| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155501 | A. BUILDING 00<br>B. WING | 09/09/2019 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: September 3, 4, 5, 6, & 9, 2019<br><br>Facility number: 000465<br>Provider number: 155501<br>AIM number: 100273870<br><br>Census Bed Type:<br>SNF/NF: 38<br>Total: 38<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 22<br>Other: 15<br>Total: 38<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed September 13, 2019. | F 0000 | The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is submitted timely and in accordance with State and Federal Regulatory Guidelines. Any additional documents can be made available for your review. | |
| F 0580<br>SS=G<br>Bldg. 00 | 483.10(g)(14)(i)-(iv)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's | | | |

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

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| | physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a change in condition for 2 of 9 residents reviewed. (Resident 13 and Resident 4) This resulted in the resident being admitted to the hospital with a severe infection.<br><br>Findings include:<br><br>1 a. The record review for Resident 13 began on 9-5-2019 at 10:04 a.m. Diagnoses included but were not limited to, end stage renal disease with hemodialysis, chronic obstructive pulmonary disease, hypertension, diabetes, subdural hematoma, history of MRSA (Methicillin Resistant Staphylococcus aureus, a bacteria that is resistant to many antibiotics) in the nares, and history of MRSA endocarditis (bacterial infection in the inner layer of the heart).<br><br>The 14 days Minimum Data Set (MDS) Assessment dated 6/6/19, indicated Resident 13 had severely impaired cognition and no other skin conditions.<br><br>A plan of care dated 12/14/18, addressed the problem of Pain, dated 6/3/19, resident had been in the hospital for sepsis, and a CV (central venous) port in his right chest for dialysis.<br><br>A plan of care dated 6/19/19, addressed the problem of Risk for complications related to central venous port for dialysis in right side of chest. Approaches included, but were not limited to, the following: Observe port site for signs and symptoms of infection as indicated, for pain at site, any tenderness, swelling of his arm or face or bleeding at site, assess and notify the doctor.<br><br>Nurses notes dated 8/23/19 at 3:39 p.m., indicated | F 0580 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Residents 4 & 13 physicians have been notified of their previous changes in condition and this has been documented in the medical record.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that has had a change of condition could be affected by the deficient practice. All residents progress notes and vital signs have been reviewed for changes in condition for the last 30 days. All changes of condition have been reported to physicians for orders and appropriate follow up.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been educated on physician notification and proper documentation practices to ensure all changes of condition are reported to the physician in a timely manner per company policy. IDT will monitor resident vital signs and progress note documentation to ensure appropriate physician notification* | 10/09/2019 |

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| | the resident returned from dialysis at 12 noon.<br><br>A dialysis note, dated 8/23/19, no time documented, indicated the resident had scabbed areas on the skin. Documentation was lacking of the form and location of the skin issues.<br><br>Nurses notes, dated 8/24/19 at 3:39 p.m. indicated the resident had an abscess developing on the right side of the forehead, nothing was open, no drainage, yet the resident was uncomfortable. the nurse gave the resident several wash cloths to apply as tolerated to draw out the abscess. Documentation was lacking as to the physician having been notified of the developing abscess.<br><br>The next entry in the nurses notes, was dated 8/25/19 at 3:53 a.m., and indicated the area remained to right forehead. Swelling was noted to right forehead and down into right eye. A PRN (as needed) Tylenol was given for c/o (complaint of) discomfort to area and was effective. No other complaints were voiced by the resident. Documentation was lacking as to the physician having been notified of condition of right forehead.<br><br>The next entry in the nurses notes, was dated 8/25/19 at 1:13 p.m., and indicated the area to right forehead had worsened that shift, more swelling to the face, and the right eye was nearly swollen shut. The resident's mother was called and informed that he needed evaluation by an MD (medical doctor) in the nurse's opinion. The mother said to go ahead and send him to ER by EMS emergency medical service and she would meet them there. 911 was called and the resident sent to ER.<br><br>The next entry in the nurse notes, dated 8/25/19 at | | *has been made*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will audit all documentation for appropriate physician notification M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | 4:26 p.m., indicated the hospital updated the facility, the resident was being transferred to (the name of hospital in nearby larger city). The resident was septic (potentially life threatening condition in which the body is fighting a severe infection that has spread via the bloodstream), hypertensive at 210/110 and had hyperkalemia (high potassium level).<br><br>A Hospital Consultation Note dated 8/26/19 included but was not limited to, the following: History of present illness; 47 year old male nursing home resident with past medical history most significant for end stage renal disease, stroke and diabetes who presents to an outside hospital with a few day history of a wound on his forehead. He stated it was getting more and more tender. He had not had any subjective fevers or chills. There was no discharge from the wound. The wound was associated with throbbing pain worse when touched. He did say he had a headache although further clarification is that the pain was from the abscess.<br><br>Nurses notes, dated 9/1/19 at 11:58 p.m., indicated the resident returned from the hospital, remained on an antibiotic, and isolation related to a septic infection.<br><br>On 9/4/19 at 10:00 a.m., the resident was observed in his room with a dressing on his forehead. An overlay was observed on the outside of his door which contained disposable isolation gown and boxes of gloves. A sign on the door indicated to go to the nurse's station prior to entering.<br><br>A Nurses note, dated 9/4/19 at 3:25 p.m., indicated the resident continued with isolation due to wounds on forehead had tested positive with MRSA (methicillin resistant staphlycoccus | | | |

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| | aureus). Isolation precautions were being observed.<br><br>On 9/6/19 at 10:22 a.m. the Administrator provide a current copy of the facility policy and procedure for "Change in Condition" dated 7/10/18. The policy and procedure included but was not limited to, the following: Facility will evaluate and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner to relay evaluation information to physician and to document actions to include but not limited to the following: A significant change in the resident's physical, mental or psychosocial status; A decision to transfer or discharge the resident from the facility and refusal of compliance with prescribed plan of care. Guidelines: Licensed nurse will evaluate any change in condition through direct observation, physical examination and vital signs at the onset of the change and as ordered by physician. Life threatening events: Call "911" if your initial evaluation indicates such action is necessary; notify the physician; complete the situation, background, assessment, recommendations (SBAR) in the electronic medical record (EMR) to provide the physician with necessary evaluation findings; If the condition does not appear to be life threatening, utilize the EMR SBAR and notify the physician. If a message is left with the physician office and a timely response is not given, follow-up with another message as needed, depending on the significance of the change. If unable to contact the physician, depending on the significance of the change, contact the Medical Director, as appropriate; Document in the medical record physician notification; The EMR SBAR communication form will serve as the nursing documentation for change in condition. | | | |

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| | On 9/6/19 at 11:22 a.m., the DON was interviewed. She indicated she was unable to find documentation of the physician having been notified of any changes in the residents condition on the following dates: 8/24/19, 8/25/19, and 8/25/19.<br><br>On 9/6/19 at 12:20 P.M., the DON was interviewed. She indicated she was unable to locate the SBAR (Situation, Background, Assessment, Recommendation) for the resident for the date of 8/25/19 at 1:13 p.m., when the resident had been sent to the emergency room.<br><br>1. b. A 14 day MDS assessment dated 6-6-2019 indicated a BIMS of 7/15 for Resident 13. The BIMS of 7 indicated the resident was severely cognitively impaired. The resident required extensive assistance of 1 staff for personal hygiene and dressing, supervision of 1 staff for bed mobility and toileting, was independent for transfers, walking in room/corridor and for locomotion on/off unit. The resident needed set up help only for eating. The resident had a surgical wound and was marked for being on dialysis while a resident at the facility.<br><br>During an observation of the medication pass for Resident 13 on 9-4-2019 at 1:16 p.m., LPN 1 was observed to obtain the resident's blood pressure with a result of 70/56. The nurse had prepared the resident's medications which included but were not limited to, a tablet of amlodipine besylate 5 mg, a tablet of clonidine 0.2 mg and a tablet of losartan potassium 100 mg. The diagnoses for each of these medications was hypertensive chronic kidney disease. The nurse was observed to administer the amlodipine besylate and the clonidine and held the losartan potassium. The medication orders for the losartan potassium did | | | |

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| | not include any parameters for holding the medication based on the results of the vital signs.<br><br>An interview with LPN 1 on 9-5-2019 at 11:03 a.m., indicated the nurse documented in the MAR the losartan potassium was administered for the 9-4-2019 noon dose. The nurse indicated she was so nervous, when she returned to her medication cart, she just wasn't paying attention and clicked that all the noon medications were administered.<br><br>A current care plan was in place for potential risk for complications for cardiovascular problems with hypertension associated with end stage renal disease, sepsis and MRSA in fistula and high blood pressure. Approaches were to monitor vital signs, including blood pressure; report any changes of condition as needed or as ordered, Report vs and changes to dialysis; and to report any signs and symptoms of hypotension (low blood pressure) or hypertension (high blood pressure) to the physician.<br><br>A review of the nurses' notes for Resident 13 for 9-4-2019 indicated LPN 1 did not report the low pressure results of 70/56 or that the losartan potassium was held. A nurses note by LPN 1 was entered on 9-4-2019 at 7:33 p.m. for an incident which occurred at 6:55 p.m. The note indicated the following: During the afternoon medication pass, and after hemodialysis, blood pressure was obtained due diagnosis of brittle diabetes, and drastic swings in BP (Blood pressure). BP was 101/85, pulse was 74 at that time prior to hemodialysis. Afternoon medication pass BP 70/59 BS (blood sugar) 484 with coverage. Losartan was held due to hypotension. Writer passed CNA (Certified Nursing Assistant) in the hall, stopped writer and requested resident be checked on, as he didn't look well, and speech | | | |

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| | was difficult to understand. Resident was pale, BS 180, and BP 54/26. Resident stated just stood up from toilet, and fell. Denied hitting his head, witnessed fall, and neuro checks initiated per protocol. 911 was called.. Sister was made aware, and agreed. EMS (Emergency Medical Services) arrived, BP was 78/60, then 100/68. Resident stood, became weak and dizzy, and after seconds sat down quickly on the bed. Resident was adamant about not going to hospital...Unable to make him go, nursing staff would closely monitor for resident for changes. Notification to the physician was not completed and documented of the resident's change in condition.<br><br>No additional paperwork or SBAR (Situation, Background, Assessment, Recommendations) documentation to indicate the physician was notified was provided by the facility.<br><br>An interview with the DON on 9-9-2019 at 10:10 a.m., indicated the nurse should have reported Resident 13's low blood pressure and holding the losartan potassium medication to the physician.<br><br>2. The record review for Resident 4 began on 9-5-2019 at 9:57 a.m. Diagnoses included but were not limited to, diabetes.<br><br>A quarterly MDS (Minimum Data Set) assessment dated 5-7-2019 indicated a BIMS of 13/15, which meant the resident was cognitively intact. Resident 4 required an extensive assistance of 1 person for bed mobility and transfers, was independent with set up help for meals and was independent with locomotion on and off the unit.<br><br>During an observation of the medication pass for Resident 4 on 9-9-2019 at 1:10 p.m., the resident refused to let LPN 1 (Licensed Practical Nurse) | | | |

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| | administer the 5 units of Novolog insulin. The resident indicated he was having right leg pain and was unable to eat his lunch.<br><br>Upon reconciling the Novolog insulin amount and refusal on 9-5-2019 at 9:57 a.m., the MAR (Medication Administration Record) was documented with a "1" in the noon box for the 9-4-2019 Novolog 5 units subcutaneous daily at noon. The code "1" meant "no insulin coverage required." The nursing notes were reviewed and there was not any mention of Resident 4 not eating his lunch and his refusal of the insulin. There was not a blood sugar entered into the MAR for 9-4-2019 at any time. The physician was not notified of the refusal of the routine insulin order.<br><br>An interview with the DON (Director of Nursing) on 9-9-2019 at 10:10 a.m., indicated the physician should have been notified about the refusal of insulin and inability to eat his lunch due to the pain in the right leg.<br><br>A current policy, titled Change of Condition last revised 7-10-2018 was provided by the Administrator on 9-6-2019 at 10:22 a.m. The policy indicated, "...The facility will evaluate and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner; to relay evaluation information to physician and to document actions to include but not limited to the following: a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment, a decision to transfer or discharge the resident from the facility...Licensed Nurse...will evaluate any change in condition through direct observation, physical examination and vital signs at the onset of the change and as ordered by the physician...Life | | | |

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| | Threatening Events: a. Call "911" if your initial evaluation indicates such action is necessary...Notify the physician...Document in the medical record physician...notification...."<br><br>3.1-5 (a)(2)<br>3.1-5(a)(3)<br>3.1-5(a)(4) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure Care Plans were updated for 2 of 4 resident's reviewed. (Resident 27 and Resident 28)<br><br>Findings include:<br><br>1. A review of Resident 27's record on 9/5/2019 at 10:26 a.m., indicated the resident had a BIMS (Brief Interview of Mental Status) score of 11 out of 15, meaning moderate cognitive impairment. The score was obtained from the MDS (Minimum Data Set) Quarterly Assessment, dated 7/23/2019. Diagnoses included, but were not limited to: heart disease and seizures.<br><br>On 9/5/2019 at 11:32 a.m., Resident 27 was observed sitting in their wheelchair, on the South Hall, with their eyes closed, and their legs were not elevated.<br><br>On 9/5/2019 at 2:48 p.m., Resident 27 was observed sitting in their wheelchair, in the Activity Room playing Bingo.<br><br>On 9/6/2019 at 10:02 a.m., Resident 27 was observed in their wheelchair, self-propelling in the Activity Room. ACE wraps were observed on their lower legs.<br><br>The Physician's Orders indicated the following:<br>Lasix (a water pill) 40 mg (milligrams), take one tablet two times daily, by mouth for high blood pressure, dated 1/30/2019.<br>Discontinue the fluid restriction, dated 8/20/2019.<br>Please put ACE wraps on legs during the day, and off at night.<br><br>A review of the Baseline Care Plan, dated 7/23/2018, indicated the resident had a risk for | F 0657 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Residents 27&28 care plans have been updated to accurately reflect the care being provided.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that has a care plan has the potential to be affected by the deficient practice. Care Plans for all residents with orders for Ace Wraps, Splints, and Fluid restrictions have been reviewed and corrected.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been educated on the need to update care plans to accurately guide care provided to our residents. DON/Designee will audit new and discontinued orders to ensure care plans are updated timely.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program | 10/09/2019 |

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| | Cardiovascular complications, an implemented goal, and an intervention to observe for edema (swelling).<br><br>A review of the Comprehensive Care Plan, dated 2/6/2018, indicated the resident had a potential for complications related to high and or low blood pressure, an implemented goal, and an intervention to observe and report any edema. The ACE wraps had not been added to Resident 27's Care Plan.<br><br>A review of the Comprehensive Care Plan, dated 2/18/2019, indicated a risk for a fluid imbalance, an implemented goal, and an intervention to follow all Physician orders for fluid restriction. The fluid restriction had not been discontinued from Resident 27's Care Plan.<br><br>During an interview on 9/3/2019 at 11:35 a.m., Resident 27 indicated they get their legs wrapped every morning because of swelling, and the facility was not good about elevating their legs.<br><br>During an interview on 9/6/2019 at 10:05 a.m., LPN (Licensed Practical Nurse) 2, indicated Resident 27 had their lower legs wrapped daily in the morning, since they had discontinued the fluid restriction.<br><br>2. A review of Resident 28's record on 9/5/2019 at 1:51 p.m., indicated the resident had a BIMS score of 15 out of 15, meaning cognitively intact. The score was obtained from the MDS Quarterly Assessment, dated 7/24/2019. Diagnoses included, but were not limited to: muscle weakness and right hand contractures.<br><br>On 9/5/2019 at 11:30 a.m., Resident 28 was observed in their room, sitting in their wheelchair, | | will be put into place: *DON or designee will audit 5 charts/care plans daily x 4 weeks, then 5 charts weekly x 4 weeks, then 5 charts monthly x 3 months. Audits will continue until 2 consecutive months of 100% compliance is achieved and then the audits will continue quarterly. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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watching television. There was no soft hand splint observed in Resident 28's right hand.

On 9/5/2019 at 2:50 p.m., Resident 28 was observed in the Activity Room, sitting in their wheelchair, playing Bingo.

On 9/6/2019 at 9:55 a.m., Resident 28 was observed in their room sitting in their wheelchair, watching television. The soft hand splint was observed lying on the bedside table.

A review of the Physician's Orders indicated the following:
Resident to wear soft grip splint daily as tolerated, dated 6/12/2019.

A review of the Comprehensive Care Plan, dated 4/3/2018, indicated a risk for developing skin breakdown, an implemented goal, and an intervention to wear a soft grip splint to the right hand as ordered for skin issues as needed. The intervention for the splint was dated 8/7/2019.

During an interview on 9/3/2019 at 12:39 p.m., Resident 28 indicated they have pain occasionally in their fingers that are contracted on the right hand. Resident 28 indicated they were contracted from a stroke, and they had a splint but chose not to wear it most of the time.

During an interview with the Regional Nurse Consultant on 9/6/2019 at 12:05 p.m., they indicated the Care Plans were updated by different staff, and the MDS Coordinators updated the Care Plans with the assessments.

During an interview on 9/9/2019 at 9:45 a.m., LPN 1, indicated they have not updated the Care Plans when new orders were received, but they would

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| | be updating the Care Plans with the new computer system that was implemented.<br><br>During an interview on 9/9/2019 at 9:58 a.m., the MDS Coordinator indicated they update the Care Plans when the MDS assessments were completed, and the staff nurses were to update when new orders were received. They further indicated this had not been happening since the former Director of Nursing had left, and that the Care Plans should have been updated when the orders were received.<br><br>During an interview on 9/9/2019 at 10:30 a.m., the Interim Director of Nursing indicated the Care Plans were to be updated as the needs of the residents changed.<br><br>A current facility policy, Comprehensive Care Plans, dated 7/19/2018, provided by the Executive Director on 9/6/2019 at 11:51 a.m., indicated the following: "...Care Plans are ongoing and revised as information about the resident and the resident's condition change..." "...The nurse/Interdisciplinary Team is responsible for the review and updating of care plans. The care plan should reflect the current status of the resident and be updated with changes in the resident status..."<br><br>3.1-35(e)(2) | | | |
| F 0684<br>SS=G<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive | | | |

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| | treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, interview and record review, the facility failed to ensure care and treatment for a change in skin condition was initiated for 1 of 1 residents reviewed. This resulted in hospital admission for a severe infection.<br>(Resident 13)<br><br>Findings include:<br>The record review for Resident 13 began on 9-5-2019 at 10:04 a.m. Diagnoses included but were not limited to, end stage renal disease with hemodialysis, chronic obstructive pulmonary disease, hypertension, diabetes, subdural hematoma, history of MRSA (Methicillin Resistant Staphylococcus aureus, a bacteria that is resistant to many antibiotics) in the nares, and history of MRSA endocarditis (bacterial infection in the inner layer of the heart).<br><br>The 14 days Minimum Data Set (MDS) Assessment dated 6/6/19, indicated Resident 13 had severely impaired cognition and no other skin conditions.<br><br>A plan of care dated 12/14/18, addressed the problem of Pain, dated 6/3/19, resident had been in the hospital for sepsis, and a CV (central venous) port in his right chest for dialysis.<br><br>A plan of care dated 6/19/19, addressed the problem of Risk for complications related to central venous port for dialysis in right side of chest. Approaches included, but were not limited to, the following: Observe port site for signs and symptoms of infection as indicated, for pain at | F 0684 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident 13 physician has been notified of their previous changes in condition and this has been documented in the medical record.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that has had a change of condition could be affected by the deficient practice. All residents progress notes and vital signs have been reviewed for changes in condition for last 30 days. All changes of condition have been reported to physicians for orders and appropriate follow up.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been educated on physician notification and SBAR documentation practices to ensure all changes of condition are reported to the physician in a timely manner per* | 10/09/2019 |

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| | site, any tenderness, swelling of his arm or face or bleeding at site, assess and notify the doctor.<br><br>Nurses notes dated 8/23/19 at 3:39 p.m., indicated the resident returned from dialysis at 12 noon.<br><br>A dialysis note, dated 8/23/19, no time documented, indicated the resident had scabbed areas on the skin. Documentation was lacking of the form and location of the skin issues.<br><br>Nurses notes, dated 8/24/19 at 3:39 p.m. indicated the resident had an abscess developing on the right side of the forehead, nothing was open, no drainage, yet the resident was uncomfortable. the nurse gave the resident several wash cloths to apply as tolerated to draw out the abscess. Documentation was lacking as to the physician having been notified of the developing skin issues or vital signs having been taken.<br><br>The next entry in the nurses notes, was dated 8/25/19 at 3:53 a.m., and indicated the area remained to right forehead. Swelling was noted to right forehead and down into right eye. A PRN (as needed) Tylenol was given for c/o (complaint of) discomfort to area and was effective. No other complaints were voiced by the resident. Documentation was lacking as to the physician having been notified of condition of right forehead, or vital signs having been taken.<br><br>The next entry in the nurses notes, was dated 8/25/19 at 1:13 p.m., and indicated the area to right forehead had worsened that shift, more swelling to the face, and the right eye was nearly swollen shut. The resident's mother was called and informed that he needed evaluation by an MD (medical doctor) in the nurse's opinion. The mother said to go ahead and send him to ER by | | *company policy. IDT will monitor all new physician orders, documentation and SBAR use, with facility activity report daily to ensure appropriate physician notification and documentation has been made.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will audit all documentation for appropriate physician notification and SBAR use, M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. IDT will review in QAPI until 2 consecutive months of 100% compliance are achieved. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | EMS emergency medical service and she would meet them there. 911 was called and the resident sent to ER.<br><br>In a confidential interview, a nurse indicated vital signs had been taken by EMS indicated BP was 130/90 and the temp was 99.1.<br><br>The next entry in the nurse notes, dated 8/25/19 at 4:26 p.m., indicated the hospital updated the facility, the resident was being transferred to ( the name of hospital in nearby larger city). The resident was septic (potentially life threatening condition in which the body is fighting a severe infection that has spread via the bloodstream), hypertensive at 210/110 and had hyperkalemia (high potassium level).<br><br>A Hospital Consultation Note dated 8/26/19 included but was not limited to, the following: History of present illness; 47 year old male nursing home resident with past medical history most significant for end stage renal disease, stroke and diabetes who presents to an outside hospital with a few day history of a wound on his forehead. He stated it was getting more and more tender. He had not had any subjective fevers or chills. There was no discharge from the wound. The wound was associated with throbbing pain worse when touched. He did say he had a headache although further clarification is that the pain was from the abscess.<br><br>Nurses notes, dated 9/1/19 at 11:58 p.m., indicated the resident returned from the hospital, remained on an antibiotic related to septic infection.<br><br>On 9/4/19 at 10:00 a.m., the resident was observed in his room with a dressing on his forehead. An overlay was observed on the outside of his door | | | |

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| | which contained disposable isolation gown and boxes of gloves. A sign on the door indicated to go to the nurse's station prior to entering.<br><br>A Nurses note, dated 9/4/19 at 3:25 p.m., indicated the resident continued with isolation due to wounds on forehead had tested positive with MRSA (methicillin resistant staphlycoccus aureus). Isolation precautions were being observed.<br><br>On 9/6/19 at 10:22 a.m. the Administrator provide a current copy of the facility policy and procedure for "Change in Condition" dated 7/10/18. The policy and procedure included but was not limited to, the following: Facility will evaluate and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner to relay evaluation information to physician and to document actions to include but not limited to the following: A significant change in the resident's physical, mental or psychosocial status; A decision to transfer or discharge the resident from the facility and refusal of compliance with prescribed plan of care. Guidelines: Licensed nurse will evaluate any change in condition through direct observation, physical examination and vital signs at the onset of the change and as ordered by physician. Life threatening events: Call "911" if your initial evaluation indicates such action is necessary; notify the physician; complete the situation, background, assessment, recommendations (SBAR) in the electronic medical record (EMR) to provide the physician with necessary evaluation findings; If the condition does not appear to be life threatening, utilize the EMR SBAR and notify the physician. If a message is left with the physician office and a timely response is not given, follow-up with another message as needed, | | | |

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| | depending on the significance of the change. If unable to contact the physician, depending on the significance of the change, contact the Medical Director, as appropriate; Document in the medical record physician notification; The EMR SBAR communication form will serve as the nursing documentation for change in condition.<br><br>On 9/6/19 at 11:22 a.m., the DON was interviewed. She indicated she was unable to find documentation of the physician having been notified of any changes in the residents condition on the following dates: 8/24/19, 8/25/19, and 8/25/19.<br><br>On 9/6/19 at 12:20 P.M., the DON was interviewed. She indicated she was unable to locate the SBAR (Situation, Background, Assessment, Recommendation) for the resident for the date of 8/25/19 at 1:13 p.m., when the resident had been sent to the emergency room.<br><br>3.1-37(a) | | | |
| F 0725 SS=F Bldg. 00 | 483.35(a)(1)(2)<br>Sufficient Nursing Staff<br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). | | | |

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| | §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were on duty to meet the needs of 38 of 38 residents who resided in the facility.<br><br>Findings include:<br><br>A confidential interview with an alert and oriented resident on 9-3-2019, indicated there was not enough staff and they have to wait and wait and wait. The resident indicated they would hear other residents hollering. The resident indicated there was only one aide at night for all the residents.<br><br>A confidential interview with an alert and oriented resident on 9-3-2019, indicated the facility was short staffed and they sometimes had to wait a half hour or 45 minutes for help on any shift. The resident indicated they had a bowel accident prior to the staff getting there.<br><br>A confidential interview with an alert and oriented resident on 9-4-2019, indicated it was hard to get people to work and staffing was better some days than others. The resident indicated it depended | F 0725 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Agency staffing has been obtained to cover open CNA shifts.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents have the potential to be affected by the deficient practice. Interviewable Residents and Staff interviews have been conducted to ensure staffing needs are being addressed. Call light times will be monitored for timeliness and Resident Council will be providing feedback on progress. Staff will be oriented and trained by the staff development coordinator or designee and/or will be sent to our sister facility in Ft. Wayne. In addition we have a appointed* | 10/09/2019 |

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| | on who was working as some go out of their way to help and others did not.<br><br>An observation in Center hall on 9-6-2019 between 9:10 and 9:45 a.m., indicated a resident had their call light on and was very upset. The resident indicated they were and had been sitting in the bed wet and had the call light on. The resident indicated a staff member came in, turned the call light off and did not assist. The resident indicated they turned the call light back on and they needed help. The resident indicated there was only one aide working in the hall and they were probably assisting a resident in the shower. At this time, another call light was on in another resident room. This resident indicated they needed help to the bathroom and they would be so embarrassed if they would mess the bed. The resident's face was observed to be in anguish and the resident was very restless.<br><br>A confidential interview with a CNA, observed coming out of the shower room, on 9-6-2019 at 9:41 a.m., indicated she was assisting a resident with a shower. She indicated she had asked other staff to watch for the call lights while she was showering a resident and did not know what happened to them. There was no other staff observed in the hall. The aide indicated she was the only aide assigned in the Center hall (300, 400 and 500 rooms), which had 22 residents.<br><br>A confidential interview with a Nurse on 9-6-2019 at 9:42 a.m., indicated she was the nurse for the Center hall and was observed to be leaving a room in the 500 hall. The nurse indicated one CNA was assigned to the Center hall and that Social Services and QMA-CNA-Receptionist-Bus Driver 4 were helping. Neither Social Services or the QMA-CNA-Receptionist-Bus Driver 4 were | | *nurse mentor to support new nursing staff.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *Agency staffing will be used to assist with staffing needs until the needed staff have been hired. Staff and Residents will be randomly interviewed, and Resident Council meetings will be held to ensure staffing needs are being met.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *The Administrator or Designee will perform a random audit of 5 residents and 3 staff M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. A Resident Council meeting will be held weekly x 4 weeks, bi-weekly x 8 weeks, and monthly thereafter. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | observed in the Center hall. The QMA-CNA-Receptionist-Bus Driver 4 was observed sitting at the receptionist desk and Social Services was in the South hall.<br><br>A review of the Resident Census and Conditions of Residents provided by the Director of Special Programs on 9-9-2019 at 10:23 a.m., indicated the current resident census was 38 residents. There were 25 residents dependent on staff for bathing, 32 residents required an assist of one or two staff for dressing, 29 residents required an assist of one or two staff for transferring and toileting and 7 residents required an assist of one or two staff for eating. There were 25 residents who had occasional or frequent incontinence of the bladder and 16 residents had occasional or frequent incontinence of the bowel. Three residents had urinary catheters.<br><br>An interview with the DON on 9-9-2019 at 11:43 a.m., indicated she and the Director of Special Projects had been creating the nursing schedule. The DON indicated they had been staffing like the facility had been scheduling staff prior to her arrival on 8-26-2019 and per the census which had been low. She indicated they staffed the facility per the PPD, (Per Patient Day, which is the amount of nursing hours allotted for patient care).<br><br>A confidential interview on 9-9-2019 with a CNA, indicated it was hard to meet the needs of the residents with 3 aides and with 2 aides it was even worse. The CNA indicated themselves and another aide were each assigned a hall and an agency aide was floating between the 2 halls.<br><br>A confidential interview with a CNA on 9-9-2019, indicated it was very difficult to meet the needs of the residents with 2 aides. The CNA indicated | | | |

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| | even with the help of a third aide, the residents that needed 2 assists would still have to wait until another one of the aides was available.<br><br>A confidential interview with a CNA on 9-9-2019, indicated there was not enough staff to care for the residents. The CNA indicated several residents required 2 assists and the residents had to wait until a second aide was available in order to assist the resident.<br><br>A confidential interview with a CNA on 9-9-2019, indicated there was not enough staff to assist the residents without them having to wait.<br><br>An interview with the Signature Care Consultant on 9-9-2019 at 3:00 p.m., indicated he was aware of the staffing concerns and the corporation had put in several changes in order to help attract staff to work at the facility. He indicated the facility was working on the staffing with getting help from a staffing agency. He indicated the facility did not have a policy and would follow the CMS rules for staffing.<br><br>3.1-17(a) | | | |
| F 0727 SS=F Bldg. 00 | 483.35(b)(1)-(3)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. | | | |

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| | §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>Based on interview and record review, the facility failed to ensure a RN (Registered Nurse) was assigned to work 8 consecutive hours per day for 7 days per week. This deficiency had the potential to affect 38 of 38 residents who resided in the facility.<br><br>Findings include:<br><br>The Director of Special Projects provided a nursing schedule for the weeks of 8-18-2019 and 8-25-2019; on 9-4-2019 at 2:33 p.m. The schedule lacked 8 hours registered nursing services for the dates of: 8-23, 24, 25, and 31, 2019 and for 9-1-2019. For the week of 8-25-2019, the current DON's (Director of Nursing) name was written in for Monday through Friday as the RN on the schedule.<br><br>The nurse schedule for 9-2-2019 through 9-9-2019 was provided on 9-6-2019 at 12:08 p.m. The Saturday, 9-7-2019 schedule, lacked a scheduled RN for 8 hours.<br><br>An interview with the DON on 9-9-2019 at 9:40 a.m., indicated on 9-7-2019, she was at the facility from 8:30 to 1:00 p.m., and provided patient care. The DON indicated she did not stay eight hours and there was not another RN who worked on Saturday 9-7-2019. The DON indicated a staff development nurse, who was an RN, started on 9-3-2019. The DON indicated she and the staff development nurse did not have resident assignments when they worked at the facility. The DON indicated on 8-24-2019, 8-25-2019, | F 0727 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice*: DON and Administrator have reviewed RN staffing needs and have corrected RN coverage.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents could be affected. DON & Administrator have reviewed the RN staffing schedule for the next 30 days, RN coverage is now in place. The facility has contracted with 3 medical staffing agencies to provide RN coverage and is actively recruiting RN staff.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *DON & Administrator have been educated on the need for 8 hours/day RN coverage. DON or Administrator will review RN coverage needs daily during morning meeting, to ensure coverage needs are being met.* | 10/09/2019 |

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| | 8-31-2019 and 9-1-2019, there was not an 8 hour per day RN coverage. The DON indicated there must not have been a RN who worked on 8-23-2019 per the copy of the schedule. The DON indicated she did not come to the facility until Monday, 8-26-2019, and she did not work on 8-31-2019 and 9-1-2019. The DON at first indicated she did not work on Labor Day, 9-2-2019, but then provided a time sheet on 9-9-2019 at 10:21 a.m., which indicated she worked 8 continuous hours on Labor Day. The DON had indicated she had forgotten she worked on Labor Day. The DON indicated the facility did not have a waiver for the RN coverage.<br><br>An interview with the Signature Care Consultant on 9-9-2019 at 11:11 a.m., indicated the facility did not have a policy for an RN 8 hours day/7 days a week coverage and the facility would just follow the CMS (Center for Medicare and Medicaid Services) rules.<br><br>3.1-17(b)(3) | | 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will audit the schedule for RN coverage daily during morning meeting x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |
| F 0732 SS=F Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law). | | | |

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| | (C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure the posted nurse staff information was prepared, posted, and retained daily. This deficiency had the potential to affect 38 of 38 residents who resided in the facility.<br><br>Findings include:<br><br>An observation inside the facility on 9-3-2019 at 10:10 a.m. and at 12:00 p.m., indicated the posted nurse staff information was not located at either nurse station, the reception desk or on the walls where it could be seen by facility visitors.<br><br>An observation inside the facility on 9-4-2-19 at | F 0732 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Staffing sheets have been updated and are posted at the front receptionist desk.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents have the potential to affected by the deficient practice. Staffing sheets will be posted by* | 10/09/2019 |

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| | 2:02 p.m., indicated there was not a posted nurse staff information located inside the facility for this date.<br><br>An observation inside the facility on 9-5-2019 at 8:36 a.m., indicated there was not a posted nurse staff information located inside the facility for this date.<br><br>An observation inside the facility on 9-6-2019 at 9:30 a.m., indicated there was not a posted nurse staff information located inside the facility for this date.<br><br>An interview with the DON (Director of Nursing) on 9-6-2019 at 9:43 a.m., indicated she did not know where the posted nurse staff information was posted and would check. The DON was observed to check with the Director of Special Projects and he indicated he would have to check.<br><br>An interview with the DON on 9-6-2019 at 9:46 a.m., indicated QMA (Qualified Medication Aide) -CNA- Receptionist-Bus Driver 4 had not prepared the posted nurse staff information as yet and was preparing it now. The DON was asked where the posted nurse staff information was placed in the facility and she indicated in a plastic stand that went on the South hall nurse station. Further interview with the DON at this time, indicated there had not been a posted nurse staff information in a plastic stand at the South hall nurse station since the survey team entered the building.<br><br>An interview with QMA-CNA-Receptionist-Bus Driver 4 on 9-6-2019 at 9:48 a.m., indicated she had not prepared the posted nurse staff information in a while. She indicated she used to get the prepared posted nurse staff information from LPN | | *Administrator or Designee daily.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *Administrator and Scheduler have been educated on the need to have staffing sheets, prepared, posted, and retained per CMS guidelines. The Administrator or Designee will audit staffing sheets daily to ensure they have been prepared, posted, and retained.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *Administrator or designee will audit staffing sheets to ensure proper preparedness, posting, and retaining of documents, daily x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | 3 (Licensed Practical Nurse) and then she would put the nurse staff information in the plastic stand at the South Hall Nurse Station.<br><br>An interview with LPN 3 on 9-6-2019 at 9:54 a.m., indicated she had not prepared the posted nurse staff information for months, probably since the beginning of the year.<br><br>An interview with the Director of Special Projects on 9-6-2019 at 9:56 a.m., indicated he was going to prepare the posted nurse staff information for today. He indicated he did not have any previous days of the posted nurse staff information and was not going to re-create them. He indicated there were some systems broken in this facility and this was one of them.<br><br>An interview with the Signature Care Consultant on 9-9-2019 at 11:11 a.m., indicated the facility did not have a policy for the posted nurse staff information and the facility would just follow the CMS (Center for Medicare and Medicaid Services) rules. | | | |
| F 0744 SS=D Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>Based on interview and record review, the facility failed to ensure care was provided per physician orders for 1 of 1 residents reviewed. (Resident 25)<br><br>Findings include: | F 0744 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice*: Resident 25 was transferred to a psychiatric hospital and was able to receive the care needed.* | 10/09/2019 |

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| | On 9/5/19 at 2:30 p.m. the clinical record of Resident 25 was reviewed. Diagnoses included but were not limited to, the following: dementia, stroke, depression, benign prostatic hypertrophy, impaired vision, renal mass, coronary artery disease, neurogenic bladder and urine retention with past stroke,<br><br>A Minimum Data Set (MDS) assessment dated 7/18/19, indicated the resident was of severely impaired cognition, had delusions and required extensive assistance with ambulating on unit.<br><br>A plan of care, dated 1/17/18 addressed the problem of Active and/or at risk for behavior problems. The care plan indicated the resident had a history of dementia with behavioral episodes of: not allowing nurse to assess wound; not keeping his clothes on going into hall not dressed appropriately; pulling catheter out; shredding briefs; calling staff names; agitated; hitting gestures; smearing feces; dated 5/22/19: started on an antidepressant for anxiety - hitting staff, cussing staff during care, not eating well; dated 6/5/19: hitting staff during care, tried to bite staff when showering him; dated 6/12/19; started on psychotropic medication; dated 6/29/19 and psychotropic medication was increased; dated 7/18/19; and a behavior of indicating he was dead and his sister was dead. Goals: Resident will not harm themselves or others secondary to their behaviors; will respond to staff interventions as evidenced by accepting the redirection without having any negative changes in mood or behaviors. Approaches included but were not limited to, the following: Report to physician changes in behavioral status as needed and refer to psychological/psychiatric consult as needed.<br><br>A plan of care dated 1/17/19, addressed the | | 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents with Dementia could affected by the deficient practice. All residents progress notes with dementia have been reviewed for Changes in Condition and for Following Physician Orders with Dementia Care for last 30 days. All changes of condition have been reported to physicians for orders and appropriate follow up.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been educated on Physician Notification and Following Physician Orders to ensure all changes of condition are reported to the physician in a timely manner per company policy. DON/Designee will monitor progress note documentation to ensure proper Physician Notification for Changes of Condition for Dementia Care and Physician Orders have been followed.*<br><br>4. How the corrective action will be monitored to ensure the | |

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| | problem of At risk for side effects of medication, dementia with difficulty expressing himself, psychotropic medications, an antipsychotic for delusions and an antidepressant for anxiety, seroquel dose was decreased 7/31/19. Approaches included but were not limited to, the following: Administer medication as prescribed by the physician and monitor for effectiveness and refer to physician as needed for specialist consult and to psych services as scheduled and as needed.<br><br>Behavior notes dated 8/19/19 at 2:26 a.m. indicated the resident was yelling, cursing, threatening and raising fist/hands at staff during bedtime care. The resident was shouting "I'll kill you for this!" and ripping clothes off. The resident was shouting "You're wrong! You're a bunch of (curse word) idiots! You need to get out of here! I'm going to knock your head off! I'll bury you in the woods for this one!" Staff provided a back rub, 1:1, and assisted resident to stand for care by holding his hands and talking calmly to him. The resident raised hands times 2 at staff but grabbed staff's hand again when offered to him. Once changed out of soiled clothes and helped into bed, the resident calmed down and took medications without difficulty.<br><br>Behavior notes dated 8/22/19 at 10:26 p.m. indicated The resident was verbally combative with incontinent care before supper saying "you're going to die! You're dead! I'm going to cut your head off and hide you in the woods!" The resident grabbed silverware off of dining room table when he finished eating and would not hand them over when asked repeatedly, he eventually set them down on table the bed before laying down at approximately 9:30 p.m. The resident refused oral medications 3 times, but allowed | | deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will audit Progress Notes for Physician Notification for Changes of Condition with Dementia Care and Physician Orders M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | glucoscan and insulin administration. The resident stated "You're an idiot! You don't know anything! Those are crap, they do nothing!" 1:1 given by 3 different staff, gave back rub, offered of foods and fluids, and incontinent care provided with very little improvement. The resident would calm down when not approached, but would continue speaking the same way when re-approached.<br><br>Behavior notes dated 8/24/19 at 5:23 p.m. indicated the following: The resident refused all oral medications this shift. Poor appetite, when alternatives were offered staff were called idiots, he was going to kill the staff and bury the bodies in the woods. A knife and fork were attempted to be taken out of the dining room, and were retrieved by both nurses without incident. Glucometers and insulin were accepted. Mood was uncooperative with care, was difficult to change when wet or soiled, was swinging at staff, cursing and threatening. Resident felt he was being mistreated when clothes were removed to be changed. A soft tone, and explained what was being done before doing seemed to help slightly.<br><br>Behavior notes dated 8/24/19 at 9:40 p.m. indicated the following: The resident was physically aggressive with staff. A Certified Nursing Assistant (CNA) was attempting to change resident's clothes after being incontinent. The resident was sitting in a wheelchair in the resident bathroom. Yelling at staff member calling her "b****." The resident stated "I'm going to get a knife and chop you up into little pieces and bury you in the woods and then you will be dead." The resident was swinging at staf,f hitting her on the arm. The resident looked at the nurse and stated "You're on death row, you are dead." While attempting to put resident gown on, the resident | | | |

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| | stood up and began swinging both arms at the CNA causing the resident to fall backwards before staff could stop the resident. Resident 25 landed on buttocks without hitting his head. He was assisted back up from the floor after a short assessment, cussing at staff. The resident was assist to bed and continued to yell and cuss at staff. The resident refused all bedtime medications and insulin. The resident removed a butter knife from the dining room table. Staff attempted to remove the butter knife from the resident prior to leaving the dining room, but the resident refused to give it to staff. The butter knife was found lying on an activity room table and removed from table at that time. A new order was received and noted to send the resident to a psych (Psychiatric) hospital.<br><br>A nurses note dated 8/25/19 at 3:20 a.m. indicated the following: The staff spoke with a Neuropsychiatric hospital but they were unable to accept the resident at that time. The resident was yelling and cussing at staff when giving incontinence care, calling staff "b******.", being resistant to care, and continued to tell staff they were going to be dead.<br><br>A behavior note dated 8/25/19 at 4:43 p.m. indicated the following: The resident refused all oral medications, glucometer check,s and insulins. The oral medications had been refused for a couple of days. the resident was cursing, swinging his arms in attempts to hit, stating he would kill staff, and bury the body in the woods. The resident was very explosive verbally and emotionally. The resident hit a CNA in the face during care, and attempted to kick staff. The resident feared he was being violated in some way, although staff constantly attempted in a soft, gentle tone explain what they were doing when, | | | |

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| | and why to take care of him and comfort him. The resident continued with threats of murdering staff. Sister POA (power of attorney), CEO (chief executive officer) and (name of social worker) were all called, informed of the violence, increasingly unsafe behaviors towards self, refusal of medications and food. EMS (emergency medical service) was scheduled to be called when next shift arrived so that more staff was available as the resident was expected to be very upset, fight the transfer to emergency room for evaluation and potential transfer to psychchistric unit.<br><br>A Social Service note dated 8/26/19 at 8:59 a.m., indicated she had spoken with the psychiatric hospital staff to follow up onthe referral given on Saturday. The staff reported the residnet's case had to be reviewed at the administrator level due to the resident's physical behaviors and that a certian form needed signed by his medical doctor before he could be accepted. Social Services had spoken with staff at physician office and paperwork had been faxed to the resident's physician for completion and it would be faxed back. When the document was received, Social Services would fax the document to the neuropsychiatric hospital referral line to follow up on the resident to be admitted for in-patient psychiatric stay.<br><br>A Social Service note dated 8/26/19 at 5:59 p.m. indicated the physician had completed paperwork for the assessment team to complete.Resident 25's referral information was faxed and the assessment team has accepted the resident for an inpatient psychiatric evaluation and treatment. Resident 25 was informed, but due to his dementia, the information was not remembered. Resident 25's sister was aware he was transfered today around 6:25 p.m. | | | |

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A Social Service note dated 8/26/19 at 7:21 p.m. indicated Resident 25 was transferred by EMS to the hospital for in-patient psychiatric stay at 7:25 p.m.

On 9/6/19 at 9:10 a.m. the DON (Director of Nursing) was interviewed. She indicated the facility should have notified and updated the physician on the residents continued behaviors. She indicated based on the documentation the resident appeared to only be a threat to staff when they attempted to provide care for him, especially incontinence care. She indicated based on the documentation, it did not appear the resident was a danger to other residents.

On 9/6/19 at 9:44 p.m., the Social Service Designee was interviewed. She provided documentation dated July and August 2019 of the resident's behaviors with the following observed: 7/11/19 1 episode of threats to harm others, cursing and throwing objects, hitting with closed fist contact, biting, paranoid statements, fidgeting; 8/18/19 1 episode of threats to harm others, cursing, hitting with closed fist attempt.

On 9/6/19 at 10:22 a.m. the Administrator provide a current copy of the facility policy and procedure for "Change in Condition" dated 7/10/18. The policy and procedure included but was not limited to, the following: Facility will evaluate and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner to relay evaluation information to physician and to document actions to include but not limited to the following: A significant change in the resident's physical, mental or psychosocial status; A decision to transfer or discharge the resident from the facility and refusal of compliance

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| | with prescribed plan of care. Guidelines: Licensed nurse will evaluate any change in condition through direct observation, physical examination and vital signs at the onset of the change and as ordered by physician. Life threatening events: Call "911" if your initial evaluation indicates such action is necessary; notify the physician; complete the situation, background, assessment, recommendations (SBAR) in the electronic medical record (emr) to provide the physician with necessary evaluation findings; If the condition does not appear to be life threatening, utilize the emr sbar and notify the physician. If a message is left with the physician office and a timely response is not given, follow-up with another message as needed, depending on the significance of the change. If unable to contact the physician, depending on the significance of the change, contact the Medical Director, as appropriate; Document in the medical record physician notification; The emr sbar communication form will serve as the nursing documentation for change in condition.<br><br>On 9/6/19 at 11:26 a.m., the DON was interviewed. She indicated she was unable to find documentation the physician had been updated on the resident's continuing behaviors after the physician order of 8/24/19 at 9:40 p.m.<br><br>On 9/9/19 at 10:25 a..m the Social Service Designee (SSD) was interviewed regarding why the resident had not been transferred to the neuropsych hospital after the order on 8/24/19 at 9:40 p.m. until 8/26/19 at 7:25 p.m. The SSD indicated the resident's behavior had gotten to the point she thought they needed to get the resident additional help. She indicated the trigger for the resident's behaviors was incontinence care. She indicated she thought the facility had received the | | | |

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| | necessary paperwork from the neuropsych hospital on Saturday evening 8/24/19. She indicated the facility thought the resident's physician would return to the facility on Sunday, August 25, 2019 but he did not. The SSD indicated she followed up with the situation on Monday, August 8/26/19 to assist with the resident's transfer. The SSD indicated the neuropsych hospital was contacted on 8/25/19 at 3:20 a.m. and indicated they had accepted the resident financially but the resident's family did not have the power of attorney for health decisions. The neuropsych hospital indicated they would need special paperwork to accept him at their facility. The SSD indicated the physician needed to sign the paperwork and then a judge would have to review and sign the paperwork as well. Documentation was lacking of the physician having been notified of the resident's need for additional paperwork completed to facilitate his transfer to the neuropsychiatric hospital. Documentation was lacking in the clinical record of the physician having been notified of the resident's continuing behaviors after the order for transfer was received. The SSD indicated she was unable to find documentation the physician had been notified of the residents continuing behaviors and/or the need for competition of additional paperwork.<br><br>On 9/9/19 at 2:45 p.m., the RN Consultant was interviewed. He indicated he was unable to locate a policy and procedure for management of behaviors for the facility.<br><br>3.1-37(a) | | | |
| F 0756 SS=D Bldg. 00 | 483.45(c)(1)(2)(4)(5)<br>Drug Regimen Review, Report Irregular, Act On | | | |

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| | §483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she | | | |

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| | identifies an irregularity that requires urgent action to protect the resident.<br>Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed for 1 of 5 residents reviewed.<br>Resident 15<br><br>1. On 9/6/19 at 11:30 a.m. the clinical record of Resident 15 was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus and long term use of insulin.<br><br>The quarterly MDS (minimum data set) assessment, dated 6/7/19 indicated the following: diagnosis of diabetes mellitus and insulin injections were received for 7 of the last 7 days.<br><br>A plan of care dated 9/27/17 addressed At risk for complications associated with hyper/hypoglycemia, new diagnosis and refuses insulin.. Approaches included but were not limited to, the following: report to physician any unstable blood sugars and perform accuchecks as ordered.<br><br>A physician order, dated 7/20/19, indicated: routine labs ordered: A1C (blood test which measures the average blood sugar level over the past 3 months), fax results to office when available.<br><br>Documentation dated July and August 2019 titled, weekly fasting blood sugars, were received from the Director of Nursing (DON) on 9/6/19 at 2:30 p.m. The following results were observed July 2019(no measure parameters were documented with the results): 7/3: 214; 7/10: 332 ; 7/17: 212 ; 7/24: 221; 7/31:229. August 2019 documented: 8/7: 178; 8/14: 233; 8/21: 279; 8/28: 284; 9/4: 214. | F 0756 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident 15 has been assessed and have found no harm from the deficient practice, pharmacy recommendation has been followed, and the physician has been notified.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that receives a pharmacy recommendation has the potential to affected by the deficient practice. Pharmacy Recommendations will be audited for last 60 days to ensure recommendations are being followed.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been educated on Implementation of Pharmacy recommendations. DON/Designee will audit Pharmacy Recommendations for proper implementation.* | 10/09/2019 |

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| | A Summary/Medical Director Report, dated 7/31/19, indicated the medical record review, dated 7/31/19, the .resident's A1C was 10.3 on 7/19, and he was.receiving glipizide (medication to control blood sugar levels) 5 mg bid (twice a day). The report suggested increasing glipizide to 10 mg bid with breakfast and dinner.<br><br>Review of the medication administration record (MAR) dated August 2019 and September 2019, indicated the resident was receiving glipizide 5 mg twice a day.<br><br>On 9/6/19 at 12:33 p.m., the Director of Nursing (DON) reviewed the resident's current MAR (medication administration record) and indicated the resident was currently ordered to have and was receiving glipizide 5 mg twice a day (BID) for type 2 diabetes mellitus with other specified complication. The DON reviewed the current MAR and indicated the current MAR did not reflect the pharmacy recommendation that had been made for 7/31/19 for a change in glipizide due to the resident's most recent A1C. The DON indicated when pharmacy provided a recommendations to the facility, the DON was to have the recommendation reviewed and/or addressed by the physician. She indicated the DON was to make the physician aware of the recommendations and then address them. She indicated currently the resident was on Glipizide 5 mg twice a day and this had an order date of 8/15/19. The resident's clinical record was reviewed at 12:40 p.m. by the DON and she indicated documentation was lacking of an order on 8/15/19 regarding a dose of glipizide 5 mg twice a day.<br><br>On 9/9/19 at 12:31 p.m., the DON was interviewed. She indicated she was not able to find a policy | | 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>*DON/Designee will audit Pharmacy Recommendations for M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | and procedure to address physician notification of pharmacy recommendations. She also indicated once the physician was made aware of the pharmacy recommendations, they had 30 days to respond to the recommendation. | | | |
| F 0759 SS=E Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 4 of 9 residents observed during the medication pass. Four medication errors were observed during 27 opportunities for error in medication administration. This resulted in a medication error rate of 14.81%. (Resident 4, Resident 13, Resident 16 and Resident 135)<br><br>Findings include:<br><br>1. During an observation of the medication pass for Resident 4 on 9-9-2019 at 1:10 p.m., LPN 1 (Licensed Practical Nurse) was observed to prepare a syringe with 5 units of Novolog insulin for diabetes. When the nurse entered the room, Resident 4 refused to let the nurse administer the insulin. The nurse observed the resident's noon meal tray on the overbed table had not been touched. Resident 4 indicated he could not eat due to the pain he had in his right leg.<br><br>Upon reconciling the Novolog insulin amount and refusal on 9-5-2019 at 9:57 a.m., the MAR (Medication Administration Record) was documented with a "1" in the noon box for the | F 0759 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Residents 4, 13, 16, and 135 have been assessed and have found no harm from the deficient practice and physician notification has been made.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that receives medication has the potential to affected by the deficient practice. DON or designee will monitor medication passes for accurate documentation, Kwikpen use, Rights of Medication administration, and physician notification; to ensure accurate medication administration has been made.* | 10/09/2019 |

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| | 9-4-2019 Novolog 5 units subcutaneous daily at noon. The code "1" meant "no insulin coverage required." The notes were reviewed and there was not any mention of Resident 4 not eating his lunch and his refusal of the insulin. There was not a blood sugar entered into the MAR for 9-4-2019 at any time. The physician was not notified of the refusal of the routine insulin order.<br><br>An interview with the DON (Director of Nursing on 9-9-2019 at 10:10 a.m., indicated the documentation should have reflected the refusal code "3" and not the code "1", no insulin coverage required.<br><br>2. During an observation of the medication pass for Resident 13 on 9-4-2019 at 1:16 p.m., LPN 1 had prepared the following medications for administration:<br>amlodipine besylate 5 mg (milligrams) po (by mouth) dly (daily), a calcium channel blocker for high blood pressure and for chest pain.<br>doxycycline hyclate 100 mg po dly, an antibiotic<br>folic acid 1 mg po daily, for anemia in chronic kidney disease<br>clonidine 0.2 mg 1 tab po 2x daily, for high blood pressure<br>losartan potassium 100 mg po dly, for high blood pressure--this medication was placed in a separate medication cup<br>renvela 800 mg po give 3 tabs (2400 mg) po dly, for end stage renal disease<br>Humalog 8 units coverage for blood sugar of 484 and 5 units routine subcutaneous<br>LPN 1 was observed to have had the white losartan potassium in a separate medication cup as she wanted to obtain the resident's blood pressure first. There were 7 other pills verified in another medication cup. | | 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been educated on physician notification, Accuracy of documentation, Education on Kwikpen use, and Rights of Medication Administration. DON or designee will monitor medication passes for accurate medication administration.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will perform a medication pass audit on 5 random residents, M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | Upon reconciling the medication pass observed for Resident 13 on 9-5-2019 at 10:04 a.m., the MAR indicated a lexapro 10 mg tab was marked as administered for the 9-4-2019 noon medication pass that was observed at 1:10 p.m. The medication was not observed to be administered with the other medications.<br><br>During an interview with LPN 1 on 9-5-2019 at 11:03 a.m., the nurse indicated she was so nervous when she returned to her medication cart, she was not paying attention and clicked that all the noon medications were administered including the losartan potassium and the lexapro, which were not observed as administered.<br><br>3. During an observation of the medication pass for Resident 16 on 9-5-2019 at 9:03 a.m., LPN 2 was observed to prepare a Basaglar KwikPen (insulin) with 20 units on the dose indicator dial for diabetes. The nurse was observed to administer the KwikPen insulin in resident's left upper arm and removed the needle from the resident's arm as soon as the dose knob was pushed. The KwikPen was not observed to have been primed prior to setting the dose indicator to the required dose and the nurse was not observed to hold the KwikPen in place against the resident's arm for 5 seconds per the manufacturer's instructions.<br><br>During an interview with LPN 2 on 9-5-2019 at 1:37 p.m., the nurse indicated for the KwikPen when it was first opened, it had to be primed. The nurse indicated the KwikPen dial was turned to get the air out. Further interview with LPN 2 at this time, indicated the nurse did not know if the pen was supposed to be held against the skin after the insulin was injected. The nurse was observed to look for instructions on administering the KwikPen, but the KwikPen was sent in a clear | | | |

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| | plastic bag with a label by the pharmacy. The nurse checked her most recent Nursing Drug Handbook and a Pharmerica drug book and was unable to locate how to administer the insulin in the KwikPen. The nurse indicated she was going to contact the pharmacist.<br><br>A current copy of the Basaglar KwikPen instructions dated 6-1-2016 was provided by LPN 2 on 9-5-2019 at 2:10 p.m. At this time, an interview with LPN 2 indicated the Kwikpen should have been held to the skin for 5 seconds after pushing the dose knob that injected the insulin. The instructions indicated to prime before each injection which meant to remove the air from the needle and cartridge that may collect during normal use. If you do not prime before each injection, you may get too much or too little insulin. The steps to prime the pen indicated to turn the dose knob to select 2 units. Then hold the pen with the needle pointing up and tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with the needle pointing up and push the dose knob in until it stops and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly and you should see insulin at the tip of the needle. Then turn the dose knob to select the number of units you need to inject. Insert the needle into the skin and push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle.<br><br>4. During an observation of the medication pass for Resident 135 on 9-5-2019 at 9:14 a.m., LPN 2 was observed to prepare the glucosamine sulfate 500 mg order for pain which indicated on the bottle label to give 2 caps by mouth daily. The nurse was observed to look at her computer screen and obtained 1 cap of the glucosamine | | | |

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| | sulfate. One tablet of the glusocamine 500 mg was observed to be administered to Resident 135.<br><br>Upon reconciling the medication orders in Resident 135's record on 9-5-2019 at 1:25 p.m., to what was administered by LPN 2, there was a discrepancy. The physician's order for the glucosamine sulfate was 1000 mg cap by mouth daily. An interview with LPN 2 at this time, indicated she should have given 2 of the 500 mg caps of the glucosamine sulfate to make the 1000 mg. The nurse indicated the orders in the computer did not match what was on the medication label.<br><br>Twenty-seven medications were observed during the medication pass observations. Of the twenty-seven opportunities, errors were observed for 4 medications. This resulted in a 14.81% error rate.<br><br>3.1-25(b)(9) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have | | | |

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| | access to the keys.<br><br>§483.45(h)(2) 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.<br>Based on observation, interview, and record review, the facility failed to ensure medication carts were locked when unattended on 1 of 3 halls, potentially affecting 6 of 6 residents who resided on that hall.<br><br>Findings include:<br><br>On 9/3/2019 at 10:14 a.m., the medication cart on the North Hall was observed to be unlocked, and unattended.<br><br>On 9/5/19 at 11:44 a.m., the medication cart on the North Hall was observed in the hall outside Room 22 unlocked and unattended, LPN(Licensed Practical Nurse) 2 was observed going into the room.<br><br>On 9/4/2019 at 1:35 p.m., LPN 1 was observed entering Room 22, the North Hall medication cart was parked next to the wall, unlocked and not visible from inside Room 22.<br><br>During an interview on 9/9/2019 at 11:23 a.m., the Regional Nurse Consultant indicated the medication carts should always be locked when unattended. | F 0761 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Medication carts were immediately locked, and no resident was found to have been harmed.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that receives medication from an unlocked medication cart has the potential to affected by the deficient practice. Audits will be performed to ensure medication carts are locked when left unattended.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nursing staff has been* | 10/09/2019 |

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| | During an interview on 9/9/2019 at 11:35 a.m., the Interim DON (Director of Nursing) indicated the med carts should be locked.<br><br>During an interview on 9/9/2019 at 1:30 p.m., LPN 1 indicated the medication cart should be locked up when not attended.<br><br>During an interview on 9/9/2019 at 1:32 p.m., LPN 9, indicated the medication carts should always be locked when unattended.<br><br>A current facility policy, Medication Storage, Storage of Medication, dated 9/2018, provided by the DON on 9/9/2019 at 11:35 a.m., indicated the following: "...The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications..." "...3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access..."<br><br>3.1-25(m) | | *educated that all medication carts are to be locked when left unattended. DON or designee will perform audit of all medication carts 4 times daily to ensure medication carts are locked when left unattended.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will perform a Medication Cart Lock Audit 4 times daily, M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained | | | |

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| | directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview and record review, the facility failed to ensure foods were stored and/or labeled in a manner to maintain sanitary practices. This deficient practice had the potential to affect 38 of 38 residents in the facility.<br><br>Findings include:<br><br>On 9/03/19 at 10:05 a.m., during a tour of the kitchen, Cook 12 was interviewed. She indicated she was the cook and a dietary aide.<br><br>The reach in cooler was observed to have a box with 14 individual packets of prefilled and sealed sour cream. All of the sour cream packets were observed to have an expiration date of 8/29/19. Also observed were 18 plastic individual containers, filled with a red colored salad dressing. All 18 of the containers were observed to have a date of 8/?? to 8/30. The first date on the container was unclear and was unable to be read.<br><br>On 9/3/19 at 10:12 a.m., a second reach in cooler was observed. An item wrapped in foil, was observed to have been labeled "diced chicken" | F 0812 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *The outdated items were removed from the use and discarded.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents have the potential to affected by the deficient practice. An initial audit of food storage areas was conducted, and any items found that were undated or outdated were discarded immediately.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: | 10/09/2019 |

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| | and had a date of 8/23/19 written on the foil. Cook 12 was observed to open the foil and inside was a plastic bag with a twist tie to secure the open portion of the bag. The bag appeared to contain 1/2 a bag of diced chicken. A half filled, 1/2 gallon container of half and half, was observed undated. A 1 gallon container of 2% milk was open and undated. Approximately one inch of milk was observed to remain in the bottom of the container. An undated, open gallon of whole milk, was observed to be 1/2 gone.<br><br>On 9/13/19 at 10:12 a.m., Cook 12 was interviewed and indicated the open chicken was to be used for the meal later that day. Cook 12 indicated there was no open date on the container of 1/2 and 1/2, the container of 2% milk, had a "best by date" of 9/1/19, and an open date on the container of whole milk of 8/29/19 and also read the "best by date" of 9/1/19.<br><br>On 9/3/19 at 10:15 a.m., a third reach in cooler was observed. On a shelf in the cooler were observed two individual servings of prepackage of majic cup. Both of the lids were askew, with discolored contents observed as compared to contents underneath the remaining part of the lid. Cook 12 removed the 2 containers and said she was going to throw them out.<br><br>On 9/3/19 at 12:35 p.m., the Food Service Manager (FSM) was interviewed regarding the bag of diced chicken in the reach in cooler dated 8/23/19. After she reviewed her records, she indicated the bag of diced chicken had been delivered to the facility on 8/19/19. She indicated the first time the staff opened the package of frozen chicken, they would have removed 1/2 of the frozen contents. She indicated staff then should have twist tied the open bag and dated it when it was opened, which | | *All dietary staff have been educated on food storage and labeling practices. The Food Services Manager will perform audits of food storage to ensure storage and labeling practices are being followed.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *Food Services Manager will audit food storage and labeling M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | was 8/23/19 and replaced the frozen contents in the freezer. The only date on the bag was 8/23/19. Documentation was lacking on the bag as to when it had been removed from the freezer to thaw in the refrigerator.<br><br>On 9/3/19 at 12:35 p.m., the FSM indicated they had a "pull out list" and per her list, the frozen chicken cubes had been pulled out last evening. The FSM indicated the frozen chicken was pre cooked.<br><br>The FSM was interviewed on 9/9/19 at 12:00 p.m. The FSM was made aware of the observations in the refrigerator on 9/3/19 of the expired sour cream packets, salad dressing packets with a end date of 8/30/19, diced chicken not dated after it had been removed from the freezer, no open date on container of half and half, no open date on two gallons of milk, each with a best by date of 9/1/19. The FSM indicated Cook 12 was training a new cook for the second shift. She indicated the cook in training had been off on 9/2/19 and she, the FSM, had instructed Cook 12 to leave the products in the reach in coolers so the Cook in training could learn how to look at dates.<br><br>On 9/9/19 at 12:45 p.m., the FSM provided a current copy of the facility policy and procedure for "Food Storage" dated 9/14/18. The policy included but was not limited to the following: Food items should be stored, thawed and prepared in accordance with good sanitary practice. Any expired or outdated food products should be discarded. Procedure: All products should be inspected for safety and quality and be dated upon receipt and when they are prepared. Use "use by dates" on all food stored in refrigerators and use dates according to the timetable in the Dry, Refrigerated and Freezer | | | |

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| | Storage Chart found in this section. Remember to cover, label and date! Any expired or outdated food products should be discarded. Thawing: Date meat when taken out of freezer. Ice Cream, Ice Milk once open, assure the lid fits tightly.<br><br>3.1-21(i)(3) | | | |
| F 0838 SS=F Bldg. 00 | 483.70(e)(1)-(3)<br>Facility Assessment<br>§483.70(e) Facility assessment.<br>The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:<br><br>§483.70(e)(1) The facility's resident population, including, but not limited to,<br>(i) Both the number of residents and the facility's resident capacity;<br>(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;<br>(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;<br>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for | | | |

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| | this population; and<br>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.<br><br>§483.70(e)(2) The facility's resources, including but not limited to,<br>(i) All buildings and/or other physical structures and vehicles;<br>(ii) Equipment (medical and non- medical);<br>(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;<br>(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;<br>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and<br>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.<br><br>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.<br><br>Based on interview and record review, the facility failed to ensure the facility assessment was completed thorough and accurately. This deficient practice had the potential to affect 38 of 38 residents in the facility.<br><br>Findings include: | F 0838 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *The Facility Assessment and the Clinical Grid has been updated to accurately reflect resources needed to care for our residents during day-to-day* | 10/09/2019 |

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| | 1. On 9/4/19 at 3:23 p.m., the facility assessment was received from the Director of Special Projects (DSP). The facility assessment was dated for the time period of 1/11/18 to 1/10/19. Review of the "Conditions" section of the assessment indicated the facility had "none" for Invasive Mechanical Ventilator (ventilator or respirator) for the frequency relative to benchmark. Under the B. Acuity-Diseases, Conditions and Treatments for Sufficiency Analysis Categories for Invasive Mechanical Ventilator (ventilator or respirator) indicated overall staff, staff competitencies and services were sufficient.<br><br>Under section B.1. of the facility assessment, the following was observed: The facility utilizes a clinical grid to determine the capability of the facility to care for common treatments, conditions and diseases processes.<br><br>On 9/6/19 at 2:00 p.m., the RN Consultant was interviewed. In regards to the facility assessment having documented the facility was sufficient for ventilator or respirators overall staffing, staff competitencies and services, he indicated he had not been involved in completing this facility assessment. He indicated it was possible the staff who completed this assessment indicated the sufficient staffing in relation to ventilators or respirators was interpreted to mean the facility would be able to sufficiently provide care for the resident who had received those services at another facility, not necessarily perform the service. He indicated if a resident on a ventilator did want to come to the facility, they did have access to respiratory therapist who could assist in providing sufficient services for the resident.<br><br>A confidential nurse interview was conducted. | | *operations and emergencies.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents could be affected by the deficient practice. The Facility Assessment & Clinical Grid will be updated at regular intervals to ensure accuracy.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *The Facility Administrator has been educated on the importance of accurately updating the Facility Assessment & Clinical Grid. CEO or Designee will monitor the Facility Assessment for completeness and accuracy.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *CEO or designee will audit the Facility Assessment & Clinical Grid for accuracy, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals, IDT will review until there* | |

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| | The nurse indicated they had never been trained in how to care for a resident who was on a ventilator and/or were never aware of there even having been a resident at the facility on a ventilator.<br><br>On 9/9/19 at 11:15 a.m., the RN Consultant provided a copy of the document the facility utilized for a clinical grid "Clinical Capabilities." This form had a date of 9/9/19, in the upper left hand corner of the form. The RN Consultant indicated on the form, when "availability" was documented as "no" the service was not provided at the facility. He indicated on the form "verify" indicated further investigation was needed to see if the service could be provided or not at the facility. On the form, the "Non-invasive Vent" and/or "ventilators" both had documented as "no" for availability.<br><br>2. On 9/6/19/19 at 1:30 p.m., the facility assessment was reviewed with the following observed: Under section B. Acuity-Diseases, Conditions and Treatments: included but was not limited to, the following: for admission stays: 25 with acuity index high, 55 with acuity index moderate, 67 with peripheral vascular disease, 55 with diabetes, 11 with Alzheimers and 26 with stroke.<br><br>Under section B.2. Describe the care requirements for your resident population considering the acuity -diseases, conditions and treatments present in your population over the last year: Documentation was lacking as to a response to this request.<br><br>Under section C. Cognitive, mental and behavioral status included, but was not limited to, the following for admission stays: memory impaired | | *has been 2 months of 100% compliance and will review quarterly. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | on BIMS (brief interview for mental status) 30; orientation and recall impaired on BIMS 41; decision making impaired 22; dementia: non-Alzheimers or Alzheimers disease was 51; wandering was 3; psychotic symptoms 8; with behavioral health care needs was 20; resident behavior impacted others was 2.<br><br>Under section C.1. Describe the care requirements for your resident population considering the cognitive, mental and behavioral status present in your population over the past year: Documentation was lacking as to a response to this request.<br><br>Under section III Physical Environment, Technology and Equipment, instructed to indicated the sufficiency of the Physical Environment, Technology and Equipment provided based on the resident population profile and any additional sources. Of the 19 areas listed, which included Activities of Daily Living, Mobility and Rehabilitative Services (for those receiving therapy), all were documented as having been sufficient for physical environment, technology and equipment.<br><br>Under the section of C.1. and D.1., for the request of "Describe how you arrived at the determinations of sufficiency indicated in the sufficiency analysis for Physical Environment, Technology and Equipment provided: Documentation was lacking as to a response.<br><br>On 9/9/19 at 2:10 p.m., the RN Consultant as made aware of documentation lacking in the facility assessment regarding describing determinations of sufficiency. He was also made aware of the facility assessment having been documented as having had sufficient staffing for the following in | | | |

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| | regards to ventilator or respirator: overall staffing, staff competitencies and services. No additional information was provided. | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should | | | |

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| | be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corresponding actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, interview and record review, the facility failed to ensure infection control practices were followed for 1 of 1 resident reviewed. (Resident 13) | F 0880 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident 13 has* | 10/09/2019 |

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| | Findings include:<br><br>During an observation of the medication pass for Resident 13 on 9-4-2019 at 1:16 p.m., the resident's door was closed and was observed to have had a contact precautions sign posted on the door.LPN 1 was observed to prepare the resident's medications for administration:<br>amlodipine besylate 5 mg (milligrams) po (by mouth) dly (daily), a calcium channel blocker for high blood pressure and for chest pain.<br>doxycycline hyclate 100 mg po dly, an antibiotic<br>folic acid 1 mg po daily, for anemia in chronic kidney disease<br>clonidine 0.2 mg 1 tab po 2x daily, for high blood pressure<br>losartan potassium 100 mg po dly, for high blood pressure<br>renvela 800 mg po give 3 tabs (2400 mg) po dly, for end stage renal disease<br>Humalog 8 units coverage for blood sugar of 484 and 5 units routine subcutaneous<br>LPN 1 was observed to have had the white losartan potassium in a separate medication cup as she wanted to obtain<br>the resident's blood pressure first.LPN 1 was observed to don a yellow gown and enter the room and walked to the bathroom to obtain gloves. There were not any gloves in the bathroom and the nurse was observed to go the door to get gloves from overlay of PPE (Personal Protective Equipment) on the door. LPN 1 was observed to don gloves. LPN 1 was observed to use a wrist blood pressure cuff to obtain the blood pressure and she used the glucometer from inside the resident's room to obtain the blood sugar. The resident had been at dialysis and had just returned and had eaten his lunch, except for the fruit. The nurse then indicated she had the | | *been assessed and found to have no harm from the deficient practice.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents in need of Isolation Precautions have the potential to affected by the deficient practice. All staff will be educated on Isolation Precautions, with LPN 1 receiving 1 on 1 instruction on Isolation & Transmission Based Precautions and Handwashing.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All staff have been educated on Isolation & Transmission Based Precautions. The DON/Designee will perform visual audits of Isolation Precautions when in use and Random Competencies of staff members with teach back to ensure proper Isolation and Transmission Based Precautions are being followed.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program | |

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| | wrong glucometer and did not let the blood sugar test finish. She then indicated that was the right one, but did not have another blood sugar test strip. She was observed to remove her gloves and put them in the red bag inside a hazardous trash can by the window, which was on the opposite wall of the room door. LPN 1 was observed to walk out into the hall with the yellow gown on and obtained the vial of strips from the medication cart, carried the vial of strips in the room, donned gloves, removed a strip and put the vial of strips in her pocket. She obtained the blood sugar and it was 484. The resident's blood pressure was 70/56 and she held the losartan potassium. She indicated the resident would get coverage of insulin of 8 units for over a 300 blood sugar and 5 units of insulin was regularly ordered. The nurse was observed to remove her gloves and left the room to prepare the insulin syringe with the yellow gown on. The nurse returned to the room, donned gloves and administered the insulin in Resident 13's abdomenShe was observed to remove her gloves and gown and dispose in the trash can with the red bag. The nurse was not observed to wash her hands at any time during this process.<br><br>An interview with LPN (Licensed Practical Nurse) 1 on 9-4-2019 at 1:16 p.m., indicated Resident 13 was on contact precautions for MRSA (Methicillin Resistant Staphylococcus aureas, a bacteria that is resistant to many antibiotics) in his head wound.<br><br>An interview with LPN 1 on 9-4-2019 at 1:38 p.m., indicated she did not know why the trash can was over by the window, on the opposite side of the room from the door. The nurse then indicated she accidentally wrapped losartan potassium white pill in her glove and threw it in the red bag inside the | | will be put into place: *The DON/Designee will perform random visual audits of 3 staff daily performing Isolation & Transmission Based precautions when precautions are in use M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Random Knowledge Checks on Isolation &Transmission Based Precautions will be performed with 3 staff daily M-F x 2 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | hazardous waste trash can.<br><br>On 9-4-2019 at 1:40 p.m., LPN 1 was observed to rummage through the red bag inside the hazardous waste trash can with the discarded yellow gowns, gloves and other trash. LPN 1 was observed with one glove on her right hand and the plunger end of the syringe she used to give the resident his insulin in her mouth. The nurse was observed not to have a yellow gown on. She then donned a glove for her left hand. She was observed to open up the folded gloves and unwrap the yellow gowns and lay them on the lid of the hazardous trash can. She was unable to locate the pill, so she put all the hazardous trash in the red bag and removed the red bag from the barrel. She removed her gloves and left the room with the hazardous red bag and took it to the soiled utility room in Center hall. There was not a hazardous waste container to place the hazardous trash bag so she sat it on the counter. She returned to the hall and asked a housekeeper about the bio-hazard trash container. The nurse indicated she had been at the facility for a year and this was the first resident with transmission based precautions she has had in her care. She then returned to the medication cart outside Resident 13's room, unlocked the medication cart and began entering in information in the computer. At no time during the medication pass for Resident 13 and the first medication pass for another resident prior to Resident 13 was LPN 1 observed to wash her hands or use hand hygiene.<br><br>The record review for Resident 13 began on 9-5-2019 at 10:04 a.m. Diagnoses included but were not limited to, end stage renal disease with hemodialysis, chronic obstructive pulmonary disease, hypertension, diabetes, subdural hematoma, history of MRSA in the nares, and | | | |

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history of MRSA endocarditis (bacterial infection in the inner layer of the heart).

A 14 day MDS assessment dated 6-6-2019 indicated a BIMS of 7/15 for Resident 13. The BIMS of 7 indicated the resident was severely cognitively impaired. The resident required extensive assistance of 1 staff for personal hygiene and dressing, supervision of 1 staff for bed mobility and toileting, was independent for transfers, walking in room/corridor and for locomotion on/off unit. The resident needed set up help only for eating. The resident had a surgical wound and was marked for being on dialysis while a resident at the facility.

A copy of laboratory results dated 8-30-2019 for Resident 13 was provided by the DON on 9-6-2019 and indicated the resident had moderate MRSA in the wound culture from the forehead incision site and to proceed with isolation protocol.

An interview with CNA 11 (Certified Nursing Assistant) on 9-6-2019 at 9:27 a.m., indicated for a resident in isolation, she would don the PPE that was in the caddy on the door, (gown and gloves) prior to entering the room. She indicated after providing care, she would remove the gown and gloves in the resident's room and ensure the gown and gloves were turned inward and not to touch any part that would have be exposed to the resident or resident surroundings. CNA 11 indicated she would dispose of the used gown and gloves in the bio hazard trash bin in the resident's room and would wash her hands in the shower room across the hall.

An interview with LPN 3 (Licensed Practical Nurse) on 9-6-2019 at 9:35 a.m., indicated for a resident in isolation, she would don the PPE as

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indicated, gown and gloves prior to entering the isolation room and would remove the gown and gloves prior to leaving the room. LPN 3 indicated she would then wash her hands in the bathroom in the resident's room. The nurse indicated the hazardous trash should not have been gone through without a gown and gloves on and she would not wear the gown out of the resident's room. LPN 3 indicated the plunger end of a syringe used to administer a medication to a resident should not be placed in the staff's mouth.

An interview with the DON (Director of Nursing) on 9-6-2019 at 11:35 a.m., indicated she was made aware of the medication pass for Resident 13 in transmission based precautions for MRSA, She indicated she was aware the nurse did not wash her hands at anytime during the medication pass prior to or when removing gloves, after rummaging through the hazardous waste without a gown, without a glove on her one hand, leaving the room with an isolation gown on, returning with a gown on and holding the plunger end of the syringe that had been used to administer the resident's insulin in the nurse's mouth.

A current policy, "Isolation-Categories of Transmission-Based Precaution" revised October 2018 was provided by the Administrator on 9-5-2019 at 2:46 p.m. The policy indicated "...6. When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer (blood pressure cuff), or digital thermometer will be dedicated to a single resident...a. If re-use of items is necessary, the the items will be cleaned and disinfected according to current guidelines before use with another resident...Contact Precautions...may be implemented for residents known or suspected to be infected with

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| | microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...staff...will wear gloves (clean, non-sterile) when entering the room...gloves will be removed and hand hygiene performed before leaving the room...staff will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed...staff...will wear a disposable gown upon entering the room and remove before leaving the room and avoid touch potentially contaminated surfaces with clothing after gown is removed...."<br><br>3.1-18(a) | | | |
| F 0883 SS=D Bldg. 00 | 483.80(d)(1)(2)<br>Influenza and Pneumococcal Immunizations<br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following: | | | |

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| | (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. | | | |
| | Based on interview and record review, the facility failed to ensure pneumonia vaccine policies and procedures were followed for 2 of 5 residents reviewed.<br>(Resident 27 and Resident 21) | F 0883 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Residents 27 and 21 have been given the* | 10/09/2019 |

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| | Findings include:<br><br>1. On 9/9/19 at 10:30 a.m., the clinical record of Resident 27 was reviewed. The Nursing Admission form indicated the resident was admitted on 1/24/18. Documentation was lacking on the nursing admission form as to date of last pneumonia vaccine.<br><br>The Immunizations Report, indicated the resident was currently 79 years old in 2019. The report indicated the resident had a Pneumovax 23 administered on 2/5/18 (resident would have been 77 years old upon receipt of this vaccine). The only documented pneumona vaccine on the report was dated 2/5/18. Documentation was lacking of the resident having been offered and received and/or refused the Prevnar 13 vaccine.<br><br>An informed consent for the Pneumococcal Vaccine was dated 9/25/18 and the resident had signed the consent providing her giving the facility her permission to administer a pneumococcal vaccination.<br><br>2. On 9/9/19 at 10:55 a.m. the clinical record of Resident 21 was reviewed. The nursing Admission form indicated the resident had been admitted on 2/24/16. Documentation indicated the date of last pneumovac was 10/1/2012.<br><br>The Immunization Report, indicated the resident was over 65 years of age in 2012, when the "pneumococcal vaccine" was documented as historically having been administered. On 9/17/16, a "Pneumococcal" vaccine was documented as having been administered. Documentation was lacking as to if the vaccine administered on | | *Prevnar 13 vaccination.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *All residents at risk of Pneumococcal Disease have the potential to affected by the deficient practice. An audit of all current resident Pneumococcal vaccination status will be performed to identify those in need of vaccinations, orders will be obtained, and vaccinations will be administered as appropriate.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *All nurses have been educated on Pneumococcal Vaccination policy. A current resident audit will be performed to identify those residents in need of Pneumococcal vaccinations, new admissions will be audited to ensure the proper pneumococcal vaccinations have been offered and received if appropriate.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *The DON/Designee will audit all new* | |

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| | 9/17/16 was a Pneumoccal 23 (PPSV23) or the Prevnar 13 (PCV 13).<br><br>On 9/9/19 at 3:50 p.m., the Director of Nursing (DON) was interviewed. She indicated she had called the facility pharmacy and the pharmacy indicated the resident had a Pneumococcal Vaccine 23 administered on 9/17/16.<br><br>Documentation was lacking in the clinical record of the resident having been offered a dose of PCV 13 at least 1 year apart from the dose of PPSV23 administed to a resident at age over 65.<br><br>On 9/6/19 at 11:00 a.m., a copy of the facility policy and procedure for "Pneumococcal Vaccine" dated August 2016, was received from the DON. The policy included, but was not limited to, the following: Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneuococcal vaccination status will be conducted within 5 days working days of the resident's admission if not conducted prior to admission. Admission of the pneumonococcal vaccines ro revaccinations will be made in accordance with current Centers for Disease Control and Prevention recommendations at the time of the vaccinations.<br><br>The CDC Pneumococcal Vaccine Timing for Adults document, dated 11/30/15, indicated the following: For those who have previously received 1 dose of PPSV23 at age over 65 and no doses of PCV 13, administer 1 dose of PCV 13 at least 1 year after the dose of PPSV23 for adults, regardless of medical condition. | | *admissions for Pneumococcal vaccination need M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review to ensure increased compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.* | |

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| | 155501 | A. BUILDING 00<br>B. WING | 09/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SIGNATURE HEALTHCARE OF BLUFFTON | 1529 W LANCASTER ST<br>BLUFFTON, IN 46714 |

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| F 9999<br><br>Bldg. 00 | 3.1-18(b)(5)<br><br>3.1-14 PERSONNEL<br><br>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:<br>(7) Documentation of orientation to the facility and to the specific job skills.<br>(8) Signed acknowledgement of orientation to residents' rights.<br>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department - approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:<br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a | F 9999 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Executive Director – completed general orientation and job specific orientation, Interim Director of Nursing – physical completed, acknowledged resident rights, general facility orientation, and job specific orientation.*<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: A *complete audit was conducted on all current employees for the following: TB test 1 and 2, general facility orientation, job specific orientation, resident rights and dementia training by the business office manager. Any missing documents were signed by appropriate staff.*<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *The Business Office* | 10/09/2019 |

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| | second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.<br><br>Based on interview and record review, the facility failed to ensure employee records were complete for 4 out of 6 employees reviewed for accurate and complete records.<br><br>Findings include:<br><br>A review of Employee Personnel Records on 9/6/2019 at 2:33 p.m., the following was indicated:<br><br>The Executive Director had no general facility orientation and no job specific orientation.<br><br>The Interim Director of Nursing had no physical examination, no signed acknowledgement of resident rights, no general facility orientation and no job specific orientation.<br><br>LPN (Licensed Practical Nurse) 1 had no completed tuberculin skin test completed and read prior to starting work, no job specific orientation, and no 6 hours of dementia training. | | *Manager/Designee has been educated on documents needed for employee files. The Business Office Manager or Designee will complete a monthly audit of employee files for TB test 1 and 2, general facility orientation, job specific orientation, resident rights and dementia training. Any missing items will be brought to attention of the appropriate Department Director and / or Administrator for intervention and follow up.*<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *The Business Office Manager will complete a monthly audit of employee and new employee files for the following: TB test 1 and 2, general facility orientation, job specific orientation, resident rights and dementia training. Education ad orientation will be conducted on any missing items. Monthly audits will be completed until there are 3 consecutive months of 100 % compliance. Then quarterly audits thee after. All audits will be submitted to QAPI for further interventions.* | |

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| | CNA (Certified Nurse Aid) 10 had no completed tuberculin skin test completed and read prior to starting work, no general facility orientaion, and no job specific orientation.<br><br>During an interview on 9/9/2019 at 2:10 p.m., the Business Office Manager (BOM) indicated the system for the employee records had fell apart when former admistrative personnel had left.<br><br>During an interview on 9/9/2019 at 4:30 p.m., the Interim Director of Nursing indicated the facility had no policy that regarded employee records. | | | |