DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	09/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 10, 11, 12, 13, and 14, 2018. Facility number: 011032 Provider number: 155683 AIM number: 200262860 Census bed type: SNF/NF: 1 NF: 23 Total: 24 Census payor type: Medicaid: 24 Total: 24 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 24, 2018	F 0000	Please accept this as our credible allegation of compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;			

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	(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must			

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	provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to notify the ombudsman that residents had discharged for 1 of 1 residents reviewed for hospitalization and 1 of 1 residents reviewed for discharge. (Resident 26 and 27) Findings include: 1. The clinical record for Resident 26 was reviewed on 9/13/18 at 12:00 p.m. The diagnosis for Resident 26 included, but was not limited to dementia. Resident 26 was discharged on 6/25/18 to another facility. The "Recap of Resident's stay" document for Resident 26 indicated "..Resident admitted to facility in w/c (wheelchair), transported by son, discharged the same way.." A transfer form dated 6/29/18, indicated Resident 26 was transferred to an Assisted Living as of 6/25/18. There was no documented notification with the Ombudsman Resident 26 had discharged. An interview was conducted with License Practical Nurse (LPN) 3 on 9/14/18 at 11:47 a.m. She indicated the staff does not notify the Ombudsman of any residents' discharges. 2. The clinical record for Resident 27 was reviewed	F 0623	An immediate call was made to the Ombudsman. A plan was put in place whereas the Ombudsman will be notified of any transfers and discharges. A record sheet of all discharges and transfers will be kept and sent to the Ombudsman on a monthly basis if any occurred during that month. All other resident's charts were audited. No other residents were identified as being affected. After speaking with the Ombudsman, an agreement was reached where a list of transfers and discharges will be faxed to him/her on a monthly basis. The resident discharge and transfer list will be checked monthly by the Administrator. This will be on an ongoing basis.	10/14/2018

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	on 9/13/18 at 12:30 p.m. The diagnosis for Resident 27 included, but was not limited to, psychosis. Resident 27 was discharged on 6/14/18, to the hospital. A physician order dated 6/14/18, indicated Resident 27 was transferred for emergency admission to psychiatric hospital. A physician order dated 6/15/18, indicated Resident 27 was discharged to another facility. An interview was conducted with LPN 3 on 9/14/18 at 11:42 a.m. She indicated Resident 27 had been discharged to the hospital on 6/14/18. Then, during her hospitalization, Resident 27 had been discharged from the hospital to another facility on 6/15/18. Resident 27 had not returned to the facility. LPN 3 indicated discharge documentation was completed, but staff had not notified the ombudsman of Resident 27's discharge. 3.1-12(a)(6)(A)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure accuracy of MDS (Minimum Data Set) assessment regarding Preadmission of Resident Review (PASARR) level II for 1 of 24 residents reviewed. (Resident 21) The clinical record for Resident 21 was reviewed on 9/13/18 at 12:00 p.m. The diagnosis for Resident 21 included, but was not limited to psychosis.	F 0641	Midtown, a mental health provider, was immediately notified and the Level 2 was completed. All resident's had the potential to be affected by this deficient practice. All residents were checked to ensure that no one else needed to be evaluated for a Level 2. One other resident was found to be in need of an updated Level 2. A Level 2 was completed	10/14/2018

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	An Annual MDS assessment dated 4/19/18, indicated Resident 21 had not been evaluated by a level II. A quarterly MDS assessment dated 7/12/18, indicated Resident 21 had not been evaluated by a level II. A level II dated 2015, indicated Resident 21 had been evaluated. An interview was conducted with the Social Services Director on 9/14/18 at 10:11 a.m. She indicated a level II had been completed on 2015 for Resident 21.		for this resident as well. No other residents were found to be in need of a Level 2. A log book of residents with Level 2's, those needing Level 2's, and those with annual Level 2 evaluations will be kept and monitored on a monthly basis. This book will be monitored monthly by the Social Services Director and Administrator. The monitoring of this log book will be done on a continuous basis.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.			
	Based on interview and record review, the facility to ensure a yearly resident review was completed	F 0644	Resident 20 was immediately seen by Midtown Mental Health	10/14/2018

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	for 1 of 1 residents reviewed for Preadmission Screening and Resident Review (PASARR). (Resident 20) Findings include: The clinical record for Resident 20 was reviewed on 9/11/18 at 9:00 a.m. The diagnosis for Resident 20 included, but was not limited to schizophrenia. A level II dated 2014, indicated Resident 20 was to have a yearly resident review. There was no level II dated 2015, in Resident 20's clinical record. An interview was conducted with Social Services Director on 9/11/18 at 2:29 p.m. She indicated she had contacted the representative that had done the level IIs for the facility, because she could not locate a level II since 2014. An interview was conducted with the PASARR representative on 9/12/18 at 9:09 a.m. He indicated Resident 20 had been followed by psych, but Resident 20's yearly review had not been completed after 2014.		and a Level 2 was completed. All residents had the potential to be affected by this deficient practice. All other residents were checked to ascertain whether they needed to be evaluated for a Level 2. One other resident was found to be in need of an updated Level 2. A Level 2 was completed for this resident as well. No other residents were found to be in need of a Level 2. A log book of residents with Level 2's, those needing Level 2's, and those with annual Level 2 evaluations will be kept and monitored on a monthly basis. This book will be monitored monthly by the Social Services Director and Administrator. The monitoring of this log book will be done on a continuous basis.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

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	Based on interview and record review, the facility failed to administer residents' hypertension medication and insulin, as ordered, for 2 of 5 residents reviewed for unnecessary medications. (Residents 10 and 22) Findings include: 1. The clinical record for Resident 22 was reviewed on 9/12/18 at 12:18 p.m. The diagnoses for Resident 22 included, but were not limited to, hypertension. The 6/27/18 hypertension care plan for Resident 22 indicated to administer medications as ordered. The 8/23/18 After Visit Summary from a neurology clinic read, "BP (blood pressure) seems to continue to be high. Will go up on propranolol to the XR formulation, 240 mg nightly, to see if both the BP can be lower/more smooth, and to help the tremor more...Blood Pressure 160/105." It indicated to start taking 2 tablets of propranolol XL 120 mg at bedtime. The August and September, 2018 MARs (medication administration records) indicated Resident 22 did not begin taking the 240 mg of Propranolol XL nightly until 9/8/18. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated Resident 22 did not receive the Propranolol XL 240 mg nightly, as ordered, because the medication was not at the facility. She indicated she informed nursing staff if a medication was unavailable, to let the physician know, but they didn't. 2. The clinical record for Resident 10 was	F 0684	The D.O.N. looked up the medication in question and found that it required a prior approval. The D.O.N. gave an inservice on what is to be done when a medication is unavailable. The medication is currently present and is being given as ordered. The Medical Director was notified of the medication error. The diabetic coverage was checked and a new system of monitoring the coverage was put into place. Coverage will be put on the accu-check sheet and the M.A.R. No others were found to be affected by this deficient practice. No orders will be transcribed until the medication is available. The MD will be notified and a substitute will be given if possible. The accu-check sheets and the M.A.R. will both have insulin coverage on them as a method of double checking to ensure accuracy. This will be monitored by the D.O.N. and charge nurse daily for one month, then bi-weekly for one month, and then monthly on a continuous basis. This process will then be evaluated by the QA Committee for its effectiveness.	10/14/2018

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reviewed on 9/13/18 at 3:24 p.m. The diagnoses for Resident 10 included, but were not limited to, diabetes mellitus.

The 8/8/18 diabetes care plan for Resident 10 indicated to administer his medications as ordered.

The 8/22/18 physician's order indicated sliding scale Humalog to be administered for the following blood sugar readings as follows:

250-299 = 4 Units
300-349 = 6 Units
350 - 399 = 8 Units

The August and September, 2018 MARs (medication administration records) indicated to "See Blood Sugar Record" for sliding scale insulin administrations.

The August and September, 2018 Diabetic Accucheck Chart indicated Resident 10 did not receive any sliding scale Humalog on the following days for the following blood sugar readings:

8/23/18, 11:00 a.m. = 300
8/23/18, 9:00 p.m. = 303
9/1/18 6:00 a.m. = 252
9/4/18, 6:00 a.m. = 256
9/5/18, 6:00 a.m. = 265
9/6/18, 6:00 a.m. = 270
9/11/18, 6:00 a.m. = 250

An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated there was no other information to indicate sliding scale Humalog was given on the above days.

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	3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, and interview the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit, at point of use, for 3 of 24 residents whose water temperatures were observed (Residents 13, Resident 14, and Resident 15) Findings include: On 9/11/18 at 10:53 a.m., the shared bathroom of resident 13, resident 14 and resident 15 was observed. The hot water coming from the bathroom faucet was 123.3 degrees Fahrenheit. On 9/14/18 at 10:45 a.m., the shared bathroom for resident 13, resident 14 and resident 15 was observed with the maintenance director during an environmental tour. The hot water temperature coming out of the sink was retrieved at 131.3 degrees Fahrenheit. The maintenance director indicated that there was steam was coming off of the water running out of the sink. During an interview on 9/14/18 at 10:50 a.m., the maintenance director indicated that a mixing valve,	F 0689	The water temperature was fixed immediately. A new gauge that monitors the water's temperature was put in place by the Maintenance Supervisor. All residents had the potential to be affected by this deficient practice. No residents were found to be harmed by this deficient practice. All residents were kept safe until the water temperature was controlled and maintained. It took approximately 20 minutes for the new gauge to be installed. The water temperature and the gauge that monitors the temperature will be checked weekly by the Maintenance Supervisor to ensure that the temperature is in the correct range and the gauge is functioning correctly. All employees will notify the Maintenance Supervisor if they think the water is too hot or not hot enough.	10/14/2018

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	which regulates the hot water temperature, needed repaired, causing the fluctuation in water temperatures. 3.1-45(a)		This will be monitored by the Administrator, D.O.N., and Maintenance Supervisor weekly on a continuous basis.	
F 0711 SS=E Bldg. 00	483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.			
	Based on interview and record review, the facility failed to ensure the physician wrote, signed, and dated progress notes at each visit for 6 of 6 residents reviewed for unnecessary medications. (Residents 1, 5, 10, 14, 16, and 22) Findings include: 1. The clinical record for Resident 10 was reviewed on 9/13/18 at 3:24 p.m. The diagnoses for Resident 10 included, but were not limited to, neuropathy and epilepsy. An interview was conducted with Resident 10 on 9/11/18 at 11:43 a.m. He indicated he'd fallen about 10 times within the past few months, but	F 0711	All charts were audited for missing progress notes. The MD was notified about the missing progress notes. He stated that he and the nurse practitioner would be on October 6th and 7th to update all resident's records. All residents had the potential to be affected by this deficient practice. All resident's charts were audited. Those that were found to be affected were put on the list to be corrected by the MD on the dates listed above. A monthly list of residents in need of progress notes will be placed in	10/14/2018

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	hadn't seen his physician to inform him of this. The most recent Physician's Note in the clinical record was dated 3/29/18. An interview was conducted with LPN (Licensed Practical Nurse) #3 on 9/14/18 at 10:04 a.m. She indicated there were no more physician or nurse practitioner progress notes, other than what was already in the clinical record. She indicated the physician was in the facility the previous week, but did not leave any progress notes. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated the nurse practitioner came into the facility "the other day for a minute." She indicated the physician came in once a month. The DON indicated she was aware of the lack of physician progress notes in residents' clinical records and planned to discuss the visits and progress notes with the nurse practitioner and physician next month. 2. The clinical record for Resident 22 was reviewed on 9/12/18 at 12:18 p.m. The diagnoses for Resident 22 included, but were not limited to, bipolar disorder and hypertension. The most recent Physician's Note in the clinical record was dated 1/30/18. An interview was conducted with LPN (Licensed Practical Nurse) #3 on 9/14/18 at 10:04 a.m. She indicated there were no more physician or nurse practitioner progress notes, other than what was already in the clinical record. She indicated the physician was in the facility the previous week, but did not leave any progress notes.		the MD's folder to be evaluated by him and his staff each month. This will be monitored monthly by the D.O.N. and the day charge nurse on an ongoing basis and will be evaluated for its effectiveness by the QA Committee on a quarterly basis.	

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	An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated the nurse practitioner came into the facility "the other day for a minute." She indicated the physician came in once a month. The DON indicated she was aware of the lack of physician progress notes in residents' clinical records and planned to discuss the visits and progress notes with the nurse practitioner and physician next month.3. The clinical record for Resident 1 was reviewed on 9/12/18 at 9:00 a.m. The diagnosis for Resident 1 included, but was not limited to schizophrenia. A physician progress note dated 1/30/18, indicated Resident 1 was seen by the Nurse Practitioner (NP) on 1/30/18. There was no other physician progress notes in Resident 1's medical record. An interview was conducted with License Practical Nurse (LPN) 4 on 9/13/18 at 10:24 a.m. She indicated there was a scheduled meeting in October 2018, regarding physician progress notes were needed with resident visits. She was unable to locate any other physician progress notes since January 2018, for Resident 1. She would need to contact the physician's office to see if she could provide. An interview was conducted with LPN 3 on 9/14/18 at 10:04 a.m. She indicated she was unable to provide any additional physician progress notes from the Medical Provider or Nurse Practitioner for Resident 1. 4. The clinical record for resident 5 was reviewed on 9/12/18 at 12:21 p.m. The diagnosis for resident 5 included, but were not limited to,			

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dementia and delusional disorder.

An attending physician's progress note dated 1/26/18 was present in the clinical record. No other attending physician's progress notes were present in any other tab in the clinical record.

During an interview on 9/14/18 at 12:45 p.m., LPN (licensed practical nurse) 3 indicated there were no other physician's progress notes available for resident 5. The physician had not provided the facility with any additional progress notes.

5. The clinical record for resident 14 was reviewed on 9/11/18 at 11:04 a.m. The diagnosis for resident 14 included, but were not limited to, dementia and schizophrenia.

An attending physician's progress note dated 1/26/18 was present in the clinical record. No other attending physician's progress notes were present in any other tab in the clinical record.

During an interview on 9/14/18 at 12:45 p.m., LPN 3 indicated there were no other physician's progress notes available for resident 14. The physician had not provided the facility with any additional progress notes.

6. The clinical record for resident 16 was reviewed on 9/11/18 at 11:51 a.m. The diagnosis for resident 16 included, but were not limited to, dementia and schizophrenia.

An attending physician's progress noted dated 3/28/18 was present in the clinical record. No other attending physician's progress notes were present in any other tab in the clinical record.

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	During an interview on 9/14/18 at 12:45 p.m., LPN 3 indicated there were no other physician's progress notes available for resident 16. The physician had not provided the facility with any additional progress notes. 3.1-22(b)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §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. Based on observation, interview and record review the facility failed to provide individualized dementia services to promote bathing for 1 of 2 reviewed for dementia services. (Resident 5) Findings include: The clinical record for resident 5 was reviewed on 9/12/18 at 12:21 p.m. The diagnosis for resident 5 included, but were not limited to, dementia and delusional disorder. A quarterly MDS (Minimum Data Set) assessment completed 5/24/18 indicated that resident 5 had cognitive impairment. He needed 1 person physical assistance with bathing, limited to transfers only. On 9/11/18 at 11:30 a.m., resident 5 was observed sitting on his bed. His clothing was clean and the room was free of odors. The clinical record for resident 5 contained a	F 0744	The prn medication for anxiety was discontinued by the physician. A no rinse body wash was obtained to assist the resident in bathing. He is allowed to wash up at the sink as opposed to taking a shower. No other residents were found to be affected. A no rinse body wash was supplied and is being kept in the resident's room. The resident's immediate family was notified that the medication was discontinued and a no rinse body wash will be supplied for the resident. The body wash will be replenished as needed. This will be checked weekly by the cna's and reported to the charge nurse when the body wash needs to be replenished. This will be an ongoing process.	10/14/2018

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	nurses note by LPN 3, dated 9/5/18 at 2:15 p.m., read, " constantly refuses showers, stating he washes up in the sink....". A nurse's note by LPN 4, dated 9/6/18 at 10: 38 a.m., read, "took shower but refuse to allow this writer to put lotion of feet." During an interview on 9/12/18 at 2:45 p.m., CNA (certified nursing assistant) 2 indicated resident 5 refused showers and becomes upset when asked about showers. When he becomes upset she lets him calm down and then reappoach later, but that it did not always work. Resident 5 does not like to take a shower. A care plan for resident 5, updated 8/29/18, read, "Rejects care... related to ... cognitive impairment... Goal... Resident will demonstrate compliance with bathing and grooming...Interventions...set goals with resident...assist resident to describe preferred routine... offer as many choices as possible...enlist assistance of residents sister when adamant about refusal.." A care plan for resident 5, updated 8/29/18, read, "Resident is independent in late loss ADL's (activities of daily living) of bed mobility and eating. He needs assistance with toileting and transfers and with bathing... Interventions....structure bathing activities to match resident's preferences....Prefers showers A.M..." During an interview on 9/12/18 at 3:05 p.m., the SSD (social service director) indicated the staff offer him a lot of encouragement to bathe. He frequently stated he was bathing in the sink, but there was no evidence that he does. The staff reapproaches him when he has refused to shower.			

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She was unsure of how he bathed prior to being in a facility. She indicated that intervention of calling his sister when adamant about refusals had been added to the care plan when it was rewritten on 3/14/18, and that the sister was not helpful in encouraging him to bath. There had been no new non pharmaceutical interventions tried to encourage him to bathe.

A psychology progress note, dated 8/16/18, read, ".....recommendations for attending physician: .....2) In view of increased anxiety and agitation on shower days, you may wish to consider the medical appropriateness of adding Ativan 0.5 mg... to be administered twice per week prior to patient's scheduled shower for better control of anxiety and agitation..".

The clinical record contained a physician's order dated 9/4/18, read, ".... add Ativan (antianxiety medication) .0.5 mg (milligrams) twice per week for control anxiety". The MAR (medication administration record) for resident 5 indicated he had received Ativan 0.5 mg on 9/10/18 at 5:00 p.m., and 9/12/18 at 5:00 p.m.

During an interview on 9/13/18 at 9:30 a.m., LPN 4 indicated that resident 5 had allowed CNA 1 to shower him that morning without refusing or being upset about the shower.

During an interview on 9/13/18 at 11:30 a.m., the DON (director of nursing) indicated resident 5 became fearful and hated the whole process of taking a shower. They had offered bed baths but he does not like those either. The facility tries to provide showers whenever he would allow. The physician had added Ativan prior to showers to help him due to his anxiety about showers. She indicated that he had an odor problem and that a

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	shower was the only way to get him clean. The DON indicated that no rinse shampoos and body washes had not been offered or tried as an alternative to showering. On 9/14/18 at 11:45 a.m., resident 5's sister was interviewed. She indicated that the she would prefer he did not receive showers due to them upsetting him so much, and that she had not been notified of the addition of Ativan to his medications. She indicated that the facility had not included her in resident 5's plan of care. She would prefer that he be allowed to wash up at the sink. 3.1-37			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review, the facility failed to assist in seeking a representative for 1 of 1 resident reviewed for Pre Admission Screening and Resident Review and 2 of 5 residents reviewed for Social Services. (Residents 14, 16, and 20) Findings include: 1. The clinical record for Resident 20 was reviewed on 9/11/18 at 9:00 a.m. The diagnoses for Resident 20 included, but were not limited to dementia and schizophrenia. A Psychological Evaluation dated 7/7/17, indicated, "...Mental Status	F 0745	The Social Service Director checked for resident's that need guardians or healthcare representatives. A plan is in place to obtain guardians or healthcare representatives for those that are in need. The residents that were found to be in need of a healthcare representative or guardian were placed on the list to have one appointed. All patients that have cognitive impairment diagnosis and have no available family will be assessed to determine if a healthcare representative or	10/14/2018

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	Examination:...Attention/Concentration: Severely Impaired...Immediate Memory: ..Severely Impaired..Recent Memory: ..Severely Impaired..Remote Memory: Severely Impaired...Insight: Severely Impaired..Judgment: Severely Impaired..." The 2/8/18, Annual MDS (minimum date set) Assessment indicated Resident 20 was cognitively impaired. The 5/3/18, quarterly MDS (minimum date set) Assessment indicated Resident 20 was cognitively impaired. The 7/26/18, quarterly MDS (minimum date set) Assessment indicated Resident 20 was cognitively impaired. A care plan dated 8/8/18, indicated "..Cognitive Deficit: Memory Problem related to Dementia/Schizophrenia as evidenced by: Able to participate in the BIMS (brief mental status) with a score of 6..." The resident face sheet indicated a case manager was Resident 20's representative which included contact information. The emergency contact information was marked NA (non applicable). A 2/8/18, Social Services progress note indicated Resident 20 had no family involvement. An interview was conducted with Resident 20's representative on 9/11/18 at 12:29 a.m. He indicated he had not been Resident 20's case manager for over a year. An interview was conducted with the Social Services Director on 9/14/18 at 1:10 p.m. She		guardian is required. All new residents will be monitored on admission to ensure that a family member, guardian, or health care representative are involved in their decision making process. If none are involved, one will be appointed.	

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indicated the facility recently realized a problem with no family or guardianship with some of the residents. She will be looking into finding a resource to help the residents with no family or guardians. 2. The clinical record for resident 14 was reviewed on 9/11/18 at 11:04 a.m. The diagnosis for resident 14 included, but were not limited to, dementia and schizophrenia.

A Quarterly MDS (Minimum Data Set) assessment completed 5/10/18, indicated that resident 14 was cognitively impaired.

A care plan updated on 8/15/18 indicated resident 14 had no family member involvement in his life.

A care plan updated on 8/15/18 indicated resident 14 needed assistance with decision making due to his cognitive impairment.

During an interview on 9/11/18 at 12:47 p.m., the emergency contact listed on resident 14's admission record indicated that he was a case manager with a mental health agency. He had not been involved in the care of resident 14 for over a year.

During an interview on 9/14/18 at 1:10 p.m., the SSD (social service director) indicated that resident 14 had no family member or guardian to assist with decisions or inform in case of emergency. The facility recently realized this was a problem and will be looking into finding a resource to assist resident 14, since he has no family or emergency contact. The facility had not contacted any resources as yet.

3. The clinical record for resident 16 was reviewed on 9/11/18 at 11:51 a.m. The diagnosis for resident 16 included, but were not limited to, dementia and

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	schizophrenia. An Annual MDS assessment completed 7/19/18 indicated resident 16 was cognitively impaired. A care plan, updated on 8/1/18, indicated resident 16 had a cognitive deficit and disordered thinking which was continually present. During an interview on 9/11/18 at 12:47 p.m., the emergency contact listed on resident 16's admission record indicated that he was a case manager with a mental health agency. He had not been involved in the care of resident 16 for over a year. During an interview on 9/14/18 at 1:10 p.m., the SSD indicated that resident 16 had no family member or guardian to assist with decisions or to inform in case of emergency. The facility recently realized this was a problem and will be looking into finding a resource to assist the resident 16, since she has no family or emergency contact. The facility had not contacted any resources as yet. 3.1-34(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

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	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on interview and record review, the facility failed to obtain a depakote lab, as ordered, to monitor a resident's depakote medication usage for 1 of 5 residents reviewed for unnecessary medications. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 9/12/18 at 12:18 p.m. The diagnoses for Resident 22 included, but were not limited to, bipolar disorder and depression. The August, 2018 Physician's Orders indicated 250 mg of depakote to be administered 3 times daily, effective 4/7/17, and to obtain a depakote level every 3 months. The most recent depakote lab result in Resident 10's clinical record was dated 4/3/18. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated there were no other depakote labs results for Resident 22.	F 0757	The labs were immediately obtained for resident #22. All charts were audited for missing labs and all labs were brought current. Labs will be monitored monthly. There will be a lab audit sheet to ensure that all labs are current. A lab audit book will be put in place and kept at the nurse's station. All charts will be audited monthly. This process will be monitored by the D.O.N. and charge nurse for 6 months and then evaluated by the QA Committee for its effectiveness.	10/14/2018

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	3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending			

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	physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on interview and record review, the facility failed to attempt non pharmaceutical interventions prior to initiating an anti-anxiety medication and to have a documented rationale for continuing a resident's PRN (as needed) antidepressant medication beyond 14 days and the duration of the order for 2 of 5 residents reviewed for unnecessary medications. (Residents 5 and 22) Findings include: 1. The clinical record for Resident 22 was reviewed on 9/12/18 at 12:18 p.m. The diagnoses for Resident 22 included, but were not limited to, bipolar disorder, depression, and insomnia. The August, 2018 Physician's Orders indicated 1/2 of a 50 mg tablet of trazodone to be administered once daily at bedtime, as needed, for insomnia, effective 5/16/17. No documented rationale for continuing the PRN trazodone beyond 14 days could be located in Resident 22's clinical record. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated they needed to get a clarification on	F 0758	The prn psychotropic medication for resident #22 was changed to routine 9pm for her diagnosis of insomnia. The Ativan for anxiety for resident #5 was discontinued. No other residents were found to be affected. All prn medications will be checked monthly when the re-writes are completed. All prn medications will be checked to see if they need to be continued, discontinued, or re-evaluated. If continuation is needed, an order will be obtained from the MD. This will be checked monthly by the D.O.N. and charge nurse on a continuous basis.	10/14/2018

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	Resident 22's trazodone order, because if she didn't receive it, she wouldn't go to sleep.2. The clinical record for resident 5 was reviewed on 9/12/18 at 12:21 p.m. The diagnosis for resident 5 included, but were not limited to, dementia and delusional disorder. The clinical record contained a physician's order dated 9/4/18, read, ".... add Ativan (antianxiety medication) .0.5 mg (milligrams) twice per week for control anxiety". The MAR (medication administration record) for resident 5 indicated he had received Ativan 0.5 mg on 9/10/18 at 5:00 p.m., and 9/12/18 at 5:00 p.m. A psychology progress note, dated 8/16/18, read, ".....recommendations for attending physician: .....2) In view of increased anxiety and agitation on shower days, you may wish to consider the medical appropriateness of adding Ativan 0.5 mg... to be administered twice per week prior to patient's scheduled shower for better control of anxiety and agitation..". The clinical record for resident 5 contained a nurses note by LPN (licensed practical nurse) 3, dated 9/5/18 at 2:15 p.m., read, " constantly refuses showers, stating he washes up in the sink....". A nurse's note by LPN 4, dated 9/6/18 at 10: 38 a.m., read, "took shower but refuse to allow this writer to put lotion of feet." During an interview on 9/12/18 at 2:45 p.m., CNA(certified nursing assistant) 2 indicated resident 5 refused showers and becomes upset when asked about showers. When he becomes upset she lets him calm down and then reappoach later, but that it did not always work. Resident 5 did not like to take a shower.			

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	A care plan for resident 5, updated 8/29/18, read, "Rejects care... related to ... cognitive impairment... Goal... Resident will demonstrate compliance with bathing and grooming...Interventions...set goals with resident...assist resident to describe preferred routine... offer as many choices as possible...enlist assistance of residents sister when adamant about refusal.." During an interview on 9/12/18 at 3:05 p.m., the SSD (social service director) indicated the staff offer him a lot of encouragement to bathe. He frequently stated he was bathing in the sink, but there was no evidence that he does. The staff reapproaches him when he has refused to shower. She was unsure of how he bathed prior to being in a facility. She indicated that intervention of calling his sister when adamant about refusals had been added to the care plan when it was rewritten on 3/14/18, and that the sister was not helpful in encouraging him to bath. There had been no new non pharmaceutical interventions tried to encourage him to bathe. During an interview on 9/13/18 at 11:30 a.m., the DON (director of nursing) indicated resident 5 became fearful and hated the whole process of taking a shower. They had offered bed baths but he did not like those either. The facility tries to provide showers whenever he would allow. The physician had added Ativan prior to showers to help him due to his anxiety about showers. She indicated that he had an odor problem and that a shower was the only way to get him clean. The DON indicated that no rinse shampoos and body washes had not been offered or tried as an alternative to showering. The clinical record indicated resident 4 had taken			

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	a shower on 8/9/18 at 10:30 a.m., and on 9/6/18 at 10:30 a.m.. During an interview on 9/13/18 at 9:30 a.m., LPN 4 indicated that resident had allowed CNA 1 to shower him that morning without refusing or being upset about the shower. She indicated that resident 5 had not received Ativan 0.5 mg prior to receiving the shower. 3.1-48(a)(4)			
F 0772 SS=D Bldg. 00	483.50(a)(1)(iv) Lab Services Not Provided On-Site §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.			
	Based on interview and record review, the facility failed to obtain labs, as ordered, for 2 of 5 residents reviewed for unnecessary medications. (Resident 10 and 22) Findings include: 1. The clinical record for Resident 10 was reviewed on 9/13/18 at 3:24 p.m. The diagnoses for Resident 10 included, but were not limited to, diabetes mellitus. The September, 2018 physician's Orders for Resident 10 indicated to obtain an HGB A1C (glycated hemoblobin) lab every 6 months.	F 0772	All charts were audited for labs and brought current. All residents had the potential to be affected. Those found to be affected were fixed immediately. All charts will be audited by the D.O.N. and charge nurse on a monthly basis. A lab audit book will be put in place at the nurse's station. This book will be audited by the D.O.N. or charge nurse and monitored by the D.O.N. monthly, on an ongoing basis to ensure its accuracy. This process will then be monitored quarterly by the QA Committee for its effectiveness.	10/14/2018

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	The most recent HGB A1C lab result in Resident 10's clinical record was dated 11/21/17. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated there were no other HGB A1C lab results for Resident 10. 2. The clinical record for Resident 22 was reviewed on 9/12/18 at 12:18 p.m. The diagnoses for Resident 22 included, but were not limited to, hypertension and diabetes mellitus. The August, 2018 Physician's Orders indicated to obtain HGBA1C (glycated hemoglobin) and CMP (complete metabolic panel) labs every 3 months. The most recent HGB A1C lab result in Resident 10's clinical record was dated 5/10/18, and the most recent CMP lab result was dated 4/3/18. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 9:55 a.m. She indicated there were no other HGB A1C or CMP lab results for Resident 22. 3.1-49(a)			
F 0803 SS=C Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;			

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	§483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.			
	Based on observation, interview, and record review, the facility failed to follow their dietary menu. This affected 24 of 24 residents in the facility. Findings include: An interview was conducted with Resident 12 on 9/11/18 at 10:05 a.m. He indicated he had a concern with the food in the facility, in that the same items were served over and over. An interview was conducted with Resident 22 on 9/11/18 at 11:27 a.m. She indicated she did not like the food in the facility and the same items were frequently served. An interview was conducted with Resident 25 on 9/11/18 at 10:09 a.m. He indicated the facility did not offer substitutes at meals, if he did not like what they were serving. Cook #7 provided the current facility menu on	F 0803	The Administrator and Dietician had a meeting to discuss and update the menus. Certain items were removed and others were added depending on the resident's likes and dislikes. In conclusion, the Administrator will purchase all items on the menu and substitute as necessary. All residents had the potential to be affected. The Dietitian will check the menus and the food inventory every Wednesday when she is in the facility. The menus will be followed unless substitutions are necessary. When items from a meal are substituted, they will be displayed in a common area where the residents can easily see. This process will be monitored by the Administration and Dietitian on	10/14/2018

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	9/12/18 at 11:10 a.m. It indicated the lunch meal on 9/11/18 was to be pork chops, baked potatoes, carrots, carrot cake, a slice of bread, margarine, and milk. It indicated the lunch meal on 9/12/18 was to be a fruit plate, meat salad or cottage cheese, red jello with topping, a blueberry muffin, milk, and tomato juice. An observation of the kitchen and main dining room was made on 9/11/18 at 12:00 p.m. The lunch meal consisted of pork chops, mixed vegetables, and mixed fruit. There was no carrot cake. A test tray of the lunch served to residents on 9/12/18 was sampled on 9/12/18 at 1:10 p.m. It consisted of meat salad, macaroni salad, peas, pineapples, and water. There was no red jello, blueberry muffin, milk, or tomato juice. An interview was conducted with Resident 25 on 9/12/18 at 1:25 p.m. He indicated he did not receive a blueberry muffin for lunch that day or carrot cake on the previous day. An interview was conducted with Cook #7 on 9/12/18 at 11:40 a.m. She indicated they did not serve carrot cake for lunch on 9/11/18 or blueberry muffins and tomato juice for lunch on 9/12/18. She indicated the oven was broken, and was unsure if getting store bought desserts was an option. An interview was conducted with the Administrator on 9/13/18 at 11:45 a.m. He indicated there should have been a substitute for the tomato juice. The facility did not utilize meal tickets for residents to choose what they eat at meals. He indicated meals were different than what was on the menu, and they could purchase desserts that didn't require the oven, but didn't.		a weekly basis. Both will check to ensure that items listed on the menus are in inventory and if not, an adequate substitute will be made available. This will be monitored by the Administration and Dietitian weekly, on an ongoing basis.	

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	3.1-20(i)(4)			
F 0838 SS=C Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. 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: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (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; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (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.			

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	§483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (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; (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 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.			
	Based on interview and record review, the facility failed to conduct and document a facility wide assessment with the potential to affect 24 of 24 residents in the facility. Findings include: An entrance conference was conducted with the DON (Director of Nursing) on 9/10/18 at 6:30 p.m. The facility assessment was requested during this conference. The Centers for Medicare & Medicaid Services	F 0838	A policy on the facility assessment was put in place by the Administrator. All residents had the potential to be affected. A facility assessment policy was put in place. The assessment will be kept in the Administrator's office along with other policies and procedures and will be made available upon request.	10/14/2018

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	Entrance Conference Woksheet indicated information needed from the facility within four hours of entrance included the facility assessment. An interview was conducted with the Administrator on 9/12/18 at 10:40 a.m. The facility assessment had not been provided by this time, and was requested a second time. An interview was conducted with the DON on 9/12/18 at 11:45 a.m. The DON indicated the facility did not have a facility assessment at this time, but would work on putting one together.			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

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following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility to maintain infection control practices during medication administration observations for 7 of 7 residents observed, and failed to ensure a glucometer's manufacture instructions had recommendations on disinfecting prior to multi use for 2 of 10 residents that receive blood sugar test. (Resident 2, 3, 12, 13, 14, 15, 16, 21 and 23) Findings include: 1a. The clinical record for Resident 2 was reviewed on 9/12/18 at 1:00 p.m. The diagnosis for Resident 2 included, but was not limited to heart failure. 1b. The clinical record for Resident 19 was reviewed on 9/12/18 at 1:00 p.m. The diagnosis for Resident 19 included, but was not limited to aphasia. 1c. The clinical record for Resident 13 was reviewed on 9/12/18 at 1:00 p.m. The diagnosis for Resident 13 included, but was not limited to heart failure. 1d. The clinical record for Resident 12 was reviewed on 9/12/18 at 2:00 p.m. The diagnosis for Resident 12 included, but was not limited to dementia. 1e. The clinical record for Resident 15 was reviewed on 9/12/18 at 11:30 p.m. The diagnosis	F 0880	A new disinfectant for the sanitation of the glucometer was immediately purchased. New glucometers were purchased for each resident on blood sugars. One on One medication passes were given to both QMA's on proper med pass and hand washing techniques. All residents had the potential to be affected. The D.O.N. will do a medication pass once weekly with QMA's and nurses to ensure proper sanitation is maintained during medication passes. This will be monitored weekly by the D.O.N. on an ongoing basis. This process will be evaluated quarterly for effectiveness by the QA Committee.	10/14/2018

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for Resident 15 included, but was not limited to dementia.

1f. The clinical record for Resident 14 was reviewed on 9/12/18 at 12:30 p.m. The diagnosis for Resident 14 included, but was not limited to dementia.

1g. The clinical record for Resident 3 was reviewed on 9/12/18 at 12:00 p.m. The diagnosis for Resident 3 included, but was not limited to schizophrenia.

An observation was made of medication administrations with Qualified Medication Aide (QMA) 5 on 09/12/18 at 8:40 a.m. QMA 5 used hand hygiene prior to preparing medication for Resident 19. She removed the medication cards and popped the pills into individual paper medication cups. One medication cup tipped over and a pill dropped out of the cup onto the medication cart. QMA 5 was observed donning gloves and placed the pill back into the medication cup. She then stacked the paper medication cups inside one another. QMA 5 entered Resident 19's room and administered the medication. During the preparation of Resident 12's medication she placed each pill in individual paper medication cups. QMA 5 then stacked the paper cups inside one another and entered Resident 12's room and administered the medication. QMA 5 then prepared Resident 2's medication. QMA 5 touched the following during the preparing the medication: medication and water cups, water pitcher, MAR, keys, and medication cards. After preparing the medication, she then stacked 4 individual paper medication cups with each pill in them inside one another. QMA 5 then entered Resident 2's room and administered the cups of medications. She was

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	then observed donning gloves and administering eye drops to Resident 2. There was no hand hygiene prior to donning her gloves. QMA 5 removed her gloves and left the room. After hand hygiene, QMA 5 prepared Resident 13's medication and stacked 4 individual paper medication cups with pills in them inside one another and then administered the medication to Resident 2. QMA 5 then used hand hygiene and prepared Resident 15's medication. During preparation, QMA 5 was observed touching the following: MAR, medication cards, medication and drinking cups, water pitcher, keys and lock to cart. After popping the pills in 6 individual paper medication cups she stacked each cup inside one another. She then entered Resident 15's room and administered the medication to him. After, QMA 5 donned gloves and administered eye drops to Resident 15. There was no hand hygiene prior to donning her gloves. She then removed her gloves and left the room. During the preparation of Resident 14's medication QMA 5 stacked 3 individual paper medication cups that she had placed 1 pill inside each of them. She then administered medication to Resident 14. QMA 5 left Resident 14's room and used hand hygiene. QMA 5 was observed preparing Resident 3's medication. She placed each pill in individual paper medication cups and then stacked the cups inside one another. She then administered to Resident 3. An interview was conducted with the Director of Nursing (DON) on 9/12/18 at 4:25 p.m. She indicated QMA 5 should not have administered the pill that had dropped on the medication cart, and she should have used hand hygiene prior to placing gloves on for administration of eye drops. The DON indicated QMA 5 was unaware she should not stack the medication cups on top of			

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eachother.

A "Eye Instillation" policy was provided by th DON on 9/14/18 at 8:45 a.m. It indicated, "...Purpose: To examine the eye...To treat infection...To Apply medications...2. Wash hands...3..Put on gloves.."

2a. The clinical record for Resident 23 was reviewed on 9/12/18 at 12:00 p.m. The diagnosis for Resident 23 included, but was not limited to diabetes.

2b. The clinical record for Resident 16 was reviewed on 9/12/18 at 9:40 a.m. The diagnosis for Resident 16 included, but was not limited to diabetes insipidus.

An observation was made of blood sugar tests with QMA 5 on 9/12/18 at 12:02 p.m. QMA 5 removed the glucometer from a black zipped case from the top drawer of the medication cart. She then wiped the glucometer with a disinfectant wipe and set the glucometer on a paper towel. After, she gathered the remaining supplies, used hand hygiene and then entered Resident 23's room. QMA 5 then donned gloves and used an alcohol wipe to wipe Resident 23's finger. She used a lancet and stuck Resident 23's finger. QMA 5 placed a droplet of blood on the strip and waited for the reading. She then removed her gloves and exited the room. After hand hygiene was used, QMA 5 then was observed preparing the glucometer for Resident 16's blood sugar test. QMA 5 using the disinfectant wipe cleaned the glucometer and sat it on a paper towel. QMA 5 then gathered her supplies and entered Resident 16's room. She donned gloves to complete the blood sugar test on Resident 16.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview was conducted with QMA 5 on 9/17/18 at 12:15 p.m. She indicated the glucometer was used for all residents needing blood sugar tests. The manufacture instructions for the glucometer was provided by the Director of Nursing (DON) on 9/12/18 at 3:19 p.m. It indicated, "..Cleaning the Meter..If the Meter gets dirty, use a moist (not wet) lint-free cloth dampened with a mild detergent. Do not get water inside the Meter or hold it under running water. Do not use glass or household cleaners on the Meter. Do not try to clean the test strip holder.." "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" at The Centers for Disease Control and Prevention (CDC) website at www.cdc.gov dated 6/8/17, was retrieved on 9/12/18. It indicated "..Recommended Practices for Preventing Bloodborne Pathogen Transmission during Blood Glucose Monitoring and Insulin Administration in Healthcare Settings...Blood Glucose Meters..Whenever possible meters must not be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared..." 3.1-18(a) 3.1-18(l)			
F 0919 SS=E Bldg. 00	483.90(g)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	09/14/2018

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	through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure working call lights were in the residents' restroom for 9 of 24 residents whose restrooms were observed. (Resident 1, 2, 3, 4,12, 13, 14, 15, 21) Findings include: 1. The clinical record for Resident 21 was reviewed on 9/13/18 at 12:00 p.m. The diagnosis for Resident 21 included, but was not limited to psychosis The clinical record for Resident 3 was reviewed on 9/12/18 at 12:00 p.m. The diagnosis for Resident 3 included, but was not limited to schizophrenia. An observation was made of Resident 21 and Resident 3's bathroom on 9/11/18 at 10:32 a.m. The call light in the bathroom did not light up or make a sound. 2. The clinical record for Resident 14 was reviewed on 9/12/18 at 2:30 p.m. The diagnosis for Resident 14 included, but was not limited to schizophrenia. The clinical record for Resident 13 was reviewed on 9/12/18 at 3:00 p.m. The diagnosis for Resident 13 included, but was not limited to dementia. The clinical record for Resident 15 was reviewed on 9/12/18 at 1:00 p.m. The diagnosis for Resident 15 included, but was not limited to dementia.	F 0919	The Maintenance Supervisor repaired all malfunctioning call lights. All residents had the potential to be affected. CNA's will check to ensure that the call lights in each room are working correctly during their rounds. Any call lights, found to be malfunctioning, will be reported to the charge nurse or Administrator who will report the problem immediately to the Maintenance Service for an immediate repair. This will be monitored by the CNA's daily during their rounds and weekly by the Maintenance Supervisor and Administrator, who will both check to ensure that all call lights are working properly on an ongoing basis.	10/14/2018

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An observation was made on 9/11/18 at 10:26 a.m., of Residents 13, 14 and 15's bathroom. The call light in the bathroom did not turn on.

3. The clinical record for Resident 1 was reviewed on 9/12/18 at 9:00 a.m. The diagnosis for Resident 1 included, but was not limited to schizophrenia.

The clinical record for Resident 2 was reviewed on 9/12/18 at 1:00 p.m. The diagnosis for Resident 2 included, but was not limited to heart failure.

The clinical record for Resident 4 was reviewed on 9/12/18 at 1:00 p.m. The diagnosis for Resident 4 included, but was not limited to heart failure.

The clinical record for Resident 12 was reviewed on 9/12/18 at 2:00 p.m. The diagnosis for Resident 12 included, but was not limited to dementia.

An observation was made on 9/11/18 at 10:24 a.m., of Residents 1, 2, 4, and 12's bathroom. The call light in the bathroom could be heard at the nurse's station, but did not light up in the hallway.

An environmental tour was made with the Maintenance Director on 9/14/18 at 10:45 a.m. Observations were made of the following residents' bathroom call lights:

Residents 1, 2, 4, and 12's call light did not light up in the hallway above the door.

Resident 14, 13 and 15's call light did not light up or sound.

Resident 3 and 21's call light did not light up or sound.

An interview was conducted with the

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	Maintenance Director on 9/14/18 at 10:47 a.m. He indicated he needed to replace the bulbs and find out what was going on. A call light policy was provided by the Administrator on 9/14/18 at 12:45 a.m. It indicated "...Policy: Call Lights..Purpose: To ensure that each resident can receive assistance as quickly as possible. A. All call lights should be operational and working at all times...C. All call lights will be operational in the resident's bathroom..." 3.1-19(u)			