STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00314889. Complaint IN00314889 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F684 and F692. Survey dates: December 30 and 31, 2019 and January 2, 3, 6 and 7, 2020. Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 16 Medicaid 111 Other: 8 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/13/20.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after February 6, 2020.**	
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in			

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

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	effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents.			
	Based on observation and interview, the facility failed to have the most recent State Department of Health survey report readily available for review. This had the potential to affect the 135 residents who resided in the facility. Finding includes: On 1/3/20 at 1:59 p.m., the State survey results binder was reviewed. It lacked the report from the complaint survey completed on 9/17/19. Interview with the Administrator on 1/3/20 at 3:02 p.m. indicated she would make sure the most current results were in the binder. 3.1-3(b)(1)	F 0577	**F577 – Right to Survey Results/Advocate Agency Info** It is the practice of this facility to have available and accessible to residents and family members and legal representatives of residents, the results of the most recent surveys of the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Results of the most recent survey of the facility conducted by Federal or State Surveyors as well as associated Plans of Correction are displayed and available in the	02/06/2020

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			Survey Binder and accessible to residents, family members and legal representatives of residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken*:*** The ISDH Survey Binder was audited, reviewed and updated to include all recent Survey findings of the facility conducted by Federal or State Surveyors as well as any associated Plans of Correction as outlined in the Regulations. The Survey Binder is posted in a place readily accessible to residents and family members and legal representatives of residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A nursing in-service will be conducted by the DNS/designee on or before 2/6/20. This in-service will include review of the facility policy related to accessibility of Federal and State Survey results. All staff will be educated on the location of the Survey Binder and the availability of recent Federal or State Survey results. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the QAPI Audit Tool monthly until 100% compliance is reached for three consecutive months related to Posting of Federal and State Survey Results. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (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			

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	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 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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, record review and interview, the facility failed to obtain orders to remove a resident from isolation in a timely manner following lab results for 1 of 3 resident's reviewed for non-UTI or respiratory infections. (Resident 36)	F 0580	**F580 – Notify of Changes (Injury/Decline/Room, etc.)** It is the practice of this provider to promptly notify the resident, consult with resident's physician, notify resident's legal	02/06/2020

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	Finding includes: On 12/30/19 at 2:35 p.m., a Contact Isolation sign was noted on the door of Resident 36's room. On 1/3/20 at 8:25 a.m., the Contact Isolation sign was still on the resident's room. At 10:50 a.m., it was observed the sign had been removed and the resident was no longer in isolation. The resident's record was reviewed on 1/4/20 at 11:15 a.m. He was admitted to the facility on 6/17/19. Diagnoses included, but were not limited to, end stage renal disease, type two diabetes, and pressure ulcers on his sacrum and left heel. He was receiving antibiotic therapy. A Nursing Note, dated 12/28/19 at 5:01 p.m., indicated the resident was on contact isolation for C. difficile (C. diff, a contagious bacterial infection in the gastrointestinal tract) and they were awaiting results from a stool sample. A Nursing Note, dated 12/31/19 at 4: 21 p.m. (recorded as a late entry on 1/2/20 at 4:24 p.m.), indicated the lab results for C. diff was negative and the doctor was notified. There were no new orders. During an interview with the Interim Director of Nursing (IDON) on 1/3/20 at 9:15 a.m., she indicated when a C. diff GDH antigen was positive and C. diff toxin was negative, that was usually considered a negative result. She was unsure why the resident was still on isolation precautions, but would look into it. During a follow up interview with the IDON on 1/7/20 at 10:20 a.m., she indicated there had no		representative or interested family when there is a significant condition change in the resident's physical, mental or psychosocial status and/or the need to alter treatment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #36 – resident has been removed from isolation. Care plans and physician's orders have been updated to reflect this resident's current status. Family and physician are aware of this resident's current status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken*:*** All residents have the potential to be affected by this finding. A chart audit of the last 30 days will be conducted by the Nurse Management Team to ensure the physician, family and/or responsible party has been notified regarding any change in resident condition including timely discontinuation of isolation precautions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A nursing in-service will be	

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	been no orders received to discontinue the isolation precautions after receiving the negative lab result at that time. The resident was on isolation for an additional four days. 3.1-5(a)(3)		conducted by the DNS/designee on or before 2/6/20. This in-service will include review of the facility policy related to Resident Change in Condition. This in-service will also include review of the facility policy and procedure for family/POA notification guidelines for any change in resident condition such as timely discontinuation of isolation precautions. Continued compliance with prompt notification will be monitored through review of nursing progress notes and physician orders during the daily clinical meeting by the DNS/designee to ensure proper follow up and notifications have occurred. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the QAPI Audit Tool related to Change in Condition daily for 3 weeks and then monthly until 100% compliance is reached. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow	

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			up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure a thorough investigation was completed related to a resident to resident altercation for 1 of 3 abuse allegations reviewed. (Residents 69 & 121) Finding includes: Interview with Resident 69 on 12/30/19 at 11:39 a.m. indicated she had an incident with Resident 121 "not too long ago." Resident 121 had entered her room while she was sleeping and took her cosmetics bag. After a while, she got up and went to Resident 121's room to get her cosmetics bag	F 0610	**F610 – Investigate/Prevent/Correct Alleged Violation** It is the practice of this facility to thoroughly investigate and report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. It is also the practice of this facility to report results of all investigations to State Survey Agency and other officials in	02/06/2020

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	back. When she entered the room, Resident 121 was sleeping and she saw her cosmetics bag on the floor so she went to pick it up. While she was doing this, Resident 121 got out of bed, pushed her to the floor, and began hitting her. At that time, staff entered the room and separated them. She felt staff blamed her for the incident because she was in Resident 121's room and, when staff entered the room they only saw her trying to get her cosmetics bag back, not what Resident 121 had done to her first. The record for Resident 69 was reviewed on 1/20/20 at 10:03 a.m. Diagnoses included, but were not limited to, hypertension, osteoarthritis, and dementia without behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/12/19, indicated she was cognitively intact. A reportable incident investigation, dated 3/17/19, indicated Resident 69 had entered Resident 121's room and had gotten in a verbal and physical altercation. Staff intervened and redirected the residents. Resident 69 had pulled Resident 121's hair which resulted in Resident 121 falling. A progress note written by LPN 8, dated 3/7/19 at 8:35 p.m., indicated Resident 69 "had a physical altercation with another resident. QMA entered other resident's [Resident 121] room and found resident (Resident 69) standing over other resident [Resident 121] pulling other resident's hair. Both residents were immediately separated. Per resident [Resident 69], other resident [Resident 121] 'comes into her room all the time and takes my things.' Resident [Resident 69] stated she keeps her things in her walker and noticed cosmetics, brushes and toothpaste were missing. Resident [Resident 69] stated 'nothing is		accordance with State law and indicate if the alleged violation is verified. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #69 – there have no other altercations between this resident and others. Family and physician were notified of this altercation. Resident #121 – there have no other altercations between this resident and others. Family and physician were notified of this altercation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents are at risk to be affected by this finding. All ISDH Reportable Incidents for the past 30 days have been reviewed and audited to ensure a thorough investigation was completed including full names and signatures of all facility staff/witnesses, written statements/interviews from involved staff/witnesses and interviews with other residents as appropriate to each situation. Any allegation or statement regarding resident abuse/mistreatment or misappropriation of resident property will be reported	

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	being done so I was taking things into my own hands. She was going to hit me so I pulled her hair and pulled her down on the ground..." The investigation included two incident forms completed by staff. There were no names listed as to who completed the forms and the forms were not signed by anyone. There were no other written statements or interviews from Resident 69, Resident 121, LPN 8, the QMA who had separated the residents, any other staff who may have been working when the incident took place, or any other residents. Interview with the Administrator on 1/3/20 at 3:02 p.m., indicated the incident had taken place prior to her working at the facility. There were two incident reports filled out by staff but she was unable to determine who the staff were as there were no names on the forms. She was unable to find any other written statements or interviews from any staff or residents other than what was written in the progress note. A facility policy titled, "Abuse Prohibition, Reporting, and Investigation," indicated, "...Resident to Resident Abuse:...6. a. Residents will be questioned (if alert and competent) about the nature of the incident. b. Statements will be taken from individuals witnessing the incident...18. A comprehensive record of the abuse investigation will be kept by the facility Executive Director and/or Director of Nursing Services..." 3.1-28(d)		immediately to the ED and DNS. The facility will then immediately report to ISDH and other agencies outlined in the facility policy and initiate a full investigation including full names and signatures of all facility staff/witnesses, written statements/interviews from involved staff/witnesses and interviews with other residents as appropriate to each situation. Results of all investigations will be reported to State Survey Agency and other officials in accordance with State law and indicate if the alleged violation is verified and what corrective action was taken. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be held on or before 2/6/20 by the ED/DNS or designee. This in-service will include review of the facility policy related to Abuse Prohibition and Investigation. Any allegation or statement regarding resident abuse/mistreatment or misappropriation of resident property will be reported immediately to the ED and DNS. The facility will then immediately report to ISDH and other agencies outlined in the facility policy and initiate a full investigation including full names and signatures of all facility staff/witnesses, written statements/interviews from	

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			involved staff/witnesses and interviews with other residents as appropriate to each situation. Results of all investigations will be reported to State Survey Agency and other officials in accordance with State law and indicate if the alleged violation is verified and what corrective action was taken. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The ED/Designee will be responsible for completing the QAPI Audit tool related to Abuse, Prohibition, Reporting and Investigation weekly for 4 weeks and monthly until 100% compliance is reached. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments.			

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	The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately complete Minimum Data Set (MDS) assessments related to pain assessments for 2 of 31 residents reviewed for MDS assessments. (Residents 76 & 60) Findings include: 1. Record review for Resident 76 was completed on 1/2/2020 at 12:06 p.m. Diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, depression, Celiac disease, and HIV (human immunodeficiency virus). The Admission MDS assessment, dated 11/24/19, indicated the resident was cognitively intact. The resident received scheduled and PRN (when necessary) pain medication. The pain assessment interview was checked yes to be completed. The pain assessment interview was not completed. The January 2020 Physician's Order Summary indicated orders for: -hydrocodone-acetaminophen (pain medication) 7.5/325 mg (milligrams) every 8 hours prn -hydrocodone-acetaminophen 7.5/325 mg twice a day Interview with the MDS Assistant on 1/2/2020 at 3:13 p.m., indicated the pain assessment interview section on the MDS was not completed. The nurses were responsible for completing the pain interview section with the resident. 2. Record review for Resident 60 was completed on 1/7/2020 at 8:50 a.m. Diagnoses included, but were not limited to, hypertension, anxiety, depression, COPD (chronic obstructive	F 0641	**F 641 Accuracy of Assessments** It is the intent of this provider that each assessment accurately reflects the resident's status. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 76 – Pain Assessment has been completed to accurately reflect the resident's pain. This resident experienced no negative outcome related to this finding. Resident # 60 – Pain Assessment has been completed to accurately reflect the resident's pain. This resident experienced no negative outcome related to thus finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by MDS Coordinator/Designee for all MDS assessments completed in the past 30 days to ensure accuracy and completion of all required Supplemental Assessments including Pain Assessments. Any identified inaccurate MDS assessments will be updated and/or modified as indicated. MDS Coordinator/designee will be	02/06/2020

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	pulmonary disease), respiratory failure, and osteoarthritis. The Quarterly MDS assessment, dated 12/17/19, indicated the resident was cognitively intact. The resident received scheduled PRN pain medication. The pain assessment interview was checked yes to be completed. The pain assessment interview was not completed. The resident received hospice care. The January 2020 Physician's Order Summary indicated orders for: -morphine concentrate (pain medication) 15 mg every 4 hours prn for severe pain or SOB (shortness of breath) -Norco (pain medication) 5/325 mg every 4 hours Interview with the MDS Coordinator on 1/7/2020 at 9:23 a.m., indicated they could go ask the residents if they were having pain, but they had to use the pain assessment observations the unit managers completed on the residents. The pain assessments were not always filled out for the residents when the MDS assessments were completed. Interview with the West Unit Manager on 1/7/2020 at 11:03 a.m., indicated the nurses are supposed to complete pain assessments quarterly. He could not find any documentation a pain assessment had been completed for the resident during the assessment period for the last MDS assessment or that one had been completed since. 3.1-31(i)		responsible for daily audits to ensure accurate and timely completion of all required Supplemental Assessments including Pain Assessments. **What measures will be put into place or what systematic change will you make to ensure that the deficient practice does not recur?** MDS Coordinator will be in-serviced by the DNS/Designee regarding accuracy and completion of all required Supplemental Assessments including Pain Assessments. Nurses and Nurse Management Team will be in-serviced on or before 2/6/20 by the DNS/Designee regarding accuracy of MDS. MDS Coordinator/designee will be responsible for daily audits to ensure accurate and timely completion of all required Supplemental Assessments including Pain Assessments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** To ensure ongoing compliance with this action, the QAPI Audit Tool titled “MDS Accuracy” will be completed weekly for 4 weeks, then monthly until 100% compliance is achieved. Findings will be reviewed in monthly QAPI Committee Meeting. If a threshold	

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			of 90% is not met, an action plan will be implemented. **By what date the systemic changes will be completed:** Completion date = 2/6/20.	
F 0661 SS=A Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on record review and interview, the facility	F 0661	**F661 – Discharge Summary**	02/06/2020

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	failed to thoroughly complete a discharge summary for 1 of 1 sampled residents reviewed for discharge. (Resident 133) Finding includes: Resident 133's closed record was reviewed on 1/2/20 at 10:30 a.m. Diagnoses included, but were not limited to, cancer and Chronic Obstructive Pulmonary Disease. The resident was discharged from the facility on 11/7/19. A Progress Note, dated 11/7/19 at 9:18 a.m., indicated the resident was discharged home with her family. The discharge paperwork was reviewed with the resident, her medications and all of her belongings were sent with her. The Discharge Summary Information form, dated 11/7/19, was incomplete for the following information: "Goals of Stay (short term rehabilitation, pending discharge to home), Recapitulation of Stay, Customary Routine, Continence, Cognitive Patterns, Dental, Communication, Nutritional Status, Vision, Clinical Discharge and Narrative, Pressure Ulcer/Injury, Mood and Behavior, Patterns, Activity Pursuits, Psychosocial Well-Being, Physical Functioning and Structural Problems, Care Team, Provider Name, Provider Type, Address and Phone." Interview with Medical Records Staff on 1/3/20 at 10:30 a.m., indicated the summary was not completed. A policy titled, "Discharge Planning," was provided by Medical Records Staff on 1/3/10 at		It is the intent of this provider that all residents anticipating discharge have a Discharge Summary completed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #133 – Discharge Summary has been completed to include all required and necessary information. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** Any resident who Discharges from the facility has the potential to be affected by this finding. A facility audit will be completed by Nurse Management Team/Designee for all Discharged Residents in the past 30 days to ensure all Discharge Summaries have been completed in their entirety and include all required and necessary information. Nurse Management Team/designee will be responsible for reviewing all Resident Discharges daily during the Clinical Meeting to ensure all Discharge Summaries have been completed per policy and include all required and necessary information. **What measures will be put into place or what systematic change will you make to**	

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	12:01 p.m. This current policy indicated, "Policy:...Discharge planning will include an ongoing person-centered evaluation of needs, caregiver support, goals and preferences...." 3.1-36 (a)(1) 3.1-36 (a)(2)		**ensure that the deficient practice does not recur?** A Nursing In-service will be conducted on or before 2/6/20 by the DNS/designee. This in-service will include review of the policy related to Discharge Planning and the importance of completing Discharges Summaries in their entirety to include accurate and resident specific information pertinent to each resident's individualized need. Nurse Management Team/designee will be responsible for reviewing all Resident Discharges daily during the Clinical Meeting to ensure all Discharge Summaries have been completed per policy and include all required and necessary information. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The Nurse Management Team/designee will be responsible for completing the QAPI Audit tool related to Resident Discharges daily for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the	

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			Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Completion date = 2/6/20.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(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, record review and interview, the facility failed to ensure activities of daily living for a dependent resident were maintained related to a soiled bed sheet not changed for 1 of 1 random observations. (Resident B) Finding includes: On 1/2/20 at 2:30 p.m., personal care was observed for Resident B while in bed. CNA 2 rolled him to the left side. While he was turned on his side, the sheet beneath him was observed to have a round, yellowish discoloration and had been covered with a chux. The CNA indicated she had also seen the soiled sheet. She indicated the resident's brief was dry. The record for Resident B was reviewed on 12/31/19 at 2:10 p.m. The resident was admitted to the facility on 3/28/19. Diagnoses included, but were not limited to, cerebral palsy and malnutrition. The Quarterly Minimum Data Set assessment, dated 9/27/19, indicated the resident needed extensive two person assistance for bed	F 0677	**F677 – ADL Care Provided for Dependent Residents** It is the practice of this facility that 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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #B – care plan has been reviewed and updated to reflect resident specific ADL care needs. This resident has been receiving assistance with activities of daily living including incontinent care and clean bed linens. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	02/06/2020

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	mobility and transfers. During an interview with CNA 2 at that time, she indicated the previous CNA had given her report several moments before and indicated to her that he was dry and had just been changed. Placing a chux over a soiled sheet was not acceptable and she indicated she was going to change it immediately. 3.1-38(a)(3)		Any resident requiring assistance with activities of daily living have the potential to be affected by this finding. The care plan and Resident Profiles were reviewed for all residents requiring assistance with ADL care such as incontinent care and clean bed linens to ensure each resident specific need was accurately addressed. Resident needs specific to incontinent care were updated as identified and communicated to all direct care staff. Changes in residents requiring ADL assistance such as incontinent care are reviewed quarterly during the care plan review process and/or with any noted change in resident condition. The DNS/designee and Care Companions will be responsible for conducting rounds on each shift to ensure residents are receiving ADL assistance as identified in their individual plan of care. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 2/6/20. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to incontinent care, bed strips and linen care. Changes in residents requiring ADL assistance such as incontinent care are reviewed	

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			quarterly during the care plan review process and/or with any noted change in resident condition. The DNS/designee and Care Companions will be responsible for conducting rounds on each shift to ensure residents are receiving ADL assistance as identified in their individual plan of care and that incontinent care is being provided as identified. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/Designee will be responsible for completing the QAPI Audit tool related to Dignity and Privacy daily for 4 weeks and then monthly until 100% compliance is reached. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20.	
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure scratches and bruising were identified and monitored for 2 of 4 resident's reviewed for non-pressure skin issues. (Residents B and C) Findings include: 1. On 1/2/20 at 2:30 p.m., personal care was observed for Resident B while in bed. CNA 2 rolled him to the the left side, there were three faint, pink scars observed on his back, approximately 2 cm (centimeters) x (by) 4 cm each. The CNA indicated that was where scratches had previously been from the abdominal binder rubbing on him. The record for Resident B was reviewed on 12/31/19 at 2:10 p.m. The resident was admitted to the facility on 3/28/19. Diagnoses included, but were not limited to, cerebral palsy and malnutrition. The Quarterly Minimum Data Set assessment, dated 9/27/19, indicated the resident needed extensive two person assistance for bed mobility and transfers. The resident had a PEG tube (a tube surgically inserted through the abdomen into the stomach) to receive nutrition. Nursing notes indicated he would pull on this tube, so an abdominal binder was placed around	F 0684	**F684 - Quality of Care** It is the practice of this facility to ensure that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B's scratches and skin alterations are being monitored at least weekly by the facility Wound Nurse and are receiving daily treatments, observations, assessments and monitoring by licensed nurses. Physician and responsible party are aware of this resident's skin status. Any resident with wounds is being monitored and assessed weekly per facility policy. Resident C's bruising and discolorations are being monitored at least weekly by the facility Wound Nurse and are receiving daily treatments, observations,	02/06/2020

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	him to prevent him from pulling on it. An Event Report, dated 12/8/19, indicated the resident had a new skin area described as dark/dull red scratches to mid and upper back. The measurements were documented as "multiple" instead of actual measurements. A follow up document, dated 12/10/19, indicated the scratches to mid back were pink and the measurements were "NA". An Event Report, dated 12/9/19, indicated the resident had a new skin area to the lower back described as scratches, the measurements section was documented as, "NA". During an interview with the Wound Nurse on 1/2/19 at 12:10 p.m., she indicated wounds should be measured weekly and documented in Skin Events or in Nursing Notes. Progress Notes were reviewed with the Wound Nurse and there was no additional monitoring noted. She indicated there was no additional documentation. 2. Interview with Resident C on 12/31/19 at 10:57 a.m., indicated she had dark purple skin discolorations to the back of her upper left arm and her stomach. She was receiving lovenox (an anticoagulant medication) injections. At that time, a circular purple discolored area was observed to the back of the resident's left arm and the resident's entire stomach area was observed to be purple in color. She was unsure if the staff were monitoring the discolorations. On 1/3/20 at 9:31 a.m., Resident C was observed seated in her wheel chair in her room. A circular purple discolored area was observed to the back of her left arm. On 1/3/20 at 10:09 a.m., Resident C was observed		assessments and monitoring by licensed nurses. Physician and responsible party are aware of this resident's skin status. Any resident with wounds is being monitored and assessed weekly per facility policy. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident with pressure areas, significant wounds and other skin alterations such as scratches and bruising have the potential to be affected by this finding. The care plan, Resident Profile and physician orders were reviewed for all residents with current wounds and other skin alterations such as scratches and bruising to ensure that treatments and weekly assessments, measurements and documentation are in place per facility policy and care plan interventions are being followed for those residents with wounds and other skin alterations. A facility wide skin-sweep to assess all resident skin conditions was completed by the Nurse Management Team/designee. Any new area identified will be reviewed, monitored assessed and measured weekly and followed per facility policy. All pressure and significant non-pressure wounds are assessed, measured and documented on weekly by Wound	

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	seated in her wheel chair in her room. She indicated she still had discolorations to her stomach from the lovenox shots. The resident's entire stomach area was observed to be purple in color. Resident C's record was reviewed on 1/2/20 at 12:14 p.m. Diagnoses included, but were not limited to, hypertension, anemia, and type 2 diabetes mellitus. The resident was admitted to the facility on 12/24/19. The Admission Observation, dated 12/24/19, indicated there were no alterations in the resident's skin. The current Physician's Order Summary indicated the resident was receiving lovenox injections two times a day. A current care plan indicated the resident was at risk for abnormal or excessive bleeding due to anticoagulant medication use. The interventions included, "...observe for signs of bleeding: excessive bruising, bruise increasing in size..." Interview with LPN 3 on 1/3/20 at 10:20 a.m., indicated she had just noticed the bruising to the resident's abdomen when she had given her lovenox injection this morning. She was unable to find any previous documentation or monitoring of the skin discolorations to the resident's stomach or left arm. A facility policy titled, "Skin Management Program," indicated, "....Procedure for Wound Prevention:...6. Any skin alterations noted by direct care givers during daily care and or shower days must be reported to the licensed nurse for further assessment, to included but not limited to		Nurse/designee. The Unit Manager/designee will be responsible for checking the New Skin Event Report daily and reviewing all newly admitted/re-admitted resident skin assessments to ensure any skin alteration is being followed and monitored per facility policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 2/6/20. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to the Skin Management Program. The Unit Manager/designee will be responsible for checking the New Skin Event Report daily and reviewing all newly admitted/re-admitted resident skin assessments to ensure any skin alteration is being followed and monitored per facility policy. DNS/designee will be responsible for ensuring that weekly wound assessments and documentation are completed per policy for all wounds and other skin alterations such as scratches and skin discolorations/bruising. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	bruises, open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported...Procedure for Alterations in Skin Integrity-Pressure and Non-Pressure:...3. All alterations in skin integrity will be documented on the admission observation in the medical record on the admission observation...4. All newly identified areas after admission will be documented on the New Skin Event. 5. The wound nurse will be notified of alteration in skin integrity. a) The wound nurse is responsible for communicating to IDT on a weekly basis by utilizing the Composite Report for pressure and non-pressure wounds..." This Federal tag relates to complaint IN00314889. 3.1-37(a)		**into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit Tool related to the Skin Management Program daily for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, record review, and interview, the facility failed to implement Physician's Orders related to the prevention and treatment of pressure ulcers for 2 of 4 residents reviewed for pressure ulcers. (Residents 36 and 331) Findings include: 1. On 1/6/19 at 1:40 p.m., Resident 36 was observed lying in his bed. LPN 2 pulled back his covers and observed his feet, he was not wearing protective boots. The record for Resident 36 was reviewed on 1/4/19 at 11:15 a.m. He was admitted to the facility on 6/17/19. Diagnoses included, but were not limited to, end stage renal disease, type two diabetes, and pressure ulcers to the sacrum and left heel. The Significant Change Minimum Data Set assessment, dated 10/14/19, indicated he was moderately cognitively impaired, and required extensive, two person assistance for transfers and toileting. A pressure ulcer Care Plan, dated 8/14/19, included the interventions of pressure reducing surfaces and to provide treatments as ordered. A Physician's Order, dated 6/17/19, indicated the resident was to wear protective boots to both feet at all times when in bed. At the time of the observation, the Nurse indicated he was not wearing his boots. She located the boots in his closet and put them on at that time. 2. A Pressure Ulcer dressing change for Resident 331 was observed on 1/2/20 at 11:23 a.m., completed by the Wound Nurse. She gathered her supplies from her cart and went into	F 0686	**F686 – Treatment/Services to Prevent/Heal Pressure Ulcer** It is the practice of this facility that any resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #36 – protective boots are being worn per the plan of care to both feet when in bed. The care plan has been reviewed and updated to ensure preventative measures are in place to prevent development of skin alterations. Resident #331 – wound treatment orders have been clarified with the Wound Center and resident's primary care physician. Resident has been receiving the Wound Center ordered treatment to her sacral wound. Physician and family are aware of this resident's current skin condition and ordered treatments. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident identified as being at risk for pressure ulcer development and/or is receiving	02/06/2020

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	Resident 331's room and placed her supplies onto a sterile paper pad on the resident's bedside table. The Wound Nurse washed her hands, gloved, placed a sterile paper pad under the resident, who was on her left side, re-washed her hands, re-gloved, cleansed the sacral (tail bone area) pressure ulcer with normal saline and sterile gauze, re-washed her hands, gloved, cut a piece of puracol (wound dressing to promote healing and decrease wound infection), placed the dressing into the wound bed with a sterile q-tip (stick side), then covered with a dry dressing. She then removed her trash in a plastic bag and cleansed her scissors with a microkill wipe. The Wound Nurse indicated the resident had already removed the original dressing. Resident 331's record was reviewed on 1/2/10 at 8:23 a.m. Diagnoses included, but were not limited to, stage 4 pressure ulcer, heart failure, diabetes mellitus and dementia. The Physician Order Summary for December 2019 indicated, cleanse the sacral wound with wound cleanser, apply puracol and cover with a dry dressing once daily. The December 2019 Medication Administration Record (MAR), indicated the puracol dressing with a dry dressing was completed as ordered, except for 12/4, 12/10 and 12/15/19 when the resident refused the treatment and 12/7 through 12/9 when the resident was hospitalized. The January 2020 MAR, indicated the puracol dressing with a dry dressing was completed as ordered. Per the Wound Nurse's "Wound Management" Report, on 12/18/19, 12/24/19 and 12/31/19 the		active or preventative treatment for wounds has the potential to be affected by this finding. An audit was completed by the Nurse Management Team/designee to review all residents with physician ordered wound treatment or preventative treatments such as protective boots. Physician Orders related to active or preventative wound treatments were verified for accuracy. Care plans and Resident Profiles were reviewed and updated as appropriate to reflect each resident specific need. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 2/6/20. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to the Skin Management Program. This in-service will include re-education regarding wound care and preventative interventions for wound prevention. Nursing Rounds will be completed daily to ensure all current wound treatments as well as prevention interventions are in place per individual plan of care. Pressure Ulcer Risk Assessments are completed on all residents upon admission, quarterly, annually, and with any significant	

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	wound improved. The Wound Clinic notes, dated 12/16/19 and 12/30/19, indicated to apply a single layer of collagen (equivalent to puracol) dressing to the wound bed, then gently fill with iodoform gauze (antimicrobial and healing properties), then cover with dry gauze and tape. Interview with the Wound Nurse on 1/3/20 at 3:30 p.m., indicated she clarified with the Wound Clinic and the dressing treatment should have included the iodoform gauze. The nurse on the unit should have changed the order when the Wound Clinic's notes were reviewed on 12/16/19. 3.1- 40(a)(2)		change in condition. Care plans related to pressure ulcer treatments and prevention are developed based on these completed assessments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit Tool related to the Skin Management Program daily for 4 weeks and monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates			

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	that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to provide treatment for limited range of motion related to splints not in place for 1 of 3 residents reviewed for range of motion. (Resident 100) Finding includes: On 12/30/19 at 12:09 p.m., Resident 100 was observed lying in bed with her eyes closed. The resident's left hand was contracted in a fist with her index finger pointing straight out. There were no splints observed in place. On 1/3/20 at 11:09 a.m., Resident 100 was observed lying in bed with her eyes closed. Her left hand was contracted in a fist with only her index finger pointing straight out. There were no splints observed in place. The resident's record was reviewed on 1/2/20 at 9:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, left hand contracture, and dependence on ventilator status. The Annual Minimum Data Set (MDS)	F 0688	**F688 – Increase/Prevent Decrease in Range of Motion** It is the practice of this provider to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #100 has been screened and evaluated by Therapy Services to determine continued need and appropriateness of palmer splint to left hand. Physician and family were informed of this resident's current condition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	02/06/2020

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	assessment, dated 11/21/19, indicated the resident had impairment to her functional range of motion on both sides to both her upper and lower extremities. The resident had not participated in any therapy or restorative programs. The resident had last received Occupational Therapy (OT) in 2018. The OT plan of care, dated 5/16/18, indicated the resident was referred to skilled occupational therapy for splinting needs and contracture management of the resident's left hand. The OT Progress and Discharge Summary, dated 6/18/18, indicated, "...patient tolerates left palmar guard for 3 hours...post discharge recommendation for staff follow through include continue for patient to wear left hand splint as tolerated..." There was lack of documentation to indicate the resident's splint had been implemented as recommended by therapy. Interview with the West Wing Unit Manager on 1/7/20 at 11:02 a.m., indicated he was unable to find any orders for a splint or documentation the resident ever had one in place. He was unsure if the resident should currently have a splint or not. Interview with the Director of Therapy on 1/7/20 at 11:42 a.m., indicated the resident last received therapy services in June 2018. The discharge recommendation was to wear the left hand splint 3 hours a day. She was not sure what happened after that, she had never been notified there were any problems with the splint. She planned to go reassess the resident's hand. Continued interview at 11:54 a.m., indicated she had reassessed the resident's left hand and the contracture had not		Any resident who requires the use of a splint and/or has impaired or limited range of motion has the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will identify all residents requiring the use of a splint and/or who has limited range of motion and requires contracture prevention interventions. Therapy Services will be consulted regarding accuracy and appropriateness of each resident's identified split orders as well as any recommendations from therapy regarding initiation of splints. Each splint program will be reviewed against the physician's order and/or therapy recommendation regarding splint wear times and range of motion programs to ensure appropriate contracture prevention interventions are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be scheduled on or before 2/6/20. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the facility policy related to splint/adaptive equipment use and strict adherence to the established splint schedule as well as	

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	gotten any worse since the resident was discharged from therapy. 3.1-42(a)(2)		contracture prevention interventions. In addition, resident care rounds will be conducted daily on different shifts to ensure splints and adaptive equipment is being applied and utilized per physician's order and/or therapy recommendation and range of motion exercises are being completed per plan of care. Range of motion programs will be evaluated for updates and changes, quarterly, annually with any significant change and when needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completion of the QAPI Audit tool related to Range of Motion daily on different shifts for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic**	

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			changes will be completed: Compliance date = 2/6/20.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure dietary recommendations were carried out as ordered for 1 of 7 residents reviewed for nutrition. (Resident D) Finding includes: On 1/2/19 at 1:10 p.m., the lunch tray for Resident D was observed in her room. She had consumed half of her lunch, there was no Magic Cup (a high calorie nutritional supplement) on the tray. The CNA indicated the resident had not received a	F 0692	**F692 – Nutrition/Hydration Status Maintenance** It is the intent of this provider to ensure that each resident (1) maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem. **What corrective action(s) will**	02/06/2020

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	Magic Cup with her lunch. The Registered Dietician was notified the Magic Cup was not on her lunch tray that day at 1:10 p.m. On 1/3/19 at 8:30 a.m., the resident's breakfast tray was observed, there was not a Magic Cup on the tray. At 9:00 a.m., the tray was observed again, and there was no Magic Cup present. The record for Resident D was reviewed on 1/2/19 at 10:15 a.m. The resident was admitted to the facility on 9/12/14. Diagnoses included, but were not limited to, generalized muscle weakness, parotid gland cancer and dementia. The Annual Minimum Data Set assessment, dated 11/7/19, indicated she was cognitively intact and needed one person supervision for eating. The resident had a significant weight loss in the past 180 days. A Dietary Care Plan, updated 12/27/19, indicated the resident should have a Magic Cup with each meal. During an interview with the Dietary Manager on 1/3/19 at 9:04 a.m., the Registered Dietician approached and stated she had noticed the resident did not have her Magic Cup and was taking it to her at that time. The Dietary Manager did not know why the Magic Cup had not been on the tray. This Federal tag relates to Complaint IN00314889. 3.1-46		**be accomplished for those residents found to have been affected by the deficient practice:** Resident #D – has been receiving the physician ordered supplement. The physician and the responsible party were made aware of this resident's current nutritional status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident with orders for supplements or nutritional enhancements have the potential to be affected by this finding. The DNS/designee will be responsible for completing a facility audit to review all residents with physician ordered supplements and/or dietary recommendations for nutritional enhancements such as Magic Cups. These orders will then be compared to each resident's dietary card and Nurse Aide Assignment Sheet. The daily Dining Room Supervisor assigned to each dining room for each meal will monitor that physician ordered supplements and nutritional enhancements are provided as ordered and noted on each resident's dietary card. Any physician order or dietary changes will be reviewed and updated during daily clinical meetings. **What measures will be put into**	

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			place or what systemic changes will be made to ensure that the deficient practice does not recur: An all staff in-service will be held on or before 2/6/20. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the policy related to Weight Management and supplement and nutritional enhancement use such as Magic Cups. In addition, the daily Dining Room Supervisor assigned to each dining room for each meal will monitor that physician ordered supplements and nutritional enhancements are provided as ordered and noted on each resident's dietary card. Any physician order or dietary changes will be reviewed and updated during daily clinical meetings by the Nurse Management Team/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with these corrective actions, the DNS/designee will complete the QAPI Audit Tool related to Nutritional Supplement use daily for 4 weeks then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed.	

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			Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure a resident with dementia received appropriate treatment and services related to lack of an individualized Activity Assessment for 1 of 2 residents reviewed for dementia care. (Resident 111) Finding includes: On 1/2/20 at 10:20 a.m., Resident 111 was observed sitting in the dining room/activity area watching the activity. Staff offered for him to join, he declined. On 1/3/20 at 9:10 a.m., Resident 111 was observed on his bed with his eyes closed, the room was dark and quiet. On 1/3/20 at 10:08 a.m., Resident 111 was observed sitting in the dining room/activity area watching the activity, drinking coffee and listening to music. Resident 111's record was reviewed on 1/2/20 at	F 0744	**F744 – Treatment/Services for Dementia** It is the practice of this facility that any resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #111 – An Activity Assessment has been completed and interviews were conducted with the resident and family to determine resident preferences and interests. **How other residents having the potential to be affected by the same deficient practice will be**	02/06/2020

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	10:19 a.m. Diagnoses included, but were not limited to, dementia, depression, irregular heart rhythm and psychotic disorder. The Minimum Data Set assessments indicated his Quarterly assessment was completed on 8/28/19, his Annual was completed on 11/1/19, and a return from the hospital assessment was completed on 11/15/19. A Nurse's Progress Note, dated 11/29/19 at 4:20 p.m., indicated the resident was moved to the dementia (locked unit) for his safety due to exit seeking and the day before he had eaten a denture tablet. The last Activity Assessment was completed on 6/7/19. Interview with Medical Records Staff on 1/6/20 at 10:24 a.m., indicated Activity Assessments should be completed within 7 days of admission, annually and with a change in condition. Every quarter, the resident or their representative should have been interviewed to find out about the resident's preferences and interests. A policy titled, "Activity Assessment Policy and Procedure," was provided by Medical Records Staff on 1/6/20 at 10:30 a.m. This current policy indicated, "Policy: It is the responsibility of the Activity department to complete an activity assessment for each resident within the facility....Procedure:...3. The Activity Assessment will be completed annually and upon change in condition to ensure that updated preferences and interests are obtained...5. Quarterly the resident will be interview in order to complete the Quarterly Activity Assessment. If the resident is not able to be understood, interview should be attempted		**identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be conducted by Activity Director/designee to ensure Activity Assessments have been completed for all residents as outlined in the facility policy. Resident Preferences and interests were determined/obtained and care plans were reviewed and updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be held on or before 2/6/20. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the policy related to Activity Assessments and honoring resident preferences and activities of interest. The Activity Department is responsible for completing Activity Assessments within seven days of admission to the facility, annually and with any change in condition to ensure updated interests and preferences are determined. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	with family/significant other. The assessment will focus on opportunities for activity involvement that reflect the resident's preferences and interests...." 3.1-37(a)		**into place:** To ensure ongoing compliance with this corrective action, the Activity Director/designee will complete the QAPI Audit Tool related to Activity Preferences weekly for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 2/6/20.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose			

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	should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to medications not administered as ordered due to medications not available, a lack of nonpharmacological interventions completed prior to PRN (when necessary) pain medications, and administering a pain medication at the incorrect time, for 2 of 5 residents reviewed for unnecessary medications. (Residents 76 & 35) Findings include: 1. Record review for Resident 76 was completed on 1/2/2020 at 12:06 p.m. Diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, depression, Celiac disease, and HIV (human immunodeficiency virus). The Admission Minimum Data Set (MDS) assessment, dated 11/24/19, indicated the resident was cognitively intact. The resident received insulin, anti-anxiety, antidepressant, and opioid (pain medication) medications. The December 2019 Physician's Order Summary (POS) indicated orders for: - Epogen (medicine to treat anemia) 10,000 unit/ml (milliliter) injection on Wednesdays, ordered 11/20/2019 and discontinued on 12/25/2019 - Epogen 10,000 unit/ml injection on Fridays, ordered 12/25/2019 - fluconazole (medication to prevent and treat fungal infections) 100 mg (milligrams) every day - Tekturna (medication to treat high blood	F 0757	**F757 - Drug Regimen Free from Unnecessary Drugs** It is the practice of this facility that each resident's drug regimen be free from unnecessary medication. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #76 – has been receiving all physician ordered medications. Physician and family/responsible party are aware of this resident's current medication regimen. Resident #35 – is being offered non-pharmacological interventions prior to administration of pain medications. Resident's medications are being administered per physician order. A Medication Error Report was completed and physician and family were informed of the Norco administered outside the physician ordered parameters during the Annual Survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A	02/06/2020

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	pressure) 150 mg every day - Tradjenta (medication to treat diabetes) 5 mg every day - Veltassa (medication to treat high potassium in the blood) 8.4 gram powder packet every day The January 2020 POS indicated orders for: - Epogen 10,000 unit/ml injection on Fridays - fluconazole 100 mg every day - folic acid (medication to treat anemia) 1 mg every day - Veltassa 8.4 gram powder packet every day The December 2019 Medication Administration Record (MAR) indicated the following medications were not administered on the ordered days due to the medication was unavailable: - Epogen was not administered on 12/4/19, 12/18/19, and 12/27/19 - fluconazole was not administered on 12/13/19 - Tekturna was not administered on 12/6/19, 12/22/19, 12/23/19, 12/24/19, and 12/27/19 - Tradjenta was not administered on 12/18/19, 12/19/19, 12/20/19, 12/21/19, 12/22/19, 12/23/19, and 12/24/19 - Veltassa was not administered on any day in December except for 12/1/19 The January 2020 MAR indicated the following medications were not administered on the ordered days due to the medication was unavailable: - Epogen was not administered on 1/3/2020 - fluconazole was not administered on 1/1/2020, 1/2/2020, and 1/3/2020 - folic acid was not administered on 1/1/2020, 1/2/2020, and 1/3/2020 - Veltassa was not administered on 1/1/2020, 1/2/2020, and 1/3/2020 Interview with Medical Records Staff on 1/3/2020		facility audit will be conducted by the Nurse Management Team to ensure medications are available for administration and to ensure residents are receiving medications per physician order. This audit will also include review of all residents with orders for PRN pain medication to ensure alternate pain relief techniques and non-pharmacological interventions are attempted prior to administration of medications when appropriate. The Nurse Management Team will be responsible for daily review of all Medication Administration Reports to ensure medications are available for administration, that medications are administered per physician's order and that non-pharmacological interventions are attempted prior to administration of pain medications when appropriate. Physician orders are reviewed daily during the Clinical Meeting. The DNS/designee will be responsible for daily review of orders and correcting and clarifying orders as needed. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be held on or before 2/6/20. The in-service will be conducted by the DNS/designee and will include	

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	at 3:29 p.m., indicated many of the medications that were supposed to be given were "specialty medications" which needed a note from the doctor for the pharmacy. Someone should have checked on these medications and followed up on them before now.2. Resident 35's record was reviewed on 1/2/20 at 10:13 a.m. Diagnoses included, but were not limited to, dementia, low back pain, muscle spasms, anxiety, depression and other fracture. The Quarterly Minimum Data Set assessment, dated 10/14/19, indicated she was cognitively impaired. The current Physician Order Summary indicated to administer Norco (pain reliever) 5-325 mg (milligrams), 1 tablet every 6 hours as needed for pain (PRN). A Care Plan for pain, dated 1/16/17, indicated an intervention was to include non pharmacological interventions such as a quiet environment, rest, a shower, back rub, weighted blanket and reposition. A Care Plan for pain related to a fracture to the left arm, dated 12/9/19, indicated interventions were to offer a quiet environment, rest, a shower, back rub, and reposition. The December 2019 Medication Administration Record (MAR) indicated the following days and times Norco 5-325 mg PRN was administered and lacked an indication any non pharmacological intervention was attempted prior to administering the pain medication: - 12/8/19 2:03 p.m. - 12/9/19 11:32 a.m., and 6:41 p.m. - 12/10/19 12:24 a.m., and 6:06 p.m.		review of the facility policy related to Pharmaceutical Services, Medication Availability and PRN Pain Medication Administration. The Nurse Management Team will be responsible for daily review of all Medication Administration Reports to ensure medications are available for administration, that medications are administered per physician's order and that non-pharmacological interventions are attempted prior to administration of pain medications when appropriate. Physician orders are reviewed daily during the Clinical Meeting. The DNS/designee will be responsible for daily review of orders and correcting and clarifying orders as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related Medication Administration weekly for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be	

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	- 12/12/19 12:33 p.m. - 12/13/19 12:19 p.m. - 12/17/19 2:00 a.m., and 3:59 p.m. - 12/19/19 9:05 p.m. - 12/20/19 10:55 p.m. - 12/25/19 6:11 p.m., and 11:43 p.m. - 12/26/19 7:35 p.m. - 12/27/19 1:28 a.m. - 12/28/19 4:12 p.m., and 11:10 p.m. - 12/29/19 3:21 p.m. - 12/31/19 1:06 a.m., and 4:41 p.m. On 12/25/19, Norco 5-325 mg PRN was not administered 6 hours apart per the Physician's Order, it was given too early. Interview with Medical Records Staff on 1/3/20 at 3:36 p.m., indicated interventions should have been documented in the Nurse Progress Notes and the Norco PRN on 12/25/19 was not given as ordered. A policy titled, "Pain Management," was provided by the Director of Nursing on 1/6/20 at 9:42 a.m. This current policy indicated, "...Procedure: 10. A plan of care will be written with the initiation of pain medication and individualized to the resident, addressing potential side effects, limitations due to pain, behavioral symptoms, and alternative pain relief techniques...." 3.1- 48(a)(6)		submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systematic changes will be completed:** Compliance Date: 2/6/20.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			

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	Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 8 residents observed during medication administration. Two medication errors were observed during 27 opportunities for error in medication administration. This resulted in a medication error rate of 7.4%. (Residents 22 and 4) Findings include: 1. On 1/3/20 at 9:50 a.m., LPN 4 was observed preparing Resident 22's medications, which included diphenhydramine (Benadryl, an antihistamine medication) liquid 12.5 mg (milligrams)/ 5 ml (milliliters). She then administered the medications via g-tube (gastrostomy tube, tube inserted into the stomach) Resident 22's record was reviewed on 1/3/20 at 11:10 a.m. The 1/2020 Physician's Order Summary lacked any order for the diphenhydramine medication. There was an order present for docusate sodium liquid 50 mg/ml, give 100 mg/10 ml per g-tube twice daily, which was not given during the observation. Interview with LPN 4 on 1/3/20 at 11:18 a.m., indicated she had given the wrong medication. She should have given the docusate and not the diphenhydramine. The prepackaged cups of the diphenhydramine and docusate medications somehow got placed in the same bag, so she thought she was giving the correct medication. 2. On 1/3/20 at 11:50 a.m., LPN 5 was observed checking Resident 4's blood sugar. The result displayed on the glucometer (machine used to test blood sugar) read 349. LPN 5 then prepared and	F 0759	**F759 – Free of Medication Error Rates of 5% or More** It is the practice of this provider to ensure that it is free of medication error rates of five percent or greater. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 22 – The physician and responsible party were notified of the medication error involving the administration of Benadryl. This resident's medication regimen has been reviewed and verified with the physician. This resident has been receiving medication per physician's order and experienced no negative outcome as a result of this finding. Resident #4 – The physician and responsible party were notified of the administration of the incorrect dose of sliding scale insulin. This resident has been receiving medications and sliding scale insulin per physician's order. This resident experienced no negative outcome as a result of this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team.	02/06/2020

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	administered Humalog (insulin) 12 u (units) subcutaneously (under the skin) to the resident's left abdomen. Resident 4's record was reviewed on 1/3/20 at 12:05 p.m. The 1/2020 Physician's Order Summary indicated an order for Humalog insulin per sliding scale (insulin dose based on blood sugar results) as follows: < (less than) 60= call Physician 151-200=4 u 201-250=6 u 251-300=8 u 301-350=10 u 351-400=12 u > (greater than) 400=20 u and call Physician Interview with LPN 5 on 1/3/20 at 12:10 p.m., indicated she had given Humalog 12 u because she had recorded the resident's blood sugar as 359. She reviewed the memory in the glucometer and it indicated the resident's blood sugar was 349. She indicated she should have given 10 u of the Humalog. A facility policy, titled "Medication Pass Procedure," indicated, "...2. Medications checked 3 times to verify order with label..." A facility policy, titled "Subcutaneous-Injection," indicated, "...1. Verify resident, physician orders and drug allergies..." 3.1-48(c)(1)		This audit will include review of each resident's most recent monthly Physician's Orders and Medication Administration Record. This audit will ensure that medications and all physician ordered insulins and glucometer checks are being administered and recorded per physician's order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted on or before 2/6/20 by the DNS/designee. This in-service will include review of the facility policy related to Medication Administration, the Five Rights of Medication Pass Procedure as well glucometer testing with appropriate sliding scale insulin administration. All nursing staff will be re-educated on the process of proper medication administration per physician order, and best practice guidelines for medication administration. In addition, the DNS and/or member of the Nurse Management Team will be responsible for daily review of the Medication Administration Compliance Reports to ensure medications are administered per physician's order. Nurses are evaluated on their proficiency with Medication Administration policies upon hire, annually during the	

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			Skills Validations check-offs and throughout the year during medication pass observations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility program Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related Medication Administration weekly for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance Date = 2/6/20.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were properly dated, labeled, not expired, and over-the-counter medications were properly labeled for 3 of 4 medication carts and 1 of 1 medication storage rooms observed. (East Rehab Medication Cart, East Front Medication Cart, Cottage Medication Cart, and East Medication Room) Findings include: 1. On 1/7/20 at 11:31 a.m. with LPN 9, the East Rehab medication cart was observed. There was a Novolog (insulin) flexpen open and in use with an open date of 12/3/19 with an additional label indicating "dispose in 30 days after opening", a Novolog flexpen without any resident name label with an open date of 12/19/19, a Novolog flexpen without any resident name label with an open date of 12/7/19, and a Basaglar (insulin) flexpen without	F 0761	**F761 – Label/Store Drugs and Biologicals** It is the practice of this facility that all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All expired, opened and undated and unlabeled medications identified during the survey were discarded. **How other residents having the**	02/06/2020

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	any resident name label with an open date of 12/30/19. 2. On 1/7/20 at 11:45 a.m. with LPN 3, the East Front medication cart was observed. There was a Levemir (insulin) flexpen open and in use with no open date, a Lantus (insulin) flexpen in use with no open date, an insulin lispro kwikpen in use with no open date, and an insulin lispro pen labeled with two open dates of 12/10/19 and 12/21/19. The following over-the-counter medications were only labeled with the resident's name: super bio vitamin C, korean ginseng, vitamin c, flax oil, multi energy multivitamin, and mega multi mineral. Interview with LPN 3 at that time, indicated all the insulin pens should have been labeled with open dates. She was unsure which date was correct for the insulin lispro pen labeled with two dates. 3. On 1/7/20 at 12:12 p.m., the Cottage medication cart was observed with LPN 10. An Iron over-the-counter medication was only labeled with the resident's name and open date. 4. On 1/7/20 at 11:20 a.m. with the East Wing Unit Manager, the East Wing Medication Room was observed. In the refrigerator, there was 1 vial of Tuberculin solution, opened and undated. Interview with East Wing Unit Manager at that time, indicated there was not an open date marked on the vial and the vial was to be discarded 30 days after it had been opened. A facility policy, titled "Over the Counter Medications," indicated, "...1. When a health care provider prescribes an over the counter medication, the over the counter medications must		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The DNS/designee will complete an inspection of all medication rooms, medication room refrigerators, medication carts, and treatment carts to ensure that any opened medications have appropriate date opened stickers in place and are within the drug expiration date per manufacturer's recommendations, and that all have been properly labeled per policy. The DNS/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturers recommendations. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:** An all nursing staff in-service will be held on or before 2/6/20. The in-service will be conducted by the DNS/designee and will review the facility policy related to Storage and Expiration dates of Medication and Biologicals. Nursing staff will be re-educated regarding applying a date opened sticker on all opened medications, the importance of checking expiration	

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	be identified with the following: resident full name, physician name, expiration date, name of drug, strength..." A facility policy, titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," indicated, "...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..." 3.1-25 (j)(k)(l) 3.1-25 (m) 3.1-25 (o)		dates prior to administration of any medication and that all medications including over the counter medications have been properly labeled per policy. In addition, the DNS/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturers recommendations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Medication Storage Review daily for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systematic changes will be completed:** Compliance Date: 2/6/20.	

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F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(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 procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to distribute fluids under sanitary conditions related to beverages uncovered during serving of the East Unit room trays. This had the potential to affect 3 of 15 residents who received room trays. (East Unit) Finding includes: During an observation of lunch service on 12/30/19 at 12:06 p.m., CNA 1 removed 4 lunch trays from a cart and set them on the top of the cart. He then poured a red liquid into 4 cups. He placed 1 cup onto each tray but did not cover the drinks.	F 0812	**F812 – Food Procurement, Store/Prepare/Serve – Sanitary** It is the practice of this provider to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food under sanitary conditions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All resident meals are being	02/06/2020

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	At 12:08 p.m., the Customer Care Coordinator (CCC) was observed to grab one of the trays from the top of the cart and deliver it down the hallway to a resident's room. The beverage of red liquid was still uncovered. At 12:09 p.m., the Social Service Assistant (SSA) was observed to grab one of the trays from the top of the cart and deliver it down the hallway to a resident's room. The beverage of red liquid was still uncovered. At 12:10 p.m., the CCC was observed to grab one of the trays from the top of the cart and deliver it down the hallway to a resident's room. The beverage of red liquid was still uncovered. Interview with CNA 1 on 12/30/19 at 12:11 p.m., indicated he was aware the drinks needed to be covered before delivering them down the hallway. He would go and find some lids for the cups. Interview with the SSA on 12/30/19 at 12:12 p.m., indicated she does not normally pass trays but she was aware the drinks should be covered before delivering them down the hallway. Interview with the CCC on 12/30/19 at 12:13 p.m., indicated she does not normally pass trays but she was aware the drinks should be covered before delivering them down the hallway. 3.1-21(i)(3)		served utilizing proper technique and facility protocol related to distribution of foods and fluids under sanitary conditions including proper coverage of beverages. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this practice. Direct Care staff is utilizing proper technique and facility protocol related to distribution of foods and fluids under sanitary conditions and proper coverage of beverages. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be conducted on or before 2/6/20 by the ED/DNS/designee. This in-service will include review of the policy related to proper technique and facility protocol during meal service and distribution of room trays. All staff will be re-educated regarding the importance of distribution and serving foods and fluids under sanitary conditions including proper coverage of beverages. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place: This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. To ensure ongoing compliance with this corrective action, the ED/DM/designee will be responsible for completion of the Food and Nutrition/Meal Observations at a minimum of one meal daily for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 2/6/20.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to maintain infection control measures related to improper cleaning of an isolation room for 1 of 3 residents reviewed for non- UTI or respiratory infections; and a Foley catheter tube resting on the floor for 1 of 1 residents reviewed for infection control. (Residents 36 and 2) Findings include: 1. On 12/30/19 at 2:35 p.m., a Contact Isolation sign was noted on the door of Resident 36's room. On 1/3/19 at 8:25 a.m., Housekeeper 1 was observed cleaning the resident's room. She was wearing a protective gown, a face mask, and gloves. Her cleaning cart was outside the room, there was a can of Disinfectant spray and a bottle of Neutral Quat disinfectant. Neither contained bleach or indicated they were effective against C. difficile (C. diff, a contagious bacterial infection in the gastrointestinal tract).	F 0880	**F880 – Infection Prevention & Control** It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #36 – Isolation precautions have been discontinued. Physician and family are aware of this resident's current status. This resident experienced no negative outcome as a result of this finding. Resident #2 – catheter drainage	02/06/2020

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	The resident's record was reviewed on 1/4/19 at 11:15 a.m. He was admitted to the facility on 6/17/19. Diagnoses included, but were not limited to, end stage renal disease, type two diabetes, and pressure ulcers sacrum left heel. A Nursing Note, dated 12/28/19 at 5:01 p.m., indicated the resident was on contact isolation for C.diff and awaiting results from stool sample. During an interview with the housekeeper on 1/3/19 at 8:25 a.m., she indicated that was her regular hall and she had been cleaning the room that week. She indicated housekeeping knew what type of isolation precautions a resident was by turning the Isolation sign over. The Isolation sign was turned over and it indicated the resident was on contact isolation. She indicated she should have asked the nurses what type of contact isolation he was on, she was aware C.diff required cleaners with bleach. She did not know the resident was on isolation for C.diff. During an interview with the Housekeeping Supervisor on 1/3/19 at 8:32 a.m., she indicated the nursing staff was supposed to inform housekeeping if the resident was on C.diff precautions. The document, "Clostridium Difficile", reviewed July 2015, was received from the Interim Director of Nursing on 1/3/20 at 9:27 a.m. The document indicated, "7. Cleaning a. Solution- 10% hypochlorite solutions (one part chlorine bleach mixed with 9 parts tap water)mixed fresh daily or commercial brand hypochlorite solutions ...Surface being disinfected should come into contact with the solution (stay wet after cleaning) for 10 minutes ...."2. On 12/30/19 at 9:42 a.m., Resident 2 was observed in a wheelchair		system and tubing are proper placed in a dignity bag and is not touching the floor. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents currently in Isolation Precautions and that have physician orders for an indwelling catheter use have the potential to be affected by this finding. An audit will be completed by the ED/designee to identify all residents with orders for Isolation Precautions to ensure that proper cleaning of isolation rooms was completed per facility protocol and infection control practices are maintained per policy. ED/designee will also conduct Housekeeping Cart Inspections to ensure that Disinfectant Supplies are available containing proper and appropriate ingredients to effectively destroy all infectious particles. In addition, all residents with catheters were audited to ensure the catheter tubing was placed in dignity bags and not resting on the floor with no additional findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	propelling himself into the hallway out of his room. The resident's catheter tubing was dragging on the floor underneath his wheelchair. On 12/31/19 at 10:50 a.m., Resident 2 was observed in a wheelchair propelling himself down the hallway. The resident's catheter tubing was dragging on the floor underneath his wheelchair. The resident was also stepping on his catheter tubing with his shoes as he propelled himself in the wheelchair. On 1/2/2020 at 9:04 a.m., Resident 2 was observed in a wheelchair propelling himself down the hallway. The resident's catheter tubing was dragging on the floor underneath his wheelchair. The resident was also stepping on his catheter tubing with his shoes as he propelled himself in the wheelchair. On 1/2/2020 at 9:57 a.m., Resident 2 was observed in a wheelchair propelling himself down the hallway. The resident's catheter tubing was dragging on the floor underneath his wheelchair. Record review for Resident 2 was completed on 1/2/2020 at 9:35 a.m. Diagnoses included, but were not limited to, obstructive uropathy, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/13/19, indicated the resident was cognitively impaired. The resident required an extensive 1 person assist for transfers, toilet use, and personal hygiene. The resident had an indwelling urinary catheter. A Care Plan indicated the resident was at risk for infection related to a suprapubic catheter. An intervention included to not allow tubing or any		A Nursing In-service will be conducted on or before 2/6/20 by the DNS/designee. This in-service will include review of the policy related to proper cleaning and disinfection of Isolation Rooms as well as infection control practices related to catheter tubing not touching the floor and the importance of ensuring that any resident utilizing an indwelling catheter has their tubing properly placed in the dignity bag. DNS/Designee will conduct rounds to ensure catheter tubing is not touching the floor each shift. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to proper cleaning and disinfection of Isolation Rooms weekly for 4 weeks and monthly until 100% compliance is achieved. The DNS/designee will also be responsible for completing the QAPI Audit tool related to indwelling catheter use. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the	

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	part of the drainage system to touch the floor. Interview with the East Unit Manager on 1/2/2020 at 9:58 a.m., indicated the resident's catheter tubing should not be dragging on the floor. 3.1-18(a)		Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 2/6/20.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the kitchen environment was clean and in good repair related to debris build up along the floors by the walls, underneath countertops, and underneath appliances, broken and loose floor tiles, and a broken door frame in the kitchen. This had the potential to affect residents who received food from the kitchen. (Kitchen) Finding includes: During the initial tour of the kitchen on 12/30/19 at 8:56 a.m., the following was observed. - The floor had a build up dirt and debris all along the walls, underneath cabinets and heavy buildup underneath the ovens. - The floor by the dishwasher had multiple missing and broken floor tiles. - The Dietary Manager's office door had a broken door frame that was bent and facing outwards.	F 0921	**F921 – Safe/Functional/Sanitary/Comfortable Environment** It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Debris build-up along the floors by the walls, debris underneath the countertops and appliances in the kitchen has been thoroughly removed and cleaned. Broken, loose floor tiles in the kitchen have been repaired/replaced. Broken door frame in the kitchen has been repaired/replaced. **How other residents having the potential to be affected by the same deficient practice will be**	02/06/2020

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	A follow up tour of the kitchen on 1/2/2020 at 10:16 a.m., had the same issues as above. Interview with the Dietary Manager on 1/2/2020 at 10:28 a.m., indicated they had the floor replaced 6 months ago but it was not completed correctly. He was unaware when they were going to be able to get the flooring fixed. He was unsure if the Maintenance Supervisor was aware of the broken door frame to his office. Staff mop the kitchen floor every day, but they do not pull out any of the appliances to mop underneath. Interview with the Maintenance Supervisor on 1/2/2020 at 10:28 a.m., indicated they had put in an order for a new floor. At the time, he was unaware when the flooring would be fixed. He was aware of the broken door frame and was going to fix it but had not done it yet. A policy titled, "Cleaning Floors, Tables, and Chairs" and received as current from the Dietary Manager indicated, "...1. Kitchen floors will be swept and cleaned after each meal. Major appliances will be moved in order to facilitate cleaning behind and underneath them at frequency indicated on the cleaning schedule...." 3.1-19(e)		**identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The kitchen was thoroughly inspected for all above listed concerns and debris has been removed and cleaned and all repairs were made where needed. In addition, the ED/designee will conduct Kitchen Inspections no less than five times per week. These Inspections will include inspections/observations of all areas of the kitchen to ensure cleanliness and proper function. Any noted issues observed during these Inspections will be directed to the ED/Maintenance Department/designee as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 2/6/20. This in-service will include review of the facility policy related to notification to the proper Department for needed repairs or maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment in all areas of the facility including the kitchen. The ED/designee will conduct Kitchen Inspections no less than five times	

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			per week. These Inspections will include inspections/observations of all areas of the kitchen to ensure cleanliness and proper function. Any noted issues observed during these Inspections will be directed to the ED/Maintenance Department/designee as appropriate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action and to ensure the environment is safe/functional/sanitary and comfortable, the ED/DNS/designee will be responsible for completion of the QAPI Audit tool related to kitchen inspections no less than five times per week for 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Completion date = 2/6/20.	