wheelchair when the ambulating resident fell. CNA further stated she had been distracted and this resulted in the residents fall. The resident was sent to the emergency room for evaluation and treatment. On 4/23/16 at 4:41 p.m., a note indicated a call had been placed to the hospital and had the resident had been admitted for a		is that a mandatory in-service has been conducted for all nursing staff on the facility's fall prevention and gait belt utilization policies. The facility has also successfully repaired the water system issue to ensure appropriate water temperatures are maintained and will continue to monitor those water temperatures as part of their routine maintenance program. The corrective action taken to monitor and assure compliance is that (5) five residents who have been identified at fall risk will be reviewed to ensure that all appropriate measures are in place in an attempt to prevent falls and to ensure that the resident is free of any fall/safety hazards. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. In addition the Director of Maintenance will check (5) five random resident's rooms to ensure the water temperature are maintained at the appropriate temperature level. These water temperature checks will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of these tools will be reviewed at each Quality Assurance meeting to determine if any additional action is warranted. As additional	

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	left humeral head fracture, left arm problems, and elbow/shoulder injury. On 7/26/16 at 10:55 a.m., the ADON indicated if a staff member was assisting a resident to ambulate and the staff member noticed another resident might fall, the staff member should call out for help. On 7/26/16 at 11:25 a.m., CNA #1 indicated she was ambulating Resident #37 from the dining room with a rolling walker. CNA #1 indicated a second resident was leaning forward in their wheelchair. CNA #1 indicated at that time she let go of Resident #37 and reached to assist the second resident. CNA #1 indicated at that time, Resident #37 fell. On 7/20/16 at 10:20 a.m., the Administrator provided the "Fall Prevention Program" policy, revised 10/19/12. The policy included, but was not limited to: It is the facility policy to ensure that the resident's environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. 2. On 7/18/16 at 11:49 a.m., a sign was observed at the North Unit Nursing		information, the facility acknowledges that the incident described in Finding #1 involving Resident #37 did, in fact, occur in the manner outlined within the survey report. The incident was self-reported to the Department, as required, in complete detail on April 28, 2016. The CNA involved in the incident was counseled and given a written warning that any repeat violation of the facility's policy with respect to the use of a gait belt when ambulating a resident, even with the assistance of a walker, would result in her immediate termination. CNA #1 fully understood in retrospect that, although she had left Resident #37 unattended for only a brief few moments in an effort to assist another resident and prevent a potential fall, the correct course of action would have been to call out for assistance from another staff member. In response to this specific incident, additional in-service training was initiated for all nursing personnel with regard to gait belt utilization and fall prevention. In the facility's judgment, the incident upon which this citation has been based was addressed, and its plan of correction implemented, nearly three months prior to the commencement of the 2016 annual survey. With regard to the issue of excessively hot water at times being present on the facility's North Unit, the facility acknowledges that, depending	

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	station, which indicated to be careful when using the hot water because it got extremely hot. The North unit had 15 (fifteen) residents residing on it. a. On 7/18/16 at 11:53 a.m., Room #222's water temperature was observed to be 136 degrees Fahrenheit. On 7/19/16 at 9:36 a.m., Room #222's water temperature was observed to be 122 degrees Fahrenheit. This would have been the during the time of meal clean-up and/or laundry being done. b. On 7/18/16 at 11:55 a.m., Room #218's water temperature was observed to be 133 degrees Fahrenheit. This would have been during the time of meal clean-up and/or laundry c. On 7/18/16 at 11:58 a.m., Room #219's water temperature was observed to be 131 degrees Fahrenheit. This would have been during the time of meal clean-up and/or laundry. On 7/18/16 at 2:41 p.m., Unit Manager #2 indicated she was not sure why there was a sign posted regarding extremely hot water. On 7/18/16 at 3:29 p.m., CNA #2 indicated there had not been any hot water issues.		upon water utilization elsewhere in the facility (i.e., in the kitchen and/or laundry facilities), there were times when the water temperatures on the North Unit exceeded the established threshold of 115 degrees Fahrenheit. Facility staff provided the survey team with multiple receipts for work completed previously in an effort to identify the cause and correct the problem of fluctuating water temperatures. In response to the continuing concern raised during the survey, the facility again contacted one of its established maintenance contractors to re-assess the situation and seek a permanent solution. As it happened, the selected contractor had recently hired a new employee with extensive experience with plumbing and water-related issues commonly found in older buildings, and this individual was able to isolate and address the likely cause of the inconsistent water temperatures on the facility's North Unit. Following the necessary repair, subsequent testing of water temperatures appeared to confirm that the situation had been resolved. It is also worth noting that while water temperatures on the North Unit were occasionally somewhat above the acceptable threshold, there had been no reported instances in which any resident sustained harm or injury as a	

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	On 7/18/16 at 3:43 p.m., the water temperatures of Room #222, Room #218, and Room #219, were observed with the Maintenance Supervisor. All the water temperatures were between 114-118 degrees Fahrenheit. The Maintenance Supervisor indicated a private company comes to the facility if there are any issues with hot water. On 7/19/16 at 7:46 a.m., the Administrator indicated a private company was in the facility on this date to inspect the hot water heaters. The Administrator further indicated they knew if laundry or dietary were functioning the hot water was okay, but there were pockets of time they knew the hot water was too hot therefore prompting the sign to be posted on the North Nursing Unit. On 7/19/16 at 7:59 a.m., the Administrator indicated the mixing valve had been replaced in December of 2015. On 7/19/16 at 9:58 a.m., the private company employees were interviewed. The employees indicated the hot water check valves were corroded and was intermittently causing hot water to get to flow through. The employees further indicated the situation had been		result of this problem. Please note also that this issue was raised, addressed, and effectively resolved on July 19, 2016, i.e., on the second day of the six-day survey period.	

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	corrected. On 7/26/16 at 1:49 a.m., the ADON provided the "Surveyor Guidance for Identified Excessively Hot Tap Water Temperatures That May Cause Scald Burns in Health Care Facilities", dated 1/2002. The policy indicated hot water temperatures in nursing homes should not exceed 115 degrees Fahrenheit. 3.1-19(r)(2) 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary			

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	drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure a resident received the correct dose of a medication for 1 of 5 residents reviewed in a total sample of 35 residents who met the criteria for unnecessary medications. A resident received the incorrect dose of a medication. (Resident # 17) Findings include: The clinical record for Resident #17 was reviewed on 7/20/16 at 2:55 p.m., Resident #17 had a physician's order, dated 4/21/16 and signed on 4/27/16, for Cholestyramine (a cholesterol lowering	F 0329	The corrective action taken for those residents found to have been affected by the deficient practice is that upon review of the physician's orders and the MAR of the resident identified as resident #17 the resident is currently receiving their medications in accordance with the physician's orders. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been conducted of each resident's physician's orders and compared to their current MARs. No other medication errors were identified. The measures that have been put into place to ensure that the	08/15/2016

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	medication) 4 (four) Grams Powder po (orally), reconstitute per package QD (everyday) x (for) 12 (twelve) days. A MAR (Medication Administration Record), dated April, 2016, indicated the resident had received the medication for 9 (nine) days during the month. A MAR, dated 5/1/16 through 5/31/16, indicated Resident #17 would receive Cholestyramine 1 (one) scoop in water twice a day x 12 days. The times listed on the MAR indicated the medication was given twice a day on 5/1/16, 5/2/16, 5/3/16, 5/4/16, 5/6/16, 5/7/16, and 5/8/16. The medication was discontinued after 16 (sixteen) days of treatment. During an interview on 7/26/16 at 10:07 a.m., QMA (Qualified Medication Aide) #1 indicated the order was transcribed incorrectly. During an interview on 7/26/17 at 11:05 a.m., the ADON (Assistant Director of Nursing) indicated the medication had not been transcribed correctly when the MAR was received from the pharmacy and the nurses did not "catch" the incorrect order. The ADON indicated the medication had been entered incorrectly on the MAR at the pharmacy for the month of May. The ADON indicated the		deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the facility policy related to validating each month the accuracy of each resident's MARs. The corrective action taken to monitor and ensure compliance is that random medication audits will be conducted to ensure that the current MARs match the current physician's orders. These audits will be completed by the Director of Nursing and/or their designee. These audits will be conducted weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of these audits will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.Furthermore, the facility acknowledges that the medication error described in this Finding involving Resident #17 did occur. While the original error can be traced back to the Medication Administration Record (MAR) initiated by the facility's pharmacy contractor, the error should have be detected by the facility's nurse who conducted the transcription from the previous month's MAR. The individual involved with this transcription error has been counseled, and all staff members involved in the monthly pharmacy "re-write" process have received additional in-service training about the need	

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	MARs were to be checked by 2 nurses when they were obtained from the pharmacy each month to ensure they were correct. A policy, dated 9/2008 and obtained from the ADON on 7/26/16 at 1:41 p.m., indicated the designated nurse would assume responsibility for checking all orders and medications listed for accuracy and completeness. 3.1-48(c)(2)		to ensure that information contained on the MAR from the prior month is accurately transcribed to the MAR applicable to the current month. With respect to the specific situation involving Resident #17, the facility believes it is worth noting that the resident suffered no ill effect whatsoever as a result of the erroneous continuation of her cholesterol lowering medication for 16 days, as opposed to the originally ordered duration of 12 days. As a matter of fact, after the cholesterol medication was discontinued as of May 8, 2016, the resident's physician subsequently re-ordered the same medication, and at twice the dosage that was initially ordered on April 21, 2016. Obviously, the facility understands that this fact in no way diminishes the significance of the medication error which did take place; however, it does offer objective evidence that Resident #17 fortunately suffered no ill effects from this particular error. As is currently the case, the facility will continue to review and monitor all documented instances involving medication errors during its regular quarterly Quality Assurance meetings.	
F 0354 SS=F Bldg. 00	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the			

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	services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on observation, interview, and clinical record review, the facility failed to provide full time Director of Nursing coverage. This had the potential to effect 70 residents who reside in the facility. Findings include: 1. On 7/18/16 at 9:00 a.m., upon arrival at the facility, it was observed that the facility lacked a full time Director of Nursing. 2. On 7/26/16 at 12:30 a.m., the Administrator acknowledged the facility did not have a full time DON (Director of Nursing) on staff. The Administrator indicated the facility had been searching for a DON but had been unable to find a replacement. The Administrator indicated the previous DON had left the facility without giving the proper notification. The Administrator indicated	F 0354	The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified under this citation however all residents have the potential to be affected by this citation. The facility has recently appointed an R.N. to fill the position as an interim DNS. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice however the facility has recently appointed an R.N. to fill the position as an interim DNS. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has continued to advertise for this position and currently has three potential candidates for the position. The corrective action taken to monitor to assure compliance is that the facility is interviewing three candidates for the position of Director of Nursing	08/15/2016

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	the State Board of Health had been notified, but the facility had not applied for a waiver. 3. On 7/26/16 at 2:56 p.m., the ADON (Assistant Director of Nursing) provided a policy indicating it was the facility's policy to fully comply with the Federal regulations found at 42 CFR Part 483, Subpart B, Section 483.30(b)(2) with respect to the designation of a properly licensed registered nurse to serve as the facility's Director of Nursing on a full-time basis. 3.1-17(b)(4)		and will determine who is best qualified to fill this position. It should be noted that during the time of the survey, the facility's MDS coordinator, a registered nurse employed on a full time basis,had been appointed to act in the capacity of interim Director of Nursing, with the support of an experienced licensed practical nurse to assist with her administrative responsibilities. However, during an informal "pre-exit-conference" meeting with the surveyors, the survey team leader informed the facility's management that it was not acceptable to have a registered nurse who was responsible for MDS-related functions also serve as the facility's interim Director of Nursing. No regulatory citation or official policy statement was offered in support of this assertion, and subsequent research by facility management revealed that registered nurses responsible for MDS-related functions are often appointed to fulfill the requirement for a full time Director of Nursing on an interim basis. In light of this apparent fact, the facility would argue that the temporary assignment of the registered nurse providing MDS services as the interim Director of Nursing did not constitute a deficiency under F-354. Notwithstanding the facility's position in this regard, and in deference to the Department's apparent concern	

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			about the ability of a single person to fulfill the duties involved with both of these roles, the facility has appointed, effective as of Monday, August 15, 2016, another of its full time registered nurses to act in the capacity of interim Director of Nursing until such time as a permanent replacement can be identified and hired.	
F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview, and record review, the facility failed to provide a dental referral for 1 (one) of 2 (two) residents reviewed, in a total sample of 35 who met the criteria for dental. A resident with a referral to see an oral surgeon, was not referred. (Resident # 86). Findings include: On 7/18/16 at 2:35 p.m., during an	F 0412	The corrective action taken for that resident found to have been affected by the deficient practice is that the resident identified as resident # 86 has an appointment scheduled for August 30, 2016 with an oral surgeon to address the resident's dental needs. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the Social Service Director has conducted a house wide audit to determine if any additional dental services were inadvertently	08/15/2016

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	interview, Resident #86 indicated he had four teeth. On 7/20/16 at 1:27 p.m., Resident #86's clinical record was reviewed. A document titled, "[Name of Dental service]", dated 3/17/16 indicated that a referral was made to an Oral Surgeon for Resident #86 to facilitate removal of teeth number 20, 21, 22, and 23. It further indicated the referral form and copy of radiographs were left with the facility for follow up. On 7/21/16 at 1:29 p.m., the Social Worker indicated during an interview, that she had not made the referral to an oral surgeon because she had missed the referral order. On 7/26/16 at 10:56 a.m., the Assistant Director of Nursing indicated the procedure to follow up on a referral would be for the nurse on duty to review the papers which returned with the resident. If a referral was ordered, the nurse would call and make the appointment. The ADON further indicated the referral would be discussed by the Interdisciplinary team in the morning meeting, and that ultimately the Unit Manager was responsible to ensure the referral was made.		overlooked. No other residents were identified. The measures that have been put into place to ensure that the deficient practice does not recur is that the Social Service Director has implemented a “monitoring checklist” to minimize the potential for overlooking future dental referrals. This is an on-going tracking tool. The corrective action taken to monitor and assure compliance is that the Quality Assurance committee will review this monitoring checklist at each Quality Assurance meeting to ensure that all dental referrals are processed in a timely manner. This will be an on-going part of the facility’s Quality Assurance process. Therefore, the facility agrees that the referral order contained within the clinical record for Resident #86 was, in fact, overlooked by the facility’s Social Services Director. When this issue was brought to light during the course of the survey, the Director immediately began the necessary follow-up process, and an appointment for Resident #86 to see an oral surgeon was scheduled for Tuesday, August 30, 2016. The Director will assist also with any transportation arrangements, as necessary. As all facility residents have the potential to be affected if a health care referral is overlooked, the Social Services Director also conducted a review of the clinical records of all current residents to	

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	On 7/26/16 at 1:40 p.m., a policy was provided by the Assistant Director of Nursing. The policy indicated that an evaluation would be obtained as soon as possible. 3.1-24(a)(b)		ensure that no other referrals have been overlooked. In addition, a new "monitoring checklist" has been developed by the Director to minimize the potential for overlooking future referral orders requiring further follow-up by medical "specialty services" (e.g., podiatry, audiology, ophthalmology, and dentistry) rendered by providers outside the facility. The information contained on this "checklist" will be reviewed during the quarterly Quality Assurance meetings, and its effectiveness in preventing recurrences of this deficiency will be evaluated periodically by members of the facility's interdisciplinary team.	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws,			

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	the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure that medications were labeled and outdated medications were disposed of properly for 1 of 4 nursing units observed. Three (3) vials of Influenza vaccine were outdated and one (1) vial of Insulin had no open date. (South Nursing Unit, Resident #54) Findings include: 1. On 7/25/16 at 10:48 a.m., three vials of Influenza vaccine were observed in the South Unit medication storage room with an expiration date of 6/16. 2. On 7/25/16 at 1:44 p.m., an opened vial of Lantus Insulin prescribed to Resident #54 was observed with no open	F 0431	The corrective action taken for those residents found to have been affected by the deficient practice is that the three vials of influenza vaccine were destroyed in the presence of the surveyors during the survey. The vial of Lantus insulin prescribed for the resident identified as resident #54 was destroyed and a new bottle of Lantus was obtained and dated when opened. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of all med carts and med rooms was conducted to identify any outdated medications or any medications that had not been dated when opened. No additional medications were identified. The measures that have been put into place to ensure that the deficient practice does not recur is that a	08/15/2016

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	date. On 7/25/16 at 1:50 a.m., Unit Manager #2 indicated that Insulin should be labeled with an open date after it was opened. On 7/25/16 at 2:27 p.m., Unit Manager #1 indicated Insulin expired 28 days after opening the vial. She further indicated that Pharmacy checked monthly for expired medications and the Unit Managers were also responsible to check for expired medications. 3. On 7/26/16 at 3:40 p.m., the Assistant Director of Nursing provided a policy that indicated that no outdated medications would be allowed in the facility, all expired medications would be destroyed, and vials without dates should be marked at the time the vial was opened. 3.1-25(j)(o)		mandatory in-service was provided for all licensed nurses on the facility policy related to the destruction of outdated medications as well as the policy that directs the nurses to date medications such as insulin when opened. The corrective action taken to monitor and assure compliance is that the Director of Nursing and/or their designee will conduct audits of med carts and med rooms for outdated medications as well as to ensure that medications such as insulins are dated when opened. This audit will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.The facility acknowledges that three vials of influenza vaccine left over from last season's administration efforts, with expiration dates of 6/16, remained in the South Unit medication storage room beyond the date upon which they should have been destroyed, and that an opened, but undated, vial of insulin was present on the medication cart on the same unit. Both of these situations were addressed immediately at the time they were brought to staff's attention. The three vials of influenza vaccine were destroyed in the presence of the surveyor. The opened, but undated, vial of	

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			insulin was disposed of, and another vial was obtained from the unit's EDK (Emergency Drug Kit), opened, and properly dated for placement on the medication cart. All professional nursing staff members received additional in-service education about the need to promptly identify and discard expired medications, as well as the need to properly date any opened medication intended for future use. Unit managers will continue to be responsible for checking their medication storage rooms on a weekly basis to detect and destroy any outdated medications. In addition, the pharmacy representative who has been routinely checking medication carts for expired medications on a monthly basis now also will be checking the medication storage rooms and refrigerators.	
F 0456 SS=D Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure call lights were accessible for 1 of 31 bathrooms observed. The bathroom call light was inaccessible to residents. (Room #204, Resident #99, Resident #68,)	F 0456	The corrective action taken for those residents found to have been affected by the deficient practice is that the call lights in the bathrooms identified in room #204, (i.e. residents #99 and #68) were repaired during the facility's survey. The corrective action taken for the other residents having the potential to be affected	08/15/2016

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	On 7/19/16 at 8:57 a.m., Room #204 was observed. The bathroom call light lacked a means to activate the call light. On 7/20/16 at 9:05 a.m., the same was observed. The bathroom was shared with the residents of Room #202. On 7/26/16 at 8:05 a.m., the ADON (Assistant Director of Nursing) indicated all bathroom call lights should be equipped with a string for activation. On 7/26/16 at 8:15 a.m., the ADON indicated the bathroom call light was being fixed. On 7/26/16 at 8:39 a.m., the ADON indicated Residents #99 and Resident #68 utilized the shared bathroom between Room #202 and Room #204. On 7/26/16 at 1:41 p.m., the ADON provided the "Call Light Assistance" policy, dated 1997. The policy included, but was not limited to: A nurse-call system is provided to each resident by electronic or manual means that can be utilized according to specific resident limitations. 3.1-19(bb)		by the same deficient practice is that a house wide audit of all resident bathrooms has been completed to ensure all bathroom call lights were accessible and functioning properly. No other bathroom call lights were identified as being defective. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all housekeepers to remind them to check the proper accessibility of bathroom call lights as part of their daily routine cleaning practices. The corrective action taken to monitor and assure compliance is that the Director of Housekeeping will audit (5) five random resident's bathrooms to ensure proper accessibility of the call light system. This audit will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of these audits will be reviewed at the facility's Quality Assurance meeting to determine if additional action is warranted.The facility acknowledges that the cord used to activate the call light in the bathroom shared by Rooms #202 and #204 was, in fact, broken, thus making the call light inaccessible to a resident seated on the commode. This problem was apparently noted by a member of the survey team on Tuesday, July 19, 2016, but was	

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			not brought to the facility's attention until the last day of the survey (i.e., Tuesday, 7/26/2016), at which time the broken cord was replaced within the hour. The facility believes it is worth noting that of the four residents who have shared access to this bathroom, one (i.e., Resident #41) is completely unable to use the bathroom facilities, and the other three residents (i.e., Residents #99, #68, and un-numbered) are only able to access the bathroom with the assistance of at least one staff person. While this fact clearly does not obviate the requirement that the cord activating the call light should have been accessible to a resident seated on the commode, it does perhaps offer some insight as to why the broken cord had not generated a specific concern in the minds of the CNAs routinely providing toileting assistance to the three residents noted above. Following the mention of the broken call light cord by the survey team on 7/26/2016, the facility's housekeeping supervisor conducted a facility-wide inspection of all bathroom call light cords and found no other problems. The housekeeping supervisor also discussed this concern with all members of her staff, and emphasized the need to monitor the accessibility of all bathroom call light cords during the course of their routine	

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			cleaning duties.	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for 7 of 31 rooms and 1 of 30 residents reviewed. A resident had a chair cushion with cracks in each corner, a room had a gouge in the bathroom wall, a bathroom floor had the threshold for the shower cracked, a black substance was on the bathroom wall and a red liquid substance was on the bathroom floor, grout on the bathroom floor tile was dirty, and bedpans were uncovered and unlabeled in the bathrooms. (Resident #124, Room 316, Room 404, Room 414, Room 204, Room 211, Room 206, Room 203) Findings include: 1) On 7/19/16 at 9:48 a.m., Resident #124 was observed to be sitting in a wheelchair on a cushion. Both corners of the cushion were split open. The same was observed on 7/25/16 at 9:08 a.m.	F 0465	1). The corrective action taken for those residents found to have been affected by the deficient practice is that the wheelchair cushion utilized by the resident identified as resident #124 was replaced as soon as it was identified during the survey. Resident #124's wheelchair cushion is free of any cracks or splits. 2). The corrective action taken for those residents found to have been affected by the deficient practice is that the identified gouges in the bathroom wall identified in Room 316 were spackled, sanded and painted as soon as it was identified during the survey process. 3). The corrective action taken for those residents found to have been affected by the deficient practice is that the bathroom of the room identified as room # 404 has been repaired. The black substance identified on the wall under the toilet paper holder has been removed and there are no unidentified personal care items in the bathroom. This task was completed by the Maintenance Director on 07-27-16. 4). The corrective action taken for those residents found to have been	08/15/2016

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	2) On 7/18/16 at 2:30 p.m., Room 316 was observed to have gouges in the bathroom wall. The same was observed on 7/25/16 at 11:03 a.m. 3) On 7/19/16 at 10:13 a.m., Room 404 was observed to have a red liquid substance on the bathroom floor in front of the commode, an unlabeled bedpan between the wall and the rail in the bathroom, an unlabeled comb on the back of the sink, and the threshold in front of the shower was cracked. The bathroom was a shared bathroom. On 7/25/16 at 11:15 a.m., the red substance, bedpan, and comb was gone but a sold black substance was observed on the wall under the toilet paper holder. 4) On 7/19/16 at 9:26 a.m., Room 414 was observed to have a brown stain in the grout by the commode. The same was observed on 7/25/16 at 10:56 a.m. 5. On 7/19/16 at 8:57 a.m., Room #204 was observed. In the bathroom, one wash basin was observed uncovered and unlabeled. The bathroom was shared by four residents. In the bedroom, the closet door was off the hinges and leaning into the closet on the residents clothes. Resident #61 indicated the closet door had been off the hinges for greater than		affected by the deficient practice is that the brown stain in the grout by the commode of the bathroom identified as room # 414 has been removed. 5). The corrective action taken for those residents found to have been affected by the deficient practice is that the facility promptly removed the uncovered and unlabeled wash basin from the bathroom of the room identified as room # 204 as soon as it was brought to the staff's attention by the surveyors. In addition the closet door of the room identified as room #204 was immediately repaired as soon as it was brought to the staff's attention by the surveyors. 6). The corrective action taken for those residents found to have been affected by the deficient practice is that the uncovered, unlabeled personal care items that were identified to be in the bathroom of room # 211 have been removed. 7. The corrective action taken for those residents found to have been affected by the deficient practice is that the uncovered bedpan and wash basin identified to be on the bathroom floor of room # 206 have been removed. 8). The corrective action taken for those residents found to have been affected by the deficient practice is that the uncovered bedpan identified in the bathroom of room # 203 has been removed. The corrective action taken for the other residents having the	

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	155621	A. BUILDING 00 B. WING	07/26/2016

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	one month. On 7/20/16 at 9:05 a.m., the same was observed. 6. On 7/19/16 at 11:01 a.m., Room #211 was observed. In the bathroom, two bed pans, one emesis basin, and one wash basin were observed uncovered and unlabeled. The Room #211 had contact isolation precautions and two residents resided in the room. On 7/25/16 at 9:51 a.m., Room #211 was observed. In the bathroom, one bed ban and one emesis basin were observed uncovered and unlabeled. The room was still under contact isolation precautions. On 7/25/16 at 10:00 a.m., CNA #1 indicated resident care equipment should be stored in a bag in the bathroom. CNA #1 further indicated if something is broken or malfunctioning, maintenance would be notified. 7. On 7/18/16 at 11:10 a.m., an uncovered bedpan was observed on the floor in the bathroom of Room 206. The bathroom was a shared bathroom. On 7/25/16 at 8:36 a.m., an uncovered bedpan was observed inside a washbasin on the floor of the bathroom. 8. On 7/18/16 at 11:57 a.m., an uncovered bedpan was observed on the		potential to be affected by the same deficient practices is that a house-wide audit has been conducted of all resident rooms and bathrooms to identify any safety or sanitation concerns. All areas of concern have been corrected. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all nursing staff and housekeeping staff on the facility's policy related to maintaining a safe and sanitary environment for the residents. The nursing staff was instructed on the proper labeling and storage of personal care equipment. The housekeeping staff was re-educated on the cleaning of the resident's bathrooms as part of their daily cleaning schedule as well as the process of timely reporting of any repair issues that need prompt attention. The corrective action taken to monitor and assure compliance is that the facility has implemented an audit tool for the monitoring of a safe and sanitary environment. This audit tool will be completed by the Housekeeping Director weekly for four weeks, monthly for three months and then quarterly for three quarters. The outcome of this audit tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. To	

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	back of the toilet in the bathroom of Room 203. The bathroom was a shared bathroom. On 7/25/16 at 8:38 a.m., the same was observed. During an interview on 7/26/16 at 10:01 a.m., Housekeeper #1 indicated the housekeeping staff has a cleaning schedule for daily cleaning and a cleaning schedule for deep cleaning. She further indicated if a room requires painting, fixing holes in the walls, et cetera, the staff fills out a form and gives the form to the maintenance department to be repaired. During an interview with the Housekeeping Supervisor (Hskg Super) on 7/26/16 at 10:28 a.m., the Hskg Super indicated all rooms are cleaned daily and deep cleaned at least once a month. A policy, revised on 5/28/14 and obtained from the Hskg Super on 7/26/16 at 10:25 a.m., indicated daily cleaning included mopping the bathrooms floors and cleaning the floors around the base of the commode. The policy indicated all bedpans should be bagged and hung on a hook with the name of the resident who it belongs to on the bag or item. The policy indicated the walls would be cleaned when soiled. The policy further indicated the maintenance/housekeeping supervisor		further clarify the specific issues included within this citation, Finding #1 indicates that a member of the survey team observed, on two different occasions, that the corners of a cushion being used by Resident # 124 were “split open” – presumably creating a potential infection control issue. When this concern was raised with facility staff on the last day of the survey (i.e., on 7/26/2016), the cushion in question was replaced within the hour. Finding #2 indicates that a member of the survey team observed, on two different occasions, that there were “gouges” in the wall of the bathroom of Room #316. When this concern was raised with staff on the last day of the survey, within the hour the facility’s maintenance supervisor had spackled, sanded, and painted the small area of the wall involved, and the “gouges” were completely eliminated. (The facility would simply point out also that in an environment in which a large majority of its residents must routinely use wheelchairs and/or walkers to access bathroom facilities, it is virtually impossible to ensure that there will not, from time to time, be instances in which doors, doorways, and walls are marred by the use of such assistive devices.) Finding #3 indicates that a member of the survey team observed, on two different	

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	would be notified immediately if there is a needed repair by submitting a request form. 3.1-19(f)		occasions, that the threshold at the front of the shower in Room #404 was cracked. Also, on 7/25/2016, a black substance was observed on the bathroom wall of Room #404. When these concerns were raised with facility staff on the last day of the survey, the Administrator and the maintenance supervisor promptly assessed the issue of the cracked shower threshold, noting that an attempt to address the problem had been made previously by an outside contractor. However, it was clear that the attempted solution had not remained effective over time. The following day (i.e., 7/27/2016), the maintenance supervisor corrected the problem with an epoxy-like mixture which eliminated the cracked appearance of the shower threshold. In addition, on 7/27/2016, the housekeeping supervisor was able to remove the dark-colored stain on the bathroom wall below the toilet paper holder. Finding #4 indicates that a member of the survey team observed, on two different occasions, that there was a brown stain in the grout by the commode in the bathroom of Room #414. When this concern was raised with facility staff on the last day of the survey, the housekeeping supervisor was notified, and the following day she applied a cleansing solution to the area resulting in the removal of	

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			the brown stain. Finding #5 indicates that a member of the survey team observed, on two different occasions, that an uncovered and unlabeled wash basin was present in the bathroom of Room #204, as well as the fact that, in the same room, a closet door appeared to have come off its railing. When these concerns were raised with facility staff on the last day of the survey, nursing staff were promptly sent to Room #204 to address the issues related to the wash basin, and the Administrator corrected the closet door issue. Finding #6 indicates that a member of the survey team observed, on two different occasions, that various items of resident care equipment were uncovered and unlabeled in the bathroom of Room #211, and also that the room was subject to contact isolation provisions. When these concerns were raised with staff on the last day of the survey, … Findings #7 and #8 both indicate that a member of the survey team observed, on two different occasions, that bedpans in the bathrooms of Room #206 and #203 were not properly stored under cover. When these concerns were raised with facility staff on the last day of the survey, members of the housekeeping staff conducted a facility-wide sweep of all resident bathrooms. All bedpans located in any resident bathroom were collected	

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			and discarded, and replaced with properly covered new bedpans which were then stored in the bottom drawers of each resident's night stand. This action was completed within one hour of having been advised of the concern by the survey team. In addition, all CNAs have been provided in-service training on the need to properly clean, bag, and label bedpans after use. In further response to the concerns noted above during the "pre-exit-conference" with the survey team, both the housekeeping supervisor and the interim assistant Director of Nursing conducted a facility-wide audit over the ensuing two days, the goal of which was to identify and correct any similar issues related to potentially unsafe and/or unsanitary conditions which might have existed within the facility. Any matters of potential concern were addressed during that exercise. Any items requiring the attention of the maintenance supervisor were noted, and he was advised accordingly. The assistant Director of Nursing has also addressed with all CNAs during a subsequent in-service the importance of properly covering and labeling all resident care equipment that is routinely used within shared bathroom facilities.	