STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155511	A. BUILDING 00 B. WING	06/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRE HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 7, 8, 9, 12, and 13, 2017 Facility number: 000446 Provider number: 155511 AIM number: 100288720 Census Bed Type: SNF/NF: 23 Total: 23 Census Payor Type: Medicare: 4 Medicaid: 19 Other: 0 Total: 23 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 20, 2017.	F 0000		
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under			

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	Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interview, the facility failed to ensure the physician was notified of abnormal movements of a resident on psychotropic medications (Resident 9) and for significant weight change (Resident 2), for 2 of 16 resident records reviewed for physician notifications. Findings include: 1. Resident 9's record was reviewed on 6/8/17 at 1:05 p.m. The physician's orders, dated June 2017, indicated the resident's diagnoses included, but were not limited to, psychotic disorder and depression. The resident's current medication regimen included, but was not limited to, quintenapine (antipsychotic medication) 300 mg (milligrams), give with 200 mg to equal 500 mg, at bedtime. An annual MDS (minimum data set) assessment, dated 12/9/16, indicated the resident exhibited behavior symptoms directed towards others, and had active diagnoses that included, but were not limited to, psychotic disorder.	F 0157	**F157** **483.10(g)(14) NOTIFY OF CHANGES (INJUR/DECLINE/ROOM, ETC)** **A facility must immediately inform the resident; consult with the resident's physician; and notify consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychological status (that is, a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** -Resident #9 physician was notified of the resident's score on the AIMS test, physician collaborated with psychologist to discuss possible medication changes, none were made at that time.	07/13/2017

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	A care plan, dated 7/12/16, indicated the resident had the potential for adverse side effects related to the use of psychotropic medications. Interventions included, but were not limited to, monitor side effects that included, but were not limited to, EPS (extra pyramidal symptoms) and tardive dyskinesia (involuntary body movements). An AIMS (abnormal involuntary movement scale) test, dated 12/1/16, indicated the observation of involuntary movements of minimal muscles of facial expression and of the lips and perioral area of the resident's face. An AIMS test, dated 3/21/17, indicated the observation of involuntary movements of the resident's lips and perioral area of his face with minimal puckering, pouting, smacking and tongue movements in and out of his mouth. A review of mental health consult notes, dated 6/28/16 through 2/5/17, indicated no documented notification of the resident's observed involuntary abnormal movements. Physician's progress notes, dated 12/23/16 through 4/17/17, indicated no documented notification of the resident's		-Resident #2 physician was notified of resident's significant weight loss. Resident #2 care plan was also amended to reflect his desire to lose weight. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** All residents in the facility could potentially be affected by this practice. However, the DON/designee will monitor 24 hr reports for physician notifications. MDSC reviewed all the care plans of residents identified abnormal involuntary movement scale scores and significant weight losses/gains to ensure care plans were being followed as written and reflect the current care treatment and services provided. All residents were reviewed for significant weight loss over the last 6 months and physician notification was madeon any that were identified. **3. What measures were put into place or systematic changes made to ensure the deficient practice not recur?** -On 6/26/17 All nursing staff were educated and in-serviced on physician notification of significant change of condition regarding abnormal involuntary movement	

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	observed involuntary abnormal movements. Nurse's Notes, dated 3/9/17 through 4/3/17, indicated no documentation of physician notification of the resident's observed involuntary abnormal movements. During an interview on 6/9/17 at 9:22a.m., the DON (Director of Nursing) indicated she was unsure if the physician was notified of the AIMS test results for December 2016 and March 2017. 2. Resident 2's medical record was reviewed 6/9/17 at 11:45 a.m. An admission record, dated 4/19/17, included but was not limited to diagnoses of type 2 diabetes without complications, edema, early onset cerebellar ataxia (inflamed brain), unspecified dementia without behavioral disturbance, and gastro-esophageal reflux disease without esophagitis. Resident 2's weight history indicated: a. 1/1/17: 230 pounds. b. 2/4/17: 218.1 pounds. c. 4/10/17: 218.9 pounds. d: 4/11/17: 219.7 pounds.		scale (AIMS) and significant weight gains/losses -Nursing staff to document on 24 hr report of any physician notifications related to significant changes of conditions, including but not limited to AIMS and weight gains/losses. **4. How will the facility monitor its corrective action?** The DON/Designee is responsible for monitoring 24 hr reports for physician notifications of significant changes associated with weight loss and AIMS QAPI audits for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI Committee Monthly. If 95% compliance is not achieved, and action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. Date completed: July 3, 2017	

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e: 4/12/17: 219 pounds.

f: 5/6/17: 209.6 pounds.

g. Undated, first week of June: 206 pounds.

A review of nurse's notes, from 3/8/17 to 6/12/17, did not include any documentation of physician notification of significant weight loss.

A care plan, created on 2/2/15, and last revised on 5/18/17, included, but was not limited to, a focus of resident had the potential for nutritional problem related to diagnosis of diabetes mellitus, dementia, and cerebellar ataxia. The goal was resident to maintain adequate nutritional status as evidenced by maintaining a weight within 5 percent of the baseline weight. Interventions included, but were not limited to, resident needed a calm, quiet environment at meal time, administered medications as ordered, provided and served diet as ordered, and registered dietitian evaluated and made diet change recommendations as needed.

A dietary progress note, dated 2/21/17, included, but was not limited to, resident had a significant weight loss of 5.1

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	percent in 30 days. Resident indicated he wanted to lose weight and was happy with the weight loss. No new recommendations were made. No documentation was included indicating physician notification of significant weight loss. During an interview on 6/13/17 at 8:33 a.m., Licensed Practical Nurse (LPN) 20 indicated as soon as the nurse was aware there was a significant weight change in a resident the physician would be notified. At the same time, LPN 20 reviewed the chart and was unable to find any documentation of physician notification of significant weight loss. On 6/12/17 at 1:45 p.m., the Regional Director of Clinical Operations provided a document, dated April 2005, titled, "Changes in Resident Condition," and indicated the policy was the one currently being used by the facility. The policy indicated, "The...attending physician...are notified when changes in condition or certain events occur...Guidelines: ...4. Changes in the resident status that affect the problem(s)/goal(s) or approach(es) on his or her care plans are documented...." 3.1-5(a)(2)			
F 0165	483.10(j)(1)			

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SS=D Bldg. 00	RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL (j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. Based on interview and record review, the facility failed to ensure access to eyeglasses for 1 of 2 residents reviewed for missing items (Resident 2). Findings include: During an interview on 6/8/17 at 10:45 a.m., Resident 2 indicated that his eyeglasses had been missing for 1 month. Staff had been notified, but eyeglasses had not been found. During an interview on 6/8/17, the MDS (Minimum Data Set) coordinator indicated she was not aware of any missing items. During an interview on 6/8/17 at 2:35 p.m., the Social Services Director (SSD) indicated she was not aware of any missing items. When a resident had an	F 0165	**F165** **483.10(J)(1)RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL** **The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** Resident #2 glasses had been missing for approximately 1month. However, resident #2	07/13/2017

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	item missing the SSD was notified and a grievance form was filled out. During an interview on 6/8/17 at 2:41 p.m., the Director of Nursing (DON) indicated Resident 2's eyeglasses had been lost. She thought they had been found in his bed. She was unaware of the eyeglasses still being missing. During an interview on 6/9/17 at 11:44 a.m., Resident 2 indicated his eyeglasses were missing. The eyeglasses were never found. The staff looked for the eyeglasses but was unable to find them. Staff was not continuing to look for the eyeglasses and had not offered to replace them. During an interview on 6/13/17 at 8:33 a.m., Licensed Practical Nurse (LPN) 20 indicated he was not aware of any missing eyeglasses. Resident had gone to the eye doctor about 2 months ago and got new eyeglasses. During an interview on 6/13/17 at 8:36 a.m., Restorative Certified Nursing Assistant (CNA) 12 indicated Resident 2's eyeglasses were lost and had not been found. The staff had looked throughout the facility and was unable to locate the eyeglasses. The eyeglasses were lost about a month and a half ago.		glasses had been found in his bed, but then he lost them again. Resident was offered to see facility eye Dr, but resident refused. Resident's sister was to take him to an eye appointment outside of the facility; however appointment was canceled due to that Dr not accepting resident's insurance. Facility has attempted to contact resident's family regarding setting up an appointment, however family will not return call. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** -All residents in the facility could potentially be affected by this practice. However, Social Service has made an appointment on 7/3/17 to get resident glasses replaced. All residents were visited to ensure that visual appliances were available to them as needed. Appointments will be scheduled for those in need. **3. What measures were put into place or systematic changes made to ensure the deficient practice not**	

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	Resident 2's record was reviewed on 6/9/17 at 11:45 a.m. An admission record, dated 4/19/17, included but was not limited to diagnoses of early onset cerebellar ataxia (inflamed brain), unspecified dementia without behavioral disturbance, and dry eye syndrome of unspecified lacrimal gland. An annual Minimum Data Set (MDS) assessment, dated 3/23/17, indicated Resident 2 was cognitively intact. A review of the grievance log from January 2017 through June 2017 did not indicate a grievance prior to 6/8/17 regarding Resident 2's missing eyeglasses. An undated policy, identified as the one currently being used by the facility, titled, "Terre Haute Nursing and Rehabilitation Center Grievance Procedure," provided by the SSD on 6/13/17 at 9:50 a.m., included, but was not limited to, "Purpose: To ensure the resident may voice grievances and make suggestions for changes in policies and services to facility staff or outside representatives of their choice without fear of reprisal, interference, restrain, coercion, or decimation...2. The staff member should assist in solving the concern when able		**recur?** -On 6/26/17 all staff was in-serviced on the grievance policy and the locations of forms that grievances will be reported on. -On 6/26/17 a Resident Council meeting was held to inform residents of their rights to voice grievances without fear of reprisal, including but not limited to missing items -Social Service Designee will monitor and log all grievances reported by residents. -Social Service Designee will report in Daily QA meeting any grievances that have been reported **4. How will the facility monitor its corrective action?** -To ensure compliance, the Social Service Director is responsible for monitoring and logging all grievances and reporting all grievances QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and	

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	and forward the grievance to the Administrator and Social Service Director...4. Once the department has corrected or solved the concern and filled out the form, the form will be given to the Social Service Director. A record of the complaint, the plan of action, and the effort made to provide a solution will be maintained by the Social Services Director." 3.1-7(a)(1)		implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. Date completed: July 3, 2017	
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health			

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	conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.			
	Based on observation, interview, and record review, the facility failed to ensure a complete assessment was done for a resident receiving oxygen therapy as needed (Resident 10), to ensure a complete pain assessment was completed for a resident with pain (Resident 10), and to accurately assess the type of fluid a resident received (Resident 32) for 2 of 16 residents reviewed for accurate assessments. Findings include:	F 0272	**F272** **483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Resident Assessment Instrument. A facility must make a comprehensive assessment of the resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.** **1. How will the corrective action be accomplished for those residents**	07/13/2017

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	1. On 6/12/17 at 10:11 a.m., Resident 10 was observed wearing oxygen at 2 liters via nasal cannula while lying in bed. During an interview on 6/12/17 at 10:20 a.m., Licensed Practical Nurse (LPN) 9 indicated Resident 10 should wear oxygen all the time, but he refused at times. Resident 10 wore oxygen when he was in bed. Oxygen administration should be documented on the Treatment Administration Record (TAR). If a resident had an order for oxygen to be given as needed then the oxygen would be administered if the resident had signs or symptoms of shortness of breath, complained of shortness of breath, or if the resident requested the oxygen. If as needed oxygen was administered then an oxygen saturation should be checked and documented on the TAR. Resident 10 was not able to administer oxygen to himself. During an interview on 6/12/17 at 10:44 a.m., the Director of Nursing (DON) indicated if as needed oxygen was given an oxygen saturation should be checked and documented either in the nurse's notes or on the TAR. Resident 10's record was reviewed on 6/9/17 at 11:17 a.m. An admission		**who are affected by this alleged deficient practice?** Resident #10 order for Oxygen as needed will have documentation of assessment, administration/refusal. O2 saturation will be documented in the TARs. DON/Designee to monitor Oxygen administration O2 saturation documentation to ensure it is completed for all residents requiring Oxygen therapy. A pain assessment was completed on Resident #10 on 6/16/17 Resident #32 care plan was updated to reflect he has no chewing and swallowing difficulties. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** -All residents in the facility could potentially be affected by this practice. However, all residents that require oxygen administration will be documented in the appropriate place. The care plans of all residents with identified pain were reviewed by MDS to ensure care plans are followed as written and reflect the current care and services provided. All resident's care plans were audited to ensure correct chewing and swallowing problems were correct.	

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TERRE HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807

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	record, dated 4/19/17, included, but was not limited to, diagnoses of chronic diastolic congestive heart failure, chronic obstructive pulmonary disease unspecified, and atherosclerotic heart disease of native coronary artery without angina pectoris. A physician's order, dated 1/10/17, indicated oxygen at 2 liters per nasal cannula as needed due to shortness of breath. The TAR for April 2017, May 2017, and June 2017 did not indicate any documentation of assessment, administration, or refusal of as needed oxygen. Nurse's notes from 2/6/17 to 6/12/17 did not include any documentation of assessment, administration, or refusal of as needed oxygen. A care plan, initiated 8/31/16, and last revised 5/15/17, included but was not limited to a focus of resident was at risk for exacerbation of chronic obstructive pulmonary disease. Resident had use of oxygen as needed. Resident did refuse oxygen at times, will take off himself and staff has to reapply frequently. Interventions included but were not limited to assess breath sounds/lung		**3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** -On 6/26/17 all Licensed Nursing Staff were in-serviced on the Oxygen Administration policy and documenting O2 saturation on the TARs. -On 6/26/17 all Licensed Nursing Staff were in-serviced on the Pain Assessment Policy, performing pain assessments and reassessments and documenting the level and the location of the pain resident is experiencing. -All resident's nutritional assessments were reviewed/revised for residents with chewing/swallowing difficulties by Dietary Manager and MDSC. -DON/Designee to monitor Oxygen documentation in TARs. -DON/Designee to perform random audits of pain assessments/reassessments, level of pain and location of pain per Pain Assessment Policy **4. How will the facility monitor its corrective action?**	

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	sounds as needed, oxygen as per physician's order, oxygen saturations as needed, and staff to reapply oxygen frequently. An annual Minimum Data Set (MDS) assessment, dated 8/11/16, included, but was not limited to, Resident 10 had received oxygen therapy while a resident in the facility. On 6/13/17 at 9:53 a.m., the Regional Director of Clinical Operations provided a document, dated December 2010, titled, "Oxygen Administration," and indicated the policy was the one currently being used by the facility. The policy indicated, "A resident will need oxygen when hypoxemia (low oxygen in blood) occurs. Oxygen saturation monitoring will determine the adequacy of oxygen therapy...PROCEDURE: 5. Monitor the residents response to oxygen therapy. Check pulse oximetry values during initial adjustments of oxygen flow...." 2. Resident 10's record was reviewed on 6/9/17 at 11:17 a.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses type II diabetes mellitus, peripheral vascular disease, muscle spasm of the back, depression, and low back pain.		-To ensure compliance, DON is responsible for monitoring Oxygen documentation in the TARs, conducting random audits of pain assessments/re-assessments, level of pain, and documentation of the location of pain per Pain Assessment Policy QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be develop and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. Date Completed: July 3, 2017	

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	A physician's order, dated 8/19/16, indicated acetaminophen (pain medication) 325 milligrams (mg), give 2 tablets by mouth every 6 hours as needed for mild pain. A physician's order, dated 11/4/16, indicated hydrocodone/acetaminophen (pain medication) 5/325 mg, give 1 tablet by mouth every 4 hours as needed for severe pain. Acetaminophen was given on 4/7/17 for back pain. There was no indication of pain severity and no reassessment of pain. Acetaminophen was given on 5/18/17 for pain of 6 on a pain scale of 1-10. Pain was 2 on a pain scale of 1-10 upon reassessment. There was no indication of the location of the pain. Acetaminophen was given on 6/6/17 for pain of 6 on a pain scale of 1-10. Pain was 2 on a pain scale of 1-10 upon reassessment. There was no indication of the location of the pain. Acetaminophen was given on 6/11/17 for pain of 5 on a pain scale of 1-10. Pain was 2 on a pain scale of 1-10 upon reassessment. There was no indication of the location of the pain.			

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A care plan, initiated 8/31/16, and last revised on 5/15/17, included, but was not limited to a focus of resident was at risk for pain. The goal, included, but was not limited to resident would voice a level of comfort with interventions for pain and pain medications. Interventions included but were not limited to administer analgesia as per orders, give a half hour before treatments or care, evaluate the effectiveness of pain interventions, monitor/document probable cause for each pain episode, monitor/document side effects of pain medication, monitor/record pain characteristics including quality, severity, anatomical location, onset, duration, aggravating factors, and relieving factors.

An annual minimum data set (MDS) assessment, dated 8/11/16, indicated Resident 10 had pain in the last 5 days occasionally and rated it at 7 on a pain scale of 1-10.

During an interview on 6/12/17 at 10:11 a.m., Resident 10 indicated he frequently had pain. He did have pain when he got up and during care. Staff did not offer pain medication prior to care.

During an interview on 6/12/17 at 10:20 a.m., Licensed Practical Nurse (LPN) 9

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	indicated she did not regularly provide pain medication to Resident 10 prior to treatment or care. Acetaminophen was given first. Hydrocodone would be given if the acetaminophen was not effective. During an interview on 6/12/17 at 10:44 a.m., the Director of Nursing (DON) indicated a pain scale of 1-10 is used for pain assessment. When an as needed pain medication was given type, location, and reassessment for medication effectiveness should be documented. Resident 10 did not need pain medication prior to treatment or care. 3. On 6/13/17 at 8:21 a.m., Resident 32 was observed in his room drinking from his water pitcher. The pitcher had regular, non-thickened water. No evidence of swallowing problems was observed. During observation of the resident's lunch meal, on 6/13/17 at 12:02 p.m., the resident was observed to drink regular thin liquids prior to his meal. The resident was provided a regular lunch meal. The meal included, but was not limited to, roast beef, mashed potatoes, and brownie. He was served regular thin liquids. No difficulty with chewing or swallowing was observed. During an interview, on 6/13/17 at 8:28 a.m., the speech language pathologist			

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	(SLP), indicated the resident received speech therapy services for cognition. The resident had no identified swallowing or chewing problems and had no order for thickened liquids or mechanically altered diets. The resident's current diet order was for a regular diet. During an interview, on 6/13/17 at 9:39 a.m., the MDS Coordinator indicated the resident had no chewing or swallowing problems and required no thickened liquids. The resident had been assessed incorrectly for his nutritional needs. Resident 32's record was reviewed on 6/12/17 at 1:36 p.m. The physician's orders, dated June 2017, indicated the resident's diagnoses included, but were not limited to, encephalopathy, schizophrenia, and psychotic disorder. The resident's admission nursing assessment, dated 1/16/17, indicated the resident was independent with eating and had no chewing or swallowing problems. An admission nutritional assessment, dated 1/16/17, indicated the resident had no chewing or swallowing problems and was on a regular diet with diet beverages and condiments. The resident's 14-day admission MDS			

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	(minimum data set) assessment, dated 1/23/17, indicated the resident was independent with eating and had no chewing or swallowing problems. A quarterly nursing assessment, dated 3/16/17, indicated the resident was independent with eating and had no chewing or swallowing problems. A communication Form, dated 6/1/17, indicated the resident had an order for a regular diet. A nutrition assessment, dated 6/9/17, indicated the resident had no chewing or swallowing problems. The resident's nutritional care plan, dated 4/23/17, indicated the resident had chewing and swallowing problems. Interventions included, but were not limited to, therapy screens as needed and thickened liquids. On 6/13/17 at 9:53 a.m., the Regional Director of Clinical Operations provided a document, dated April 2007, titled, "Resident Assessment Instrument," and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Statement: A comprehensive assessment of a resident's needs shall be made...Policy			

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	Interpretation and Implementation...3. The purpose of the assessment is to describe the resident's capacity to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning...." 3.1-31(a) 3.1-31(b)(2)(5)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the			

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	comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record. (iv)In consultation with the resident and the resident’s representative (s)- (A) The resident’s goals for admission and desired outcomes. (B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	Based on observation, interview, and record review, the facility failed to develop a care plan for a resident who had a significant weight loss (Resident 10) and a resident who self-administered medication (Resident 7) for 2 of 16 residents reviewed for care plans. Findings include: 1. Resident 2's record was reviewed on 6/9/17 at 11:45 a.m. An admission record, dated 4/19/17, included but was not limited to diagnoses of type 2 diabetes without complications, edema, early onset cerebellar ataxia (brain swelling), unspecified dementia without behavioral disturbance, and gastro-esophageal reflux disease without esophagitis Resident 2's weight history indicated: a. 1/1/17: 230 pounds. b. 2/4/17: 218.1 pounds c. 4/10/17: 218.9 pounds d: 4/11/17: 219.7 pounds e: 4/12/17: 219 pounds	F 0279	**F279** **483.20(d);483.20(b)(1)DEVELOP COMPREHENSIVE CARE PLANS** **A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessment to develop, review, and revise the resident's comprehensive care plan.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** Resident #2 care plan was amended for a significant weight loss. Resident #7 re-educated on placing nebulizer tubing and mouth piece into a plastic bag; resident refuses to place items in bag. After resident does breathing treatment, nursing will clean /dry out medication cup of the mouth piece, place the tubing, mouth piece into a bag labeled with resident's name and place in med cart. All updated care plans will be placed in the active Care Plan binder for Nurse's to access. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?**	07/13/2017

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	f: 5/6/17: 209.6 pounds g. Undated, first week of June 2017: 206 pounds. A dietary progress note, dated 2/21/17, included, but was not limited to, resident had a significant weight loss of 5.1 percent in 30 days. Resident indicated he wanted to lose weight and was happy with the weight loss. No new recommendations were made. An annual minimum data set (MDS) assessment, dated 3/23/17, indicated Resident 2 was cognitively intact. A nutrition assessment, dated 4/18/17, included, but was not limited to, resident would maintain current body weight with no significant changes, and would continue with current plan of care and monitor. A care plan, created on 2/2/15, and last revised on 5/18/17, included, but was not limited to, a focus of resident had the potential for nutritional problem related to diagnosis of diabetes mellitus, dementia, and cerebellar ataxia. The goal was resident to maintain adequate nutritional status as evidenced by maintaining a weight within 5 percent of the baseline weight. Interventions		-All residents in the facility could potentially be affected by this practice. Care plans must be developed for any resident that has had a significant weight loss/gain; if resident expresses the desire to lose weight, the resident's care plan must reflect those wishes. All resident care plans were reviewed to ensure all active care plans are available in the active care plan binder. Corrections were made where needed. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** -On 6/26/17 all nursing staff were in-serviced regarding proper care and storage of nebulizer equipment -MDS will monitor any changes that may need to be completed on resident care plans. -MDS will perform random audits ensuring resident's care plans are included in the active Care Plan binder for Nurses to access. **4. How will the facility monitor its corrective action?** -To ensure compliance, the MDSC will be responsible for monitoring care plans for accuracy. The DON/Designee will be responsible	

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	included, but were not limited to, resident needed a calm, quiet environment at meal time, administered medications as ordered, provided and served diet as ordered, and registered dietitian evaluated and made diet change recommendations as needed. There was no indication of a plan for resident's expressed desire to lose weight. During an interview on 6/13/17 at 8:28 a.m., Resident 2 indicated he would like to lose weight and had a goal weight of 170 pounds. 2. On 6/7/17 at 11:26 a.m., Resident 7 was in his room giving self a breathing treatment, when completed the resident turned the machine off per self and placed tubing and mouthpiece onto bedside table, and did not place in bag. On 6/9/17 at 8:57 a.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. On 6/9/17 at 2:08 p.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. On 6/12/17 at 11:02 a.m., Resident 7's nebulizer tubing and mouth piece were		for monitoring the proper cleaning and storage of nebulizer equipment QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3, 2017	

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	observed on bed side table, not placed inside of bag. On 6/13/17 at 9:21 a.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. Resident 7's record was reviewed on 6/8/17 at 1:24 p.m. The diagnosis on the care plan included, but was not limited to COPD (Chronic Obstructive Pulmonary Disease) and allergies. A review of physicians orders included, but was not limited to, start date 9/29/16 budesonide (steroid and decongestant) 0.25 mg (milligrams)/ 2 ml (milliliters) suspension inhale 2 ml (milliliters) via nebulizer (device used to deliver medication in the form of a mist) 2 times a day, after use: rinse mouth and spit. A review of the original comprehensive physician's order sheet, dated 3/19/17, included, but was not limited to, resident may administer nebulizer treatments to self. On 6/9/17 at 12:07 p.m., a copy of a care plan obtained from the nurses station care plan book with a revision date of 9/14/16 was provided by the MDS (Minimum Data Set) coordinator and included, but			

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	was not limited to, " ...focus: the resident has potential for exacerbation of COPD and has allergies. Interventions with a revision date of 2/23/17 included, but was not limited to, give medications as ordered, monitor and document any side effects and effectiveness. There were no other care plans provided that included the self-administration of medication on the resident's comprehensive plan of care at this time ...." During an interview on 6/9/17 at 2:04 p.m., Resident 7 indicated he administered his breathing treatments and when finished puts his tubing and mouthpiece on his bedside table, indicated he did not place the mouthpiece back into bag because it was too much trouble and that he did not clean the equipment after each use. During an interview on 6/9/17 at 2:08 p.m., the DON (Director of Nursing) indicated the resident cleaned the nebulizer equipment after use and should place the mouthpiece in the bag once the nebulizer treatment was completed. Also indicated, the CNA's (Certified Nursing Assistants) would place the mouthpiece back into the bag if the resident did not. During an interview on 6/13/17 at 9:32 a.m., the DON indicated there was an			

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	updated care plan hand written in for self-administration and was found in the MDS files located in the MDS office. During an interview on 6/13/17 at 9:40 a.m., the MDS coordinator indicated that back up charts were kept in the MDS office and the updated self-administration care plan was placed there. Also indicated that the updated care plans should be placed in the active care plan book at the nurses' station for the nurses to have access to. On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document titled, "Using the Care Plan," and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation: 1. Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses' station. 5. Changes in the resident's condition must be reported to the MDS assessment coordinator so that a review of the resident's assessment and care plan can be made. 6. Documentation must be			

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	consistent with the resident's care plan...." On 6/12/17 at 1:12 p.m., the DON (Director of Nursing) provided a document titled, "Self-Administration of Medication," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Documentation: ...2. Document the self-administration of medication on the resident's comprehensive plan of care...." 3.1-35(a)			
F 0282 SS=E Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to obtain lab work as ordered by the physician for 2 residents (Resident 4 and 7), provide one on one activity visits to encourage fluid intake as indicated on the care plan (Resident 4), provide nail care as indicated on the care plan (Resident 12), and to notify the physician for an abnormal assessment of a resident (Resident 9) for 4 of 16 residents	F 0282	**F282** **483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **Comprehensive Care Plans The services provided by the facility as outlined by the comprehensive care plan must-be provided by qualified persons in accordance with each resident's written plan of care.**	07/13/2017

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	reviewed for care plans. Findings include: 1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions. A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6 month in March and September. A physician's order, dated 8/9/16, included, but was not limited to HgbA1C (blood test related to diabetes mellitus) every 3 months (September, December, March, and June). A review of all Resident 4's lab work from January 2017 to June 2017 did not include any documentation of a dilantin level, TSH, or HgbA1C being done or refused. A care plan, initiated 7/21/16, and last revised on 5/15/17, indicated a focus of Resident 4 has a potential for abnormal		**1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -Labs were obtained for Resident #4for a Dilantin Level, TSH and HgbA1C on 6/29/17 and was added to 1:1 activity for fluids. -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17 -Resident #12 received nail care per Nail Care policy -Resident #9 physician was notified of AIMS results. **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -All residents could potentially be affected by this practice, However, due to the implementation of the Lab Monitoring Form and double checking the monthly re-writes for upcoming labs this alleged practice will not recur. All resident's chart were audited to ensure nothing else has been missed, any missed lab was ordered to be done. - DON will monitor resident showers sheets and Point, Click, Care for nail care completion documentation and will conduct random audits of	

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	labs related to seizure disorder, diabetes mellitus, and hypothyroidism. Interventions included, but were not limited to, labs/tests as per physician's order and notified physician of all lab/test results. During an interview on 6/9/17 at 11:24 a.m., the Director of Nursing (DON) indicated she contacted the lab to ask for results from the dilantin level, TSH, and HgbA1C that should have been done in March 2017. The lab did not have any labs from March of 2017. Dilantin level, TSH, and HgbA1C were not done in March 2017. 2. On 6/7/17 at 2:00 p.m., Resident 4's lips were noted to be dry. On 6/7/17 at 2:08 p.m., Resident 4 was observed to be eating lunch in her room, no drinks were provided for lunch. On 6/8/17 at 2:46 p.m., Resident 4's water pitcher in room was observed to be less than half full with no ice. No straw or cup were observed in Resident 4's room. Lips were dry. On 6/9/17 at 10:31 a.m., Resident 4 was observed to be sitting up in the wheelchair in her room, lips were dry.		regarding nail care. -DON/Dietary Manager will conduct random audits during meal service times to ensure adequate fluid options are offered to each resident. -A review was made of all resident's AIMS results to ensure physician was aware if abnormal movement was noted. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** - On 6/26/17 all Licensed Nursing Staff were in-serviced on "Obtaining Labs as ordered by Physician" policy. - On 6/26/17 all Nursing Staff were in-serviced on "Nail Care" Policy, Nail care is to be completed on shower days and as needed. -On 6/26/17 all Nursing and Dietary staff were in-serviced on offering 2-3 fluid options with each meal with Hydration Cart being accessible to Staff and Residents 24/7. - On 6/26/17 all Nursing Staff were in-serviced on passing fresh ice water each shift. **4. How will the facility monitor its corrective action?** -To ensure compliance,	

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	During a second lunch observation on 6/9/17 at 12:08 p.m., Resident 4 was served lunch with 8 ounces of coffee. No fluid choices were offered. Staff was not observed to encourage Resident 4 to drink her fluids. On 6/9/17 at 12:31 p.m., Resident 4 asked for lemonade to go with lunch. Lemonade was served as requested. During an interview on 6/9/17 at 10:12 a.m., the Director of Nursing (DON) indicated fluids were documented in the Certified Nursing Assistant's (CNA) computer charting only. Fluids were not documented anywhere else in the record. There were no hydration concerns that had been communicated to the DON. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. A admission record, dated 4/19/17, included, but was not limited to, paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, edema, and gastro-esophageal reflux disease without esophagitis. A nutrition assessment, dated 2/4/17, included, but was not limited to, a fluid need of 2925 milliliters (ml) daily. Average fluid consumption with meals was 480-600 ml.		DON/designee is responsible for the completion of the monitoring of physician order for all lab testing, monitoring residents shower sheets and Point, Click, Care for nail care completion. QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. Dietary Manager/DON are responsible for ensuring resident have adequate fluid options available during meal service QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. Dietary Manager/Dietary Staff are responsible for ensuring hydration cart is adequately stocked for use after kitchen closes for the evening. QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3,2017	

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	A review of Resident 4's daily fluid consumption indicated the following: a. 5/28/17: No fluid consumption or refusal was documented. b. 5/29/17-6/2/17: Resident 4 was out of the facility to the hospital. c. 6/3/17: Resident 4 returned from the hospital and consumed 480 ml of fluids the remainder of the day. d. 6/4/17: 960 ml. e. 6/5/17: 1200 ml. f. 6/6/17: 960 ml. g. 6/7/17: 480 ml. h. 6/8/17: 1180 ml A care plan, initiated on 9/23/15, and last revised on 5/15/17, included, but was not limited to, a focus of resident had the potential for fluid deficit and dehydration. A goal, included, but was not limited to, resident will be free from symptoms of dehydration and will maintain moist mucous membranes. Interventions included, but were not limited to, invite resident to activities that			

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	promote additional fluid intake, offer drinks during one on one visits. During an interview on 6/9/17 at 10:38 a.m., the Activity Director indicated Resident 4 is not on the list for one on one activity visits. Resident 4 did not have any special activity needs. Resident 4 was not offered anything special during activites, including fluids. During an interview on 6/9/17 at 10:47 a.m., the Director of Nursing (DON) indicated the Activity Director assessed residents to see if one on one visits were needed and updated the care plans accordingly. One on one visits were discussed during morning meeting and during care plan meetings. 3. On 6/7/19 at 2:06 p.m., Resident 12 was observed with long fingernails and dark debris under them. On 6/9/17 at 12:25 p.m., Resident 12 was observed with long fingernails and dark debris under them, the left thumb nail was cracked. On 6/9/17 at 3:07 p.m., Resident 12 was observed with long fingernails and dark debris under them, the left thumb nail was cracked. On 6/12/17 at 9:33 a.m., Resident 12 was			

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	observed with long fingernails and dark debris under them, the left thumb nail was cracked. During an interview on 6/9/17 at 2:32 p.m., CNA (Certified Nursing Assistant) 13 indicated the resident was totally dependent for nail care and assist of 1 with bathing. During an interview on 6/9/17 at 3:07 p.m., Resident 12 indicated he did not cut his own fingernails. During an interview on 6/12/17 at 10:26 a.m., Restorative CNA 12 indicated the resident received showers daily and nail care was provided on shower days. During an interview on 6/12/17 at 1:56 p.m., the DON (Director of Nursing) indicated CNA's were responsible for documenting nail care provided to a resident. During an interview on 6/12/17 at 2:12 p.m., the Regional Director of Clinical Operations indicated there was no documentation from CNA's indicating nail care was performed for Resident 12 this month. Resident 12's record was reviewed on 6/9/17 at 9:02 a.m. Diagnosis from the			

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	care plan included, but were not limited to, need for assistance for personal care. An annual MDS assessment, dated 12/17/16, indicated Resident 12 required extensive assistance of one person physical assist for personal hygiene. A care plan initiated on 9/14/16 and revised on 2/7/17 indicated an Activities of Daily Living (ADL) self care performance deficit related to diagnosis of mild intellectual disabilities psychosis, and need of assist with dressing and grooming. Interventions included but was not limited to check nail length and trim and clean on bath day as necessary. A review of shower sheets included, but was not limited to, Resident 12 received a shower on 6/1, 6/2, 6/3, 6/5, 6/6, 6/7, 6/8 and 6/9/17. No documentation was observed for refusal of showers for those days. 4. Resident 7's record was reviewed on 6/8/17 at 1:24 p.m. Diagnosis from the care plan included, but were not limited to, coronary artery disease, hyperlipidemia, constipation, chronic obstructive pulmonary disease, hypertension, gerd and benign prostatic hyperplasia.			

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	A review of physicians orders dated 12/14/15 included, but were not limited to, labs: lipid profile, hepatic profile and tsh (thyroid-stimulating hormone every 6 months in February and August. A review of labs dated August of 2015 for lipid profile, hepatic profile and tsh, there were no results provided for February of 2016. A review of care plans indicated, focus revised on 2/24/17: resident has potential for abnormal labs related to diagnosis. Interventions updated 9/14/16: labs and test as per medical director ordered. During an interview on 6/8/17 at 2:15 p.m., LPN 9 indicated she phoned the laboratory services used by the facility and at that time they found no record for a lipid profile, hepatic profile and tsh drawn in February of 2016, and indicated the last time these labs were drawn were dated August of 2016. During an interview on 6/9/17 at 8:22 a.m., LPN 9 indicated she followed up with the facilities laboratory services and there was no record the resident received labs in February 2016 as ordered by physician. 5. Resident 9's record was reviewed on 6/8/17 at 1:05 p.m. The physician's			

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	orders, dated June 2017, indicated the resident's diagnoses included, but were not limited to, psychotic disorder and depression. The resident's current medication regimen included, but was not limited to, quintenapine (antipsychotic medication) 300 mg, give with 200 mg to equal 500 mg, at bedtime. An annual MDS (minimum data set) assessment, dated 12/9/16, indicated the resident exhibited behavior symptoms directed towards others, and had active diagnoses that included, but were not limited to, psychotic disorder. A care plan, dated 7/12/16, indicated the resident had the potential for adverse side effects related to the use of psychotropic medications. Interventions included, but were not limited to, monitor side effects that included, but were not limited to, EPS (extra pyramidal symptoms) and tardive dyskinesia (involuntary body movements). An AIMS (abnormal involuntary movement scale) test, dated 12/1/16, indicated the observation of involuntary movements of minimal muscles of facial expression and of the lips and perioral area of the resident's face. An AIMS test, dated 3/21/17, indicated			

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	the observation of involuntary movements of the resident's lips and perioral area of his face with minimal puckering, pouting, smacking and tongue movements in and out of his mouth. A review of mental health consult notes, dated 6/28/16 through 2/5/17, indicated no documented notification of the resident's observed involuntary abnormal movements. Physician's progress notes, dated 12/23/16 through 4/17/17, indicated no documented notification of the resident's observed involuntary abnormal movements. Nurse's Notes, dated 3/9/17 through 4/3/17, indicated no documentation of physician notification of the resident's observed involuntary abnormal movements. During an interview on 6/9/17 at 9:22a.m., the DON (director of nursing) indicated she was unsure if the physician was notified of the AIMS test results for December 2016 and March 2017. On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document, revised August 2006, titled, "Using the Care Plan," and indicated the			

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	policy was the one currently being used by the facility. The policy indicated, "Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation: 1. Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses' station. 5. Changes in the resident's condition must be reported to the MDS assessment coordinator so that a review of the resident's assessment and care plan can be made. 6. Documentation must be consistent with the resident's care plan...." On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document titled, "Laboratory Management," and indicated the policy was the one currently being used by the facility. The policy indicated, "Overview: Residents requiring laboratory services will receive accurate and timely laboratory services so that the utilization of laboratory testing for diagnosis, treatment, prevention, or assessment is maximized. The facility is responsible for quality and timely laboratory services whether or not services are provided by the facility or an outside agency...."			

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	On 6/12/17 at 1:45 p.m., the Regional Director of Clinical Operations provided a document, dated April 2005, titled, "Changes in Resident Condition," and indicated the policy was the one currently being used by the facility. The policy indicated, "The...attending physician...are notified when changes in condition or certain events occur...Guidelines: ...4. Changes in the resident status that affect the problem(s)/goal(s) or approach(es) on his or her care plans are documented...." 3.1-35(g)(2)			
F 0312 SS=D Bldg. 00	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review the facility failed to provide nail care for 1 of 3 residents reviewed for activities of daily living (ADL's) (Resident 12). Findings include: On 6/7/19 at 2:06 p.m., Resident 12 was observed with long fingernails and dark debris under them.	F 0312	**F312** **483.24(a)(2)ADL CARE PROVIDED FOR DEPENDENT RESIDENT** **(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.** **1. How will the corrective action be accomplished for those residents**	07/13/2017

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	On 6/9/17 at 12:25 p.m., Resident 12 was observed with long fingernails and dark debris under them, the left thumb nail was cracked. On 6/9/17 at 3:07 p.m., Resident 12 was observed with long fingernails and dark debris under them, the left thumb nail was cracked. On 6/12/17 at 9:33 a.m., Resident 12 was observed with long fingernails and dark debris under them, the left thumb nail was cracked. During an interview on 6/9/17 at 2:32 p.m., Certified Nursing Assistant (CNA) 13 indicated the resident was totally dependent for nail care and assist of 1 with bathing. During an interview on 6/9/17 at 3:07 p.m., Resident 12 indicated he did not cut his own fingernails. During an interview on 6/12/17 at 10:26 a.m., Restorative CNA 12 indicated the resident received a shower daily and nail care was provided on shower days. During an interview on 6/12/17 at 1:56 p.m., the Director of Nursing (DON) indicated CNA's was responsible for		**who are affected by this alleged deficient practice?** Resident #12 fingernails were cleaned, trimmed, and filed **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** --All residents in the facility could potentially be affected by this practice. All residents requiring assist with ADLs will have had their fingernails cleaned, trimmed, and filed immediately and on their respective shower day and as needed. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** On 6/26/17 all nursing staff were in-serviced on nail care, including but not limited to trimming, filing and cleaning of resident fingernails during resident shower and as needed. -Area to document nail care of the resident shower sheets was added. -Electronic documentation for providing nail care was added to CNA's ADL documentation on kiosks.	

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	documenting nail care provided to a resident. During an interview on 6/12/17 at 2:12 p.m., the Regional Director of Clinical Operations indicated there was no documentation from CNA's indicating nail care was provided this month for Resident 12. Resident 12's record was reviewed on 6/9/17 at 9:02 a.m. Diagnosis from the care plan included but was not limited to need for assistance for personal care. An annual MDS assessment, dated 12/17/16, indicated Resident 12 required extensive assistance of one person physical assist for personal hygiene. A care plan initiated on 9/14/16 and revised on 2/7/17 indicated a an Activities of Daily Living (ADL) self care performance deficit related to diagnosis of mild intellectual disabilities psychosis, and need of assist with dressing and grooming. Interventions included but was not limited to check nail length and trim and clean on bath day as necessary. A review of shower sheets included, but was not limited to, Resident 12 received a shower on 6/1, 6/2, 6/3, 6/5, 6/6, 6/7,		**4. How will the facility monitor its corrective action?** -To ensure compliance, the DON is responsible for the nail care QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3, 2017	

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	6/8 and 6/9/17. No documentation was observed for refusal of showers for those days. On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document titled, "Using the Care Plan," and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation: ... 6. Documentation must be consistent with the resident's care plan...." On 6/12/17 at 1:45 p.m., the Regional Director of Clinical Operations provided a document titled, "Care of Fingernails/Toenails," and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections... Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individuals who administered the nail care... 6. If the			

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	resident refused the treatment, the reasons why and the intervention taken. 7. The signature and title of the person recording the data." 3.1-38(a)(3)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and			

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	weight. Based on record review, and interview, the facility failed to provide preventative maintenance for 1 of 1 residents (Resident 5), wheelchair brakes which resulted in a fall, and to ensure that resident's side rails were secure while in the upright position for 3 of 3 beds observed with half side rails installed (Residents 5, 12, and 24). 1. On 06/09/17 9:07 a.m., a medical record review was completed for Resident 5. The most recent comprehensive assessment of a Quarterly MDS (Minimum Data Set), dated 5/23/17, indicated Resident 5 had diagnosis including but not limited to: muscle weakness, depression, and Psychotic Disorder; and a BIMS (Brief Inventory of Mental Status) of 4. MDS indicated, "...yes... the resident had falls since admission/entry or reentry to the prior assessment..." falls were coded as 2 or more falls with no injuries. MDS indicated that Resident 5's self-performance of transfer between surfaces including to or from the wheelchair, was coded as a 3, indicating extensive assistance. A focus care plan dated 04/04/17	F 0323	**F323** **483.25(d)(1)(2)(n)(1)-(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **The resident environment remains as free from accident hazards as is possible.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** Resident #5 wheelchair brakes were repaired to ensure they were functioning properly. Maintenance Director tightened Resident #5, 12, and 24 side rails to prevent movement while transferring. **How will the facility identify resident having the potential to be affected by the same deficient practice?** -All residents that use bed rails for mobility and assist with transferring have the potential to be affected by this alleged deficient practice, as well as any resident in a wheelchair. However, Maintenance Director completed a facility wide audit of loose side rails as well as inspecting all wheelchairs to ensure brakes were functioning properly.	07/13/2017

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	indicated, "...Resident will attempt at intervals to get up out of wheel chair by self...Has history of falls..." Care plan interventions included but were not limited to, "...The resident needs a safe environment..." A focus care plan dated 08/02/16 indicated, "...Resident has had (perceived/actual) altercation in mood state...expressions of anxious or fidgety/restless appearance..." Nurses notes dated 05/03/17 indicated, "...Res [resident] in w/c [wheelchair] in dining room was attempting to set himself back in the w/c seat when the w/c rolled backwards and resident slid to the floor on his buttocks...noted w/c brakes were not completely set..." A "Nurse Investigation of Fall" dated 5/3/17 indicated, "...w/c brakes do not engage- worn- w/c rolled backwards..." On 06/09/17, at 10:33 a.m., the Maintenance Director indicated, he had only just begun looking at wheelchairs, and the maintenance request from 5/3/17 was handled by Employee 24. 06/09/2017 2:40:48 p.m., Maintenance Director and Employee 24 indicated that they should have been doing maintenance		**What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** On 6/26/17Maintenance Director completed facility wide audit of all bed rails including but not limited to tightening of any loose bed rails and measuring bed rails to ensure residents could not become entrapped. Maintenance Director completed a facility wide inspection to ensure all wheelchair brakes functioned properly. All staff were in-serviced on 6/26/17 on reporting any loose or poorly functioning bed rails or equipment in the Maintenance Repair Log book. -Maintenance Director will conduct monthly maintenance audits of all bed rails. -Maintenance Director will monitor Maintenance Repair Log daily for any items that may need repaired. **How will the facility monitor its corrective action?** -To ensure compliance, the Maintenance Director is responsible for the completion of monitoring wheelchair brake function and bed	

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	checks on chairs, but did not know if they were at the time Resident 5 fell. On 06/12/17, at 9:59 a.m., Physical Therapist [PT] 16 indicated that Resident 5 was referred to therapy after his fall on 5/3/17. PT 16 indicated she began working with Resident 5 regarding positioning in his wheelchair and his wheelchair seat had been adjusted by bringing the back down and raising the front, so that his hips remained a little lower that knee level, because his fall reports kept indicating that he was sliding out. 06/12/17, at 10:03 a.m., OT 25 [Occupational Therapist] indicated that he has worked with the Resident 5 including but not limited to: core strengthening to improve trunk control, education with patient and staff on proper positioning and using non-skid socks. 2. On 06/08/17, at 1:07 p.m., Resident 5 was observed sitting in his wheelchair in his room. Resident 5's right 1/2 side rail is in the upright position and was observed to be loose. It wobbled back and forth from the mattress, horizontally, and up and down, vertically. Resident 5 indicated that he did use the bed rails to help him get in and out of bed.		rail tightening QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3, 2017	

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	On 06/09/17, at 10:48 a.m., Resident 5 was observed laying in bed with eyes closed. His 1/2 side rails were observed lowered, in the upright position. On 06/12/17, at 10:15 a.m., LPN 9 indicated that Resident 5 does use his bed rails for mobility to get himself in and out of bed on a daily basis, at least three times a day On 06/12/17, at 10:19 a.m., CNA 23 indicated that Resident 5 was an extensive assist who needed the side rails to be lowered into the upright position whenever he is in bed, and he does use his side rails to help pull himself upright to get in and out of bed. On 06/12/17, at 11:36 a.m., the Maintenance Director measured Resident 5's bed rail while in the upright position, and indicated that the gap between the mattress and the lower most portion of the rail, measured 4 inches from the mattress to the end of the rail while pushed away from the bed. He Indicated that the bed rail was loose and not in good working condition. On 06/12/17, at 11:55 a.m., the Maintenance Director indicated that the bed rail for Resident 5 had been tightened and that the gap between the mattress and			

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	the lower most portion of the rail, measured 2.5 inches from the mattress to the end of the rail while pushed away from the bed. On 06/12/17 at, 1:26 p.m., the Administrator indicated there was no current Policy and Procedure for bed rails and provided a document titled, "Bed Entrapment Assessment."which indicated, "...Zone 4 : This space is the gap that forms between the mattress compressed by the patient, and the lower most portion of the rail, at the end of the rail...dimensional limit of less than 60mm (2 3/8 inches) measured between the mattress support platform and the lowest portion of the rail at the rail end to prevent neck entrapment..." Administrator indicated that this assessments what the facility should go by, and that bed rails should never be loose. On 06/12/17, at 1:30 p.m., the Maintenance Director re-measured the tightened bed rail using the guidelines from the provided "Bed Entrapment Assessment" and indicated the gap was measured at 2.5 inches. On 06/09/17 9:07 a.m., a medical record review was completed for Resident 5.			

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	The most recent comprehensive assessment of a Quarterly MDS (Minimum Data Set), dated 5/23/17, indicated Resident 5 had diagnosis including but not limited to: muscle weakness, depression, and Psychotic Disorder, and a BIMS (Brief Inventory of Mental Status) of 4. MDS indicated, "...yes... the resident has had falls since admission/entry or reentry of the prior assessment..." falls were coded as "2 or more falls with no injuries." MDS indicated that Resident 5's self-performance of transfer between surfaces including to or from the bed, was coded as a 3, meaning extensive assistance. A focus care plan dated 04/04/17 indicated, "...Resident displays moderate impairment with decision making...BIMS score is between 8-12..." A focus care plan dated 04/04/17 indicated, "...Resident will attempt at intervals to get up out of wheel chair by self...Has history of falls..." Care plan interventions included but were not limited to, "...The resident needs a safe environment..." A focus care plan dated 08/02/16 indicated, "...Resident has had (perceived/actual) altercation in mood			

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	state...expressions of anxious or fidgety/restless appearance..." A "Fall Risk Assessment" completed 5/26/17, that indicated a score of 10 or more would be considered a "high fall risk," Resident 5 was scored at a 13. A "Quarterly Nursing Assessment" for March of 2017 indicated that Resident 5's bed rails were properly installed and that the gap between the rails/bed frame and mattress edges was not greater than 2.5 inches. 3. On 6/7/17 at 2:08 p.m., Resident 12 was observed to have a quarter side rail to the outer side of the bed. The rail was observed to be loose, moved back and forth when pulled on. On 6/12/17 at 9:33 a.m., the quarter side rail to the bed was observed to be loose, moved back and forth when pulled on. During an interview on 6/9/17 at 3:07 p.m., Resident 12 indicated he used the side rail on his bed to position himself. During an interview on 6/12/17 at 9:33 a.m., the restorative CNA 12 indicated the resident used the quarter side rail to get in and out of bed. During an interview on 6/12/17 at 10:37			

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	a.m., the Director of Nursing (DON) indicated the resident used the side rail if he was unsteady. During an interview on 6/12/17 at 11:22 a.m., the Maintenance Director indicated that Resident 12's side rail was not in good working condition and needed to be tightened. Resident 12's record was reviewed on 6/9/17 at 9:02 a.m. Diagnosis from the care plan included, but were not limited to, difficulty in walking, low back pain and other reduced mobility. An annual MDS assessment, dated 12/17/16, indicated Resident 12 was independent for bed mobility and required no physical help from staff and independent for transfers (moves between surfaces including to or from bed) and required no physical help from staff. A care plan initiated on 1/18/16 and revised on 4/5/17 indicated the resident had potential for falls related to psychotropic medication use, resident transfers self, independent for bed mobility and had poor safety awareness. 4. On 6/12/17 at 8:50 a.m., during a random observation of Resident 24's room, the side rail (left facing head of bed) was observed to be loose.			

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	On 6/12/2017 at 11:29 a.m., during a random environmental round with the Maintenance Director the resident's side rail was observed to be loose. During an interview, on 6/12/17 at 10:23 a.m., the DON (director of nursing) indicated the resident used his side rails for bed mobility at times. During an interview, on 6/12/17 at 11:02 a.m., Physical Therapist (PT) 16 indicated the resident used his side rail to pull himself up to a sitting position at times when he is getting out of bed. During an interview, on 6/12/17 at 11:09 a.m., Restorative CNA 12 indicated the resident used his side rail to assist himself both to a sitting position in his bed and to assist himself to stand up several times a day. The bedrails should not be loose fitted to a bed. A loose rail could be a problem if a resident used it to steady themselves. During an interview, on 6/12/17 at 11:29 a.m., the Maintenance Director indicated the resident's rail was loose and needed tightened. He was unaware of how often bed rails should be checked for appropriate tightness.			

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	During an interview, on 6/12/17 at 1:28 p.m., the Regional Director of Clinical Operations indicated they did not have a policy for side rails, but rails should not be loose and should fit securely to the bed. During an interview, on 6/13/7 at 10:54 a.m., the Administrator indicated the "Preventative Maintenance Testing & Inspection Requirements," was the current policy being used by the facility. On 6/13/17 at 10:37 a.m., the Maintenance Director provided a document, dated 7/20/08, titled, "Preventative Maintenance Testing & Inspection Requirements," and indicated the policy was the one currently being used by the facility. The policy indicated, "NFPA Life Safety Code-101 (2000 Edition) & GHCC Required Tests & Inspections...23. Resident Items: A. Inspect resident bed...bolt tightness...B. Inspect...ensure proper operation of manual/electric wheel chairs...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0327 SS=D Bldg. 00	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. Based on observation, interview, and record review the facility failed to provide adequate fluids for 1 of 1 residents reviewed for hydration (Resident 4). Findings include: On 6/7/17 at 2:00 p.m., Resident 4's lips were noted to be dry. On 6/7/17 at 2:08 p.m., Resident 4 was observed to be eating lunch in her room, no drinks were provided for lunch. On 6/8/17 at 2:46 p.m., Resident 4's water pitcher in room was observed to be less than half full with no ice. No straw or cup were observed in Resident 4's room. Lips were dry. On 6/9/17 at 10:31 a.m., Resident 4 was observed to be sitting up in the wheelchair in her room, lips were dry. During a second lunch observation on 6/9/17 at 12:08 p.m., Resident 4 was	F 0327	**F327** **483.25(g)(2)** **SUFFICIENT FULUID TO MAINTAIN HYDRATION** **Based on a resident's comprehensive assessment, the facility must ensure that a resident-is offered sufficient fluid intake to maintain proper hydration and health.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -Resident #4 hydration needs were assessed to ensure adequate fluids are provided. Care plans were updated to reflect to the necessary changes. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** -All residents in the facility could	07/13/2017

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	served lunch with 8 ounces of coffee. No fluid choices were offered. Staff was not observed to encourage Resident 4 to drink her fluids. On 6/9/17 at 12:31 p.m., Resident 4 asked for lemonade to go with lunch. Lemonade was served as requested. During an interview on 6/9/17 at 10:12 a.m., the Director of Nursing (DON) indicated fluids were documented in the Certified Nursing Assistant's (CNA) computer charting only. Fluids were not documented anywhere else in the record. There were no hydration concerns that had been communicated to the DON. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. A admission record, dated 4/19/17, included, but was not limited to, paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, edema, and gastro-esophageal reflux disease without esophagitis. A nutrition assessment, dated 2/4/17, included, but was not limited to, a fluid need of 2925 milliliters (ml) daily. Average fluid consumption with meals was 480-600 ml. A review of Resident 4's daily fluid		potentially be affected by this practice. The hydration needs of all residents were reviewed by MDS for accuracy. Any discrepancies were corrected. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** -On 6/26/17 all staff were in-serviced on offering residents 2-3 drink options per meals. -On 6/26/17 Nursing Staff were in-serviced on encouraging fluids to resident to ensure adequate hydration and passing fresh ice water every shift. On 6/26/17 Dietary Staff were in-serviced on stocking the hydration cart for use after hours and having hydration cart be accessible for use **4. How will the facility monitor its corrective action?** To ensure compliance, the DON is responsible for the completion of fluid intake monitoring QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. It is the Dietary Manager responsibility to	

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	consumption indicated the following: a. 5/28/17: No fluid consumption or refusal was documented. b. 5/29/17-6/2/17: Resident 4 was out of the facility to the hospital. c. 6/3/17: Resident 4 returned from the hospital and consumed 480 ml of fluids the remainder of the day. d. 6/4/17: 960 ml. e. 6/5/17: 1200 ml. f. 6/6/17: 960 ml. g. 6/7/17: 480 ml. h. 6/8/17: 1180 ml. A physician's order, dated 8/8/16, included, but was not limited to, furosemide (a diuretic) 40 milligram (mg) tablet, give 1 tablet by mouth daily for edema. A physician's order, dated 6/3/17, included, but was not limited to, Bactrim double strength (an antibiotic), 1 tablet by mouth twice daily for 7 days for urinary tract infection (UTI).		stock the hydration cart for use after hours QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintain for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3, 2017	

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	A dehydration risk assessment, dated 6/3/17, included, but was not limited to, risk factors for dehydration of urinary tract infection, diabetes, and routine diuretics. A care plan, initiated on 9/23/15, and last revised on 5/15/17, included, but was not limited to, a focus of resident had the potential for fluid deficit and dehydration. A goal, included, but was not limited to, resident will be free from symptoms of dehydration and will maintain moist mucous membranes. Interventions included, but were not limited to, administer medications as ordered and monitor/document side effects, encourage the resident to drink fluids of choice, invite resident to activities that promote additional fluid intake, offer drinks during one on one visits, monitor/document/report to physician any signs or symptoms of dehydration, and obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated. On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document, dated November 2014, titled, "Weight/Hydration Management," and indicated the policy was the one currently being used by the facility. The			

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	policy indicated, "Overview...residents are provided with sufficient fluid intake to maintain proper hydration and health...." 3.1-46(b)			
F 0329 SS=D Bldg. 00	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a GDR (gradual dose reduction) of an antipsychotic medication was attempted when recommended for 1 of 5 residents reviewed for unnecessary medications	F 0329	**F329** **483.45(d)€(1)-(2)DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **Unnecessary Drugs-General. Each resident's drug regimen must be**	07/13/2017

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	(Resident 7). Findings include: The record for Resident 7 was reviewed on 6/8/17 at 1:24 p.m. Diagnosis from the care plan included, but were not limited to paranoid personality disorder, dementia with behaviors, psychosis, agitation, and paranoia. A review of "Orders" included, but was not limited to haloperidol (antipsychotic) 1 mg (milligrams) tablet give 1 tablet by mouth at bedtime for paranoia start date 10/2/15. A pharmacy report titled, "Consultation Report" and, dated 10/21/16, indicated, "...Comment: Resident 7 has received haloperidol 1 mg since 10/15. Recommendation: please consider a gradual dose reduction (GDR) to haloperidol 0.5 mg HS (at bedtime)... rational for recommendation: federal regulations require that antipsychotics being used to treat a psychiatric disorder be evaluated at least quarterly with documentation regarding continue clinical appropriateness and undergo gdr attempts in 2 separate quarters within the first year in which a resident is admitted or after the facility has initiated the medication, then annually... Physicians		**free from unnecessary drugs.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -Resident #7medication regimen to be evaluated by psychologist and attending physician, changes will be made if deemed as appropriate. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** -All residents on psychotropic medication have the potential to be affected by this alleged deficient practice. A review was made of the last 30 days' worth of pharmacy recommendations to ensure no other recommendations were missed. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** -On 6/26/17 all nursing staff were in-serviced on new procedures for evaluation, monitoring signs/symptoms and behaviors with medications of psychotropic nature, notifying the physician of changes in patient conditions, as well as	

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	response: decline the recommendation above because GDR is clinically contraindicated... signed by physician dated 10/24/16...." A physicians order, dated 10/26/16, indicated, continue haloperidol 1 mg QHS (every bedtime) for paranoia due to failed dose reduction. There was no further documentation provided of a failed attempted gradual drug reduction for haoperidol from 10/2/15 through 10/21/16 (the recommendation date of the annual gdr). A review of Care plans included, but was not limited to, "Focus: resident is at risk for drug related side effects from the use of psychotropic medications. Interventions with a revised ate of 2/7/17 included, but were not limited to administer medication as ordered, gradual dose reduction (GDR) per federal state guidelines." A review of MDS (minimum data set) quarterly assessment, dated 5/10/16, included, but was not limited to potential indicators of psychosis: none and behavioral symptom presence and frequency: behavior not exhibited. A review of MDS quarterly assessment, dated 6/10/16, included, but was not		resident family members. -DON will be monitoring GDR with IDT and physicians monthly **4. How will the facility monitor its corrective action?** -To ensure compliance, the DON is responsible for monitor and following pharmacy recommendations for GDR, conduct chart audits and physician progress notes verifying GDRs are being achieved QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3, 2017	

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	limited to potential indicators of psychosis: none and behavioral symptom presence and frequency: behavior not exhibited. A review of MDS comprehensive assessment, dated 9/9/16, included, but was not limited to potential indicators of psychosis: none, behavioral symptom presence and frequency: behavior not exhibited and overall presence of behavioral symptoms: no. During an interview on 6/9/17 at 1:54 p.m., the MDS coordinator indicated she could not find a failed attempted drug reduction of haloperidol between the dates of October 2015 through October 2016. During an interview on 6/9/17 at 2:29 p.m., CNA 13 indicated if a resident has exhibited behaviors she would report it to the nurse and chart the behavior in the behavior book. During an interview on 6/12/17 at 11:51 a.m., [physican name] indicated the last attempted GDR for haloperidol he found documented was on 10/2/15. On 6/12/17 at 2:46 p.m., the Regional Director of Clinical Operations provided a policy titled, "Psychotropic			

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	Management," and indicated was the one currently being used by the facility. The policy included, but was not limited to, "... 13. the physician and consulting pharmacist will review the progress of the resident and advice the nursing staff in the development of goals and a plan to maintain the resident at the lowest dosage possible to control symptoms... 15. Monitoring and evaluation of the resident for the potential reduction of psychoactive medication will be reviewed at the resident's quarterly care plan meeting...." 3.1-48(b)(2)			
F 0371 SS=D Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not			

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	procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview, and record review, the facility failed to ensure food and drinks were served under sanitary conditions, during 2 of 2 dining observations. Findings include: On 6/07/17 at 11:59 a.m., during initial dining observation, CNA (Certified Nursing Aide) 2 was observed holding Resident 10's drinking glass around the rim with her bare hands. On 6/13/17 at 12:07 p.m., during a random meal observation, RN (Registered Nurse) 26 was observed touching Resident 14's bread with her bare hands when buttering it. During an interview, on 6/13/17 at 12:28 p.m., CNA 2 indicated it was never okay for anyone to touch the rims of drinking glasses or food with their bare hands, when serving the resident meals.	F 0371	**F371** **483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY** **Have a policy regarding use and storage of foods brought to residents by family and other by visitors to ensure safe and sanitary storage, handling, and consumption.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -When brought to facility's attention on 6/13/17, after meal service had been completed that staff members improperly handled food items and drinking glasses. All staff members were immediately in-serviced on Food Service. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?**	07/13/2017

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	During an interview, on 6/13/17 at 12:32 p.m., RN 26 indicated staff should not touch food with their bare hands when serving or assisting with resident meals. On 6/13/17 at 1:09 p.m., the Regional Director of Clinical Operations provided a document, dated 2009, titled, "Dietary Services," and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To prevent contamination of food products...VI. Proper Food Handling: ...C. Foods are...served...so as to avoid manual contact of prepared foods...G. Fingers are to be kept out of food...." 3.1-21(i)(3)		-All residents in the facility could potentially be affected by this practice. Education given to all staff with particular emphasis on safe food handling while assisting a resident to eat. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** -All staff were in-serviced on 6/13/17 on safe food handling and meal service. -Residents also educated during a Resident Council meeting that they have the right to request new meal items if they feel they were improperly handled. **4. How will the facility monitor its corrective action?** -To ensure compliance, the Department Heads are responsible for monitoring adequate food/drink handling QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. Activity Director is responsible for asking residents if they have any complaints/concerns related to handling of food during Resident Council QAPI audits weekly for four weeks and monthly for six months until compliance is achieved for two consecutive quarters. The	

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			results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. Date Completed: July 3,2017	
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			

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	(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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and	F 0441	F441	07/13/2017

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	record review, the facility failed to ensure proper cleaning, storage and weekly changing of nebulizer equipment for 1 of 5 resident's reviewed for unnecessary medications (Resident 7). Findings include: On 6/7/17 at 11:26 a.m., Resident 7 was in his room giving self a breathing treatment, when completed the resident turned the machine off and placed tubing and mouthpiece onto bedside table, and did not place in bag. On 6/9/17 at 8:57 a.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. On 6/9/17 at 2:08 p.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. On 6/12/17 at 11:02 a.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. The bag used for storage of nebulizer equipment was observed laying on resident's night stand and was dated 6/5/17, the nebulizer tubing was also dated 6/5/17.		**483.80(a)(a)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS** **The facility must establish an infection prevention and control program that must include at a minimum a system for preventing, identifying, reporting, investigation, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -Resident #7 re-educated on placing nebulizer tubing and mouth piece into a plastic bag; resident refuses to place items in bag. After resident does breathing treatment, nursing will clean /dry out medication cup of the mouth piece, place the tubing, mouth piece into a bag labeled with resident's name and place in med cart. **2. How will the facility identify resident having the potential to be affected by the same deficient practice?** -All resident that self-administration	

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	155511	A. BUILDING 00 B. WING	06/13/2017

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	On 6/13/17 at 9:21 a.m., Resident 7's nebulizer tubing and mouth piece were observed on bed side table, not placed inside of bag. The bag used for storage of nebulizer equipment was observed laying on resident's night stand and was dated 6/5/17, the nebulizer tubing was also dated 6/5/17. Resident 7's record was reviewed on 6/8/17 at 1:24 p.m. The diagnosis on the care plan included, but was not limited to COPD (Chronic Obstructive Pulmonary Disease) and allergies. A review of physicians orders included, but was not limited to, start date 9/29/16 budesonide (steroid and decongestant) 0.25 mg (milligrams)/ 2 ml (milliliters) suspension inhale 2 ml via nebulizer (device used to deliver medication in the form of a mist) 2 times a day, after use: rinse mouth and spit. A review of the original comprehensive physician's order sheet dated 3/19/17 included, but was not limited to, resident may administer nebulizer treatments to self. During an interview on 6/9/17 at 2:04 p.m., Resident 7 indicated he administered his breathing treatments and when finished placed tubing and		could potentially be affected. However, those resident that perform self-administration of nebulizer treatment were assessed immediately and will continue to be monitored quarterly for their ability to self-administer medications. **3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** -All nursing staff were in-serviced on the proper cleaning/drying, and storage of nebulizer tubing and medication cup. -Handling of nebulizer equipment was added to the MAR for documentation and accountability **4. How will the facility monitor its corrective action?** -To ensure compliance, the DON is responsible monitoring resident MARs for documentation and the storage of nebulizer equipment QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are	

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	mouthpiece on bedside table, indicated he did not place the mouthpiece back into bag because it was too much trouble and that he does not clean the equipment after each use. During an interview on 6/9/17 at 2:08 p.m., the DON indicated the resident cleans the nebulizer equipment after use and should place the mouthpiece in the bag once the nebulizer treatment is completed. Also indicated, the CNA's (Certified Nursing Assistants) will place the mouthpiece back into the bag if the resident did not. On 6/12/17 at 1:12 p.m., the DON (Director of Nursing) provided a document titled, "Aerosolized Medication Therapy Education," and indicated the policy was the one currently being used by the facility. The policy indicated, "... 17. When finished, place the nebulizer equipment in a labeled bag with patient name and date. 18. Change the nebulizer equipment weekly... Documentation should include: medication left in cup needs poured out and dried after each treatment...." On 6/12/17 at 1:12 p.m., the DON provided a document titled, "Aerosol Treatments," and indicated the policy was the one currently being used by the		submitted to regional operations staff and corporate risk management for review. Date Completed: July 3, 2017	

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	facility. The policy indicated, "... Policy: ... B. Nebulizers are to be shaken dry after each use and stored aseptically. C. Nebulizer set up including masks are to be changed weekly and prn (as needed)...." 3.1-18(a)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (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:	F 9999	**F999 FINAL OBSERVATIONS** **3.1-14(t)(1) PERSONEL** **A physical examination shall be required for each employee at a facility within one month prior to employment. The examination shall include 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: At time**	07/13/2017

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	(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 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. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 6 of 10 employees had a health review conducted by the Director of Nursing (DON) or Registered Nurse (RN) designee, and failed to ensure 3 out of 10 employees had tuberculosis (TB) screening upon hire. This deficiency had the potential to affect 23 out of 23 residents residing at the facility. Findings include: On 6/19/17 at 2:00 p.m., ten employee records were reviewed for proof of		**of employment, or within one month prior to employment, and at least annually thereafter, employees and nonpaid personnel of the facility shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve months, the baseline tuberculin skin testing should employ the two step method. If the first step is negative, a second test should be performed on to three weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.** **1 . How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -The DON/RN Designee will monitor, document and sign all employee physical examinations. -The DON/RN Designee will monitor all employee tuberculin skin testing to ensure compliance. **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -All residents in the facility could potentially be affected by this practice. However, the DON/RN	

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	physical examination and tuberculosis (TB) screening upon hire. Six employee records; Registered Nurses (RN 5, 4), Licensed Practical Nurse (LPN 6) and Certified Nurse Aides (CNA 1, 2, 3), failed to show documentation of physical examination upon hire. Three employee records, (CNA 1, 2, 3), failed to show documentation of TB screening upon hire. State form 5440, "Employee Records", provided on 6/7/17 at 2:00 p.m. by the Administrator, indicated RN 5 began employment on 1/26/17, RN 6 began employment on 3/5/16, LPN 6 began employment on 10/7/16, CNA 1 began employment on 2/24/17, CNA 3 began employment on 2/9/17, CNA 7 began employment on 4/6/17, and CNA 2 began employment on 3/18/17. 1. RN 5, had a Post-Offer Pre-Employment Physical completed and signed by LPN 9. RN 4, had a Post-Offer Pre-Employment Physical completed and signed by LPN 8. LPN 6, had a Post-Offer Pre-Employment Physical completed and signed by LPN 8. CNA 1, had a Post-Offer		Designee will be monitor, document and sign all employee physicals. DON/RN Designee will be responsible for monitoring all employee tuberculin skin testing. **3. What measures were put into place or systemic changes made to ensure the deficient practice will not recur?** - Implemented on 6/19/17 DON/RN Designee will monitor, document and sign all employee physical examinations. Once physical examination is signed by DON/RN Designee, it will then be given the Business Office Manager to file in the respective employees' file. -DON/RN Designee will maintain and monitor all employee's tuberculin skin test until completion. Once tuberculin skin test are completed, DON/RN Designee will give those results to Business Office Manager to file in the respective employee's file **4. How will the facility monitor its corrective action?** -The DON/RN Designee is responsible for monitoring and signing all physicals, including but not limited to tuberculin skin test results QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive	

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	Pre-Employment Physical completed and signed by LPN 10. CNA3, had a Post-Offer Pre-Employment Physical completed and signed by LPN 10. CNA 7, had a Post-Offer Pre-Employment Physical completed and signed by LPN 10. 2. CNA 1, was administered the first step TB skin test on 2/23/17 and the second step TB skin test on 3/23/17. CNA 3, was administered the first step TB skin test on 2/10/17 and the second step TB skin test on 3/27/17. CNA 2, was administered the first step TB skin test on 9/14/16 and was not administered a second step TB skin test. On 6/7/17 at 2:00 p.m., the June 2017 Nursing Schedule from 6/1/17 to 6/30/17 was reviewed and indicated RN's 5 and 4, LPN 6, CNA's 1, 2, 3, and 7 had worked during the time frame. On 6/12/17 at 10:23 a.m., the Director of Nursing (DON) and Administrator indicated the Business Office Manager (BOM) is responsible for keeping employee files current.		quarters. The results of these audits will be reviewed by the QAPI Committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management team for review. **Date Completed: July 3, 2017**	

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	On 6/12/17 at 1:20 p.m., during an interview with the DON, Administrator and Regional Clinical Director, the DON and Administrator indicated that LPN's had completed the Post-Offer Pre-Employment Physical form and it should have been a RN. The Regional Clinical Director agreed and indicated they cannot fix the past. On 6/12/17 at 10:45 a.m., the Regional BOM, indicated employees have not been sent out for pre-employment physicals. The "Post-Offer Pre-Employment Physical" is being utilized. 2-step TB skin results are kept in the employee file and in a binder at the desk. The DON, on 06/12/17 at 10:35 a.m., provided a current policy titled, "Human Resources Policies and Procedures Manual; Section 1. Employment; Subject, HR-106: Health Requirements Revised 4/15/15". The Health Review indicated: "The DON or RN designee will conduct the health review to include the TB test, vital sign assessment, and ability to perform the essential functions of the job ..." The Regional Clinical Director, on 6/12/17 at 11:00 a.m., provided a duplicate of the "Human Resources			

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	Policies and Procedures Manual; Section 1. Employment; Subject, HR-106: Health Requirements Revised 4/15/15" and indicated this is the most current policy. Health Review indicates: "The DON or RN designee will conduct the health review to include the TB test, vital sign assessment, and ability to perform the essential functions of the job". On 6/12/17 at 11:00 a.m., the Regional Clinical Director provided a current policy, "Infection Prevention Manual for Long Term Care" and indicated this is used for TB skin testing. The policy indicates, " ...All qualified applicants for employment shall be screened for presence of infection with M. tuberculosis using the Mantoux TST. Skin testing will employ the two-step procedure ..." 3.1-14(t)(1)			