STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	09/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00238074 and IN00238390. This visit was in conjunction with the Investigation of Complaint IN00240323. Complaint IN00238074 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F312, and F465. Complaint IN00238390 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F312, F323, and F465. Complaint IN00240323 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F323. Survey dates: September 11, 12, 13, 14, 15 and 18, 2017 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census bed type: SNF/NF: 147	F 0000	F0000 St. Anthony Home (“the provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1)are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (“CMS”), the state of Indiana or any other entity; or (2) to serve, in any way to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of	

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

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	SNF: 13 NCC: 2 Total: 162 Census payor type: Medicare: 17 Medicaid: 98 Other: 47 Total: 162 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/21/17.		Evidence and should be inadmissible in any proceeding on that basis.	
F 0241 SS=E Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation, interview, and record review, the facility failed to care for residents in a dignified manner, related to residents who required assistance with meals sitting with meals in front of them with assistance not provided timely and sitting at a table without their meals when others at the	F 0241	F241 We request desk compliance. 1:1: regarding resident B, 63, 65, 99, 149, & 161 no adverse reactions were noted. 1:2: The Unit Manager/designee assessed their unit dining room's seating arrangement ensuring	10/16/2017

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	table had been served for 6 residents in 1 of 10 dining rooms observed. (2D Dining Room, and Residents, B, 63, 65, 99, 149, and 161). The facility also failed to ensure residents were provided dignity and privacy related to posted signs containing personal information visible to the public for 2 of 40 resident rooms observed. (Residents 120 & 71) Findings include: 1. The following was observed on 09/11/17 at 12:28 p.m. through 12:52 p.m. in the 2D dining room: Upon entering the 2D dining room at 12:28 p.m., Resident B was sitting at the table. There was a cup of coffee in front of the resident and no food had been served. Resident 149 was sitting next to Resident B, and also had no food served. Residents 99 and 161 were at the same table with food in front of them. Resident 161 was asleep. Resident 63 was at another table asleep with food on the table in front of her and no staff assistance. At 12:31 p.m., Resident 99 was observed with food still in front of him and Resident 161 had food in front of him and was asleep. There was no staff		accurate placement of residents who require assistance with eating. 1:3: Director of Staff Development/designee re-inserviced the nursing staff caring for resident in a dignified manner related to assisting all the residents at the same table at the same time during meal service. The Unit Manager/designee will observe 5 meal services per unit per week to ensure staff is following the proper feeding assistance for 6 months. 1:4: The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5: Systemic changes will be completed by 10/16/17 2:1 regarding resident 120 & 71 the signs that were posted in their rooms were removed. 2:2 The Unit Manager/designee assessed resident rooms for signs that contained personal information & removed them or placed them out of sight. 2:3: Director of Staff Development/designee re-inserviced staff regarding proper placement of	

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	assistance. There were three staff members in the Dining Room. The CNA's were serving food. At 12:33 p.m., CNA 1 was passing out cookies to the residents. No staff were assisting Residents B, 99, 149, and 161. At 12:37 p.m., LPN 1 sat and began assisting Resident 99 with his meal. 12:40 p.m., Resident B received a meal. There was no staff assistance. 12:41 p.m., Resident 149 received a meal. There was no staff assistance. 12:43 p.m., Resident 63 remained asleep with food sitting in front of her. There had been no staff interventions to awaken/assist the resident to eat. Resident 161 remained asleep, without staff interventions to awaken/assist him. Resident B and Resident 149 now had been served lunch, which was sitting in front of them and no staff was assisting the residents to eat. 12:46 p.m., CNA 2 sat next to Resident 161 and woke the resident up to remind him to eat. 12:47 p.m., CNA 1 sat and began		signage that contains the resident personal information. The Unit Manager/designee will conduct audits of 5 resident rooms per unit per week to ensure no signs are posted with personal information for 6 months. 2:4: The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 2:5: Systemic changes will be completed by 10/16/17	

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	assisting Resident B. 12:49 p.m., CNA 2 began assisting Resident 149. 12:50 P.M., Resident 63 remains asleep with lunch in front of her without staff intervention. During an observation of the 2D Dining Room on 09/12/17 at 8:30 a.m. through 9:14 a.m. the following was observed: 8:30 a.m., Residents 149, 65, and 99 was sitting at the table with uncovered breakfast food in front of them. No staff were assisting the residents. There were two CNA's in the Dining Room. 8:31 a.m., the Unit Manager entered the Dining Room, then turned and left the Dining Room. The Nurse on the Unit was at the Medication Cart. 8:33 a.m., CNA 1 began to assist Resident 99. 8:39 a.m., CNA 1 began to assist Resident 65. 8:40 a.m., Resident 149 remained with uncovered food and no assistance from staff.			

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	8:43 a.m., the Unit Manager gave Resident 149 a bite of ham. 8:49 a.m., CNA 2 stopped assisting Resident 65, who had consumed 75% of cereal and began assisting Resident 149. Resident 65 had an unopened health shake and a plate with scrambled eggs, ham and toast in front of her. 8:52 a.m., staff assistance with Residents 65 and 63 had ceased. 8:57 a.m., the Unit Manager gave Resident 149 a drink of coffee, which had been sitting on the table since 8:39 a.m. Resident 149 started to cough and the Unit Manager assisted her out of the dining room to "clean out her mouth". 9:06 a.m., the Unit Manger brought Resident 149 back to the Dining Room and left the resident at the table with food sitting in front of her. No one was assisting Resident 65 with the rest of her meal. The health shake remained unopened. 9:09 a.m., the Unit Manager returned to the Dining Room and removed Resident 149's food from the table. The resident had consumed a few bites of ham and one bite of egg.			

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	9:12 a.m., Resident 65 remained without assistance and an unopened health shake. 9:14 a.m., CNA 1 assisted Resident 65 with the health shake. During an interview on 09/13/17 at 8:15 a.m. the Unit Manager indicated they try to assist everyone timely, they are trying to hire a second Dietary Assistant to assist with serving. Resident 63's record was reviewed on 09/13/17 at 3:08 p.m. Diagnoses included, but were not limited to, dementia and the Admission Minimum Data Set (MDS) assessment, dated 06/16/17, indicated extensive assistance was needed for eating. Resident 65's record was reviewed on 09/13/17 at 2:55 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and the Quarterly MDS assessment, dated 8/24/17, indicated extensive assistance was needed for eating. Resident 99's record was reviewed on 09/13/17 at 3:14 p.m. Diagnoses included, but were not limited to, dementia and the Quarterly MDS assessment, dated 7/18/17, indicated extensive assistance was needed for			

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	eating. Resident 149's record was reviewed on 09/13/17 at 2:59 p.m. Diagnoses included, but were not limited to, dementia and the Quarterly MDS assessment, dated 6/13/17, indicated limited assistance was needed for eating. Resident 161's record was reviewed on 09/13/17 at 3:17 p.m. Diagnoses included, but were not limited to, dementia and the Annual MDS assessment, dated 07/14/17, indicated limited assistance was needed for eating. Resident B's record was reviewed on 09/12/17 at 12:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and the Quarterly MDS assessment, dated 06/13/17 indicated limited assistance with eating was needed. 2. On 9/12/17 at 12:28 p.m., a written sign was observed posted on Resident 120's closet door. The sign indicated "Attention, briefs: night only, pull ups: day only. Please have in pajamas not gowns." The sign was visible from the hallway. On 9/13/17 at 2:08 p.m., the resident was resting in her bed with her eyes closed. A written sign was observed posted on			

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	the resident's closet door and was visible from the hallway. Resident 120's record was reviewed on 9/13/17 at 11:41 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia. The Annual Minimum Data Set (MDS) assessment, dated 7/28/17, indicated the resident was cognitively impaired. Interview with the 2C Unit Manager on 9/18/17 at 10:43 a.m. indicated the sign was posted per family preference and should have been care planned. She indicated she would move the sign because it was supposed to be a reminder for staff and not for anyone else to see from the hallway as they walked by the resident's room. 3. On 9/12/17 at 9:55 a.m., a written sign was observed posted on Resident 71's closet door. The sign indicated "Wear pull ups during day and briefs at night." The sign was visible from the hallway. On 9/13/17 at 2:04 p.m., the resident was resting in her bed watching television. The written sign was observed posted on the resident's closet door and was visible from the hallway. Resident 71's record was reviewed on			

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	9/13/17 at 10:13 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/17, indicated the resident was cognitively impaired. Interview with the 2C Unit Manager on 9/18/17 at 10:43 a.m. indicated the sign was posted per family preference and should have been care planned. She indicated she would remove the sign because the information no longer applied to the resident and it wasn't meant for anyone else to see from the hallway as they walked by the resident's room. The facility's Resident Rights, provided by the Director of Nursing as current on 9/14/17, indicated, "...Homelike Atmosphere. Each resident has the right to a safe, clean, comfortable, and homelike environment...Resident Dignity. [Name of Facility] must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality..." 3.1-3(t)			

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F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on interview, record review, and observation, the facility failed to ensure a resident's preference was followed related to wake up time for 1 of 3 residents reviewed for choices. (Resident 203) Finding includes: During an interview with Resident 203 on 9/12/17 at 10:17 a.m., she indicated her preference was to get up between 9:00 a.m. and 10:00 a.m. and the aide had been getting her up between 7:00 a.m. and 7:30 a.m., then she sat and waited a half an hour before getting served breakfast in the Main Dining Room. The	F 0242	We request desk compliance F242 1:1 Resident #203 was reassessed to develop an individualized plan of care to address the resident's choice of waking for the day. 1:2 Residents will be reviewed to determine if their preferences have changed. Care plans and care cards will be adjusted, based on this review. 1:3 Residents will be assessed upon admit/quarterly and change of condition related to	10/16/2017

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	resident explained she liked to go to bed late and sleep in, as she had done all of her life. . Another interview with the resident on 9/13/17 at 2:15 p.m., indicated the aide had been getting her up at 7:00 a.m., and had to be by the elevator to be transported downstairs to the Main Dining Room to sit and wait for breakfast that is served at 8:00 a.m. Review of the resident's record was on 9/13/17 at 11:37 a.m. Diagnoses included, but were not limited to, repeated falls. The Quarterly Minimum Data Set assessment, dated 7/27/17, indicated the use of a wheelchair with a two person extensive assist. The "Resident Choice Questionnaire," was undated and indicated the preference for "get up in a.m." was 8:00 a.m. Interview with CNA 6 on 9/13/17 at 11:32 a.m., indicated she would go into the resident's room and get her up at 7:00 a.m., then took her to sit by the elevator by 7:30 a.m. to go the the Main Dining Room downstairs. During a continuous observation on 9/14/17 of the resident from 6:24 a.m. -7:17 a.m., the following was observed:		preference sheets. Staff will be educated regarding these preferences and that if resident condition changes their choice may need to be re-adjusted. Random observation and a record review will be completed five (5) times per week by DON/designee for the next 60 days post education to assure compliance. 1:4 Random interview will be conducted with residents five(5) times per unit per week for the next six(6) months to assure satisfaction. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continue compliance 1:5 Systemic changes will be completed by 10/16/17	

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	- 6:24 a.m. dressed, in bed, eyes closed. - 6:44 a.m. dressed, in bed, eyes closed. - 7:01 a.m. CNA 6 entered the resident's room, assisted the resident with her stockings, performed pericare, fixed her hair and assisted with her sweater, then transferred her via wheelchair to the elevators at the end of the hallway at 7:17 a.m. There were two clocks, side by side, in the residents room, with the correct times. Interview with resident on 9/14/17 at 7:19 a.m., indicated the aide woke her up and did not ask if she was ready to get up, just proceeded to get her out of bed. Interview with CNA 6 on 9/14/17 at 7:24 a.m., indicated she knocked on the door, and was unaware if the resident was awake or asleep. Resident 203 is the last resident to be transported to go downstairs to the Main Dining Room. Interview with 2A's Unit Manager on 9/14/17 at 9:32 a.m., indicated the preference questionnaire was not dated, she came from another unit, and was eating her breakfast in her room when she came to this floor. The preference questionnaire should have been updated. 3.1-3 (u)(1)			

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F 0250 SS=D Bldg. 00	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of a resident, related to a lack of follow up for a resident's dentures for 1 of 1 residents reviewed for dental services. (Resident C) Finding includes: On 9/11/17 at 12:40 p.m., Resident C was observed eating lunch in the Unit Dining Room (UDR). The resident was edentulous (lacking teeth). The record for was reviewed on 9/11/17 at 3:27 p.m. Diagnoses included, but were not limited to, dementia, stroke, hypertension (high blood pressure) and arthritis.	F 0250	F tag 250 1:1 Regarding resident C, the diet was altered immediately following report of her lost dentures. No adverse reaction noted. 1:2 Social Service Director/designee assessed residents on concern list related to other medical-related devices which could affect their psychosocial welfare and found no other residents at this time. Concern/grievance log will list residents with loss or broken dentures, hearing aides, or glasses separately from other concerns/grievances. 1:3 Social Service Director re-inserviced her staff regarding	10/16/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Quarterly MDS (Minimum Data Set) assessment, completed on 8/16/17, indicated the resident was cognitively impaired and required extensive assist of 2 staff members for bathing and was dependent on staff for personal hygiene. The resident did not have any natural teeth. Interview with the resident's sons on 9/13/17 at 11:15 a.m., indicated the resident's daughter had reported the missing dentures on 8/9/17 and the resident still did not have a replacement set of dentures, nor had they been updated on any upcoming appointments. Interview with the Social Service Director (SSD) on 09/15/2017 9:51 a.m., indicated the resident's daughter had reported the resident's dentures missing on 8/9/17, as indicated in the grievance log provided. The search conducted to located the dentures was unsuccessful. The daughter was informed on 8/9/17 the resident would be added to the list to be seen by the dentist but was not given a specific date. The SSD went on to explain the next time the dentist was scheduled to be in the facility was 8/10/17, but due to the intake process of the provider, the resident could not be added to the 8/10/17 list on such short		the necessity of checking with affected residents weekly for the first 60 days after a reported problem to assure that they are not negatively affected. Social Service Director/designee with meet with administrator weekly to review the concern/grievance log for next six (6) months. 1:4 Social Service Director/designee will report findings to the QAPI committee monthly for six(6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	notice and was scheduled to be seen on 9/11/17. The provider canceled the visit for 9/11/17 and the resident was then re-scheduled to see the dentist on 9/26/17. The SSD indicated she had not spoken to the resident's daughter (Health Care Representative) since their initial conversation on 8/9/17. Interview with the Director of Nursing on 9/15/17 at 11:21 a.m., indicated the HCR should have been informed of the outcome of the investigation and the status of all dental appointments and was not. A current policy, titled "Resident/Client Grievance Process," dated 4/2012 and provided by the SSD on 9/15/17 at 10:42 a.m., indicated, "...Procedure (Addendum)...6) Upon completion of the Complaint Investigation and development of the resolution(s) the individual(s) who offered the concerns will be informed of the outcomes/resolutions. Documentation of process and resolutions will be recorded on the grievance log .7) In the event individuals disagree with the method of resolution or continue to be dissatisfied, a formal meeting with the appropriated associates is recommended in an attempt to resolve the issues...."			

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	This Federal tag relates to Complaints IN00238074 and IN00238390. 3.1-34(a)			
F 0312 SS=D Bldg. 00	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide Activities of Daily Living (ADL) assistance to a dependent resident related to unclean fingernails for 1 of 3 residents reviewed for Activities of Daily Living. (Resident C) Finding includes: During an observation on 09/11/2017 at 12:40 p.m., Resident B was observed in the dining room on unit 3A sitting in a broda chair (a reclining wheelchair) drinking a glass of juice. The resident's fingernails were observed to have black/brown debris underneath and	F 0312	F312 We request desk compliance 1:1: regarding resident C her fingernails were cleaned by the nursing staff. 1:2: The Unit Manager/designee assessed residents on all units to ensure ADL's are completed evidenced by personal daily care tasks; such as bathing, dressing, teeth, hair, toileting, eating drinking including clean fingernails are complete with any deficiencies corrected at that time. 1:3: Director of Staff Development/designee re-inserviced the nursing staff on personal daily care tasks. The Unit	10/16/2017

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	around the cuticle area. During an observation on 09/14/2017 8:53 a.m., Resident B was observed in the dining room on unit 3A eating breakfast. The resident's fingernails were observed to have black/brown debris underneath and around the cuticle area. The Annual Minimum Data Set (MDS) assessment, completed on 5/24/17, indicated the resident was cognitively impaired and was dependent on staff for all activities of daily living. . Interview with the Unit Manager on 9/14/17 at 10:16 a.m., indicated when the resident was given a.m. care, her nails should have been checked and cleaned. This Federal tag relates to Complaints IN00238074 and IN00238390. 3.1-38(a)(2)(A) 3.1-38(a)(3)(E)		Manager/designee will assess 5 residents per unit per week to ensure proper nail care has been performed for 6 months. 1:4: The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5: Systemic changes will be completed by 10/16/17	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -			

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	(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. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, related to hi-protein supplements to assist in wound healing not provided to the resident as ordered by the Physician, for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Finding includes: During an observation on 09/11/17 at 12:40 p.m., Resident B was sitting in the dining room. The lunch meal consisted of pureed cod and corn. During an observation on 09/13/17 at 8:30 a.m.,8:30 a.m., the Unit Manager	F 0314	F314 Request desk compliance 1:1 Regarding Resident "B", both tray card and order were reviewed to ensure that they were consistent with what was being served. No adverse reaction noted. 1:2 Audit completed to assess resident's with wounds and/or open areas to ensure that interventions are in place as ordered to promote wound healing. 1:3 Dietary manager/designee re-inserviced staff related to highlighting the tray ticket for any ordered hi protein supplement and importance of placing ordered supplements on the resident's tray. DON/designee will assess	10/16/2017

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	was feeding the resident breakfast in her room. The resident remained in bed. The breakfast consisted of cranberry juice, coffee, and regular peaches, puree pancakes and sausage. There was no yogurt on the breakfast tray. During an interview at 8:40 a.m. on 9/13/17, the Unit Manager indicated there was no yogurt on the breakfast tray. An Observation of wound care with the Wound Nurse and Unit Manager on 09/13/17 at 8:45 a.m. to 9:25 a.m., indicated there was an unstageable deep tissue injury (purple pressure areas on the skin, damage to the tissue cannot be confirmed due to slough or eschar) on the right heel, stage 2 (partial thickness loss) on the right ischium, and an unstageable pressure ulcer on the coccyx, which had tunneling (deeper area into the tissue). Resident B's record was reviewed on 09/12/17 at 12:10 p.m. Diagnoses included, but were not limited to, repeated falls and Alzheimer's disease. A care plan, dated 9/27/16, indicted a risk for pressure ulcers due to decreased mobility, poor safety awareness, on 8/11/17 a blister blood filled right outer heel noted, 8/24/17 a coccyx wound noted, and 08/31/17 upon readmission		and monitor that pressure ulcer interventions are in place as ordered. Dietary manager/designee will audit five(5) high risk trays each week for six(6)weeks, then ten(10) trays monthly for total of six(6) months. DON/designee will audit five(5) residents with ordered wound interventions each week for six(6) weeks, then ten (10) residents with wound interventions monthly for total of six(6) months. 1:4 The dietary manager/designee as well as DON/designee will report findings to the QAPI committee monthly for six(6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	from the hospital a right ischium and left ischium wound (healed) 9/12/17, was added to the care plan problem. The interventions included dietary consult. A Dietary Consult Note, dated 8/15/17 at 11:05 a.m., indicated the resident had a pressure area and was receiving fortified pudding with lunch and recommended yogurt with breakfast and ice cream with dinner. A Physician's Order, dated 09/01/17, indicated to resume yogurt with breakfast, fortified mashed potatoes with lunch, and ice cream with dinner for wound healing. This Federal Tag relates to complaint IN00240323. 3.1-40(a)(2)			

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F 0322 SS=D Bldg. 00	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (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- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration,			

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	metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes received the necessary care and treatments related to medication administration for 1 of 1 residents reviewed for PEG tubes. (Resident 209) Finding includes: During a medication pass observation, on 9/14/17 at 11:57 a.m., LPN 2 was observed preparing a medication for Resident 209. At that time, LPN 2 crushed the Carbidopa/Levodopa (Sinemet) tablet in a plastic sleeve and brought it to the resident's room. She washed her hands and donned clean gloves. LPN 2 then poured the crushed medication into a plastic med cup and added 20 cubic centimeters (cc) of water and stirred it with a spoon. She unclamped the PEG-tube, removed the cap, and flushed 30 cc of water into the tube. She poured the medication into the tube and followed it with 30 cc of more water and then the resident's scheduled 200 cc water flush. LPN 2 clamped the PEG-tube and placed the cap back over the top.	F 0322	F322 We request desk compliance 1:1 regarding resident #209, no adverse reactions were noted as the LPN already assessed Percutaneous Endoscopic Gastrostomy tube (PEG) placement that shift per Physician Order. 1:2: all residents who have a Percutanoeus Endoscopic Gastrostomy tube (PEG) have orders to check for placement once a shift per Physician Order. The Enteral Tube Medication Administration Policy was updated to reflect current standard of practice. Unit Manager/designee will audit resident records for all resident s with Percutaneous Endoscopic Gastrostomy tube (PEG) weekly to ensure placement is being checked as well as monitor correct medication administration is followed once a shift for 6 months. 1:3: Director of Staff Development/designee re-inserviced licensed staff as well as QMAS regarding the policy change and proper medication administration. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further	10/16/2017

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	LPN 2 had not confirmed placement of the PEG tube by using a stethoscope and air bolus, nor did she check for residual prior to the administration of the medication. Interview with LPN 2 on 9/14/17 at 12:08 p.m.., indicated she had checked for residual earlier in her shift but not immediately prior to administering the Carbidopa/Levodopa medication. The facility's policy to confirm PEG tube placement was to check for residual once per shift as they no longer used the air bolus method. A facility policy, titled, "Enteral Tube Medication Administration", received from the Director of Nursing as current, indicated, "...Procedure...13. Check for proper placement of the feeding tube by air bolus or aspiration. 14. Flush the feeding tube with 30 ml of water...15. Administer prescribed medications..." 3.1-44(a)(2)		monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			

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	(d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, record review, and interview, the facility failed to ensure a resident received adequate assistive devices to prevent accidents, related to interventions to assist in fall prevention were not in use as ordered by the Physician, for 1 of 3 residents reviewed for falls. (Resident B)	F 0323	F323 We request desk compliance 1:1 regarding resident B, the safety alarms were applied & no injuries were noted. 1:2: Unit Managers/designee completed an audit on all residents with fall interventions to ensure they were intact with any deficiencies corrected at that time.	10/16/2017

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	Finding includes: Resident B was observed on 09/12/17 at 2:45 p.m. sitting in her room in a Broda chair (High back/reclining wheelchair). There was no personal alarm observed on the chair. During an observation on 09/13/17 at 9 a.m. with the Unit Manager and Wound Nurse present, the resident was lying in bed and a safety alarm was not located on the bed. The Unit Manager acknowledged there was no safety alarm on the bed. Resident B's record was reviewed on 09/12/17 at 12:10 p.m. Diagnoses included, but were not limited to, repeated falls and Alzheimer's disease. A Fall Risk Assessment, dated 06/22/17, indicated a high risk for falls. A Quarterly Minimum Data Set (MDS) assessment, dated 06/13/17, indicated severely impaired cognition, extensive assistance of two for bed mobility, extensive assistance of one for transfers, and not steady without help for standing, walking, and moving on and off toilet. A care plan, dated 09/27/16, indicated a fall risk due to history of falls. The		1:3 Director of Staff Development /designee re-inserviced nursing staff on ensuring all fall prevention interventions are in place per the care plan/care card. The Unit Manager/designee will assess 5 residents per unit per week on all shifts with fall interventions to ensure compliance for 6 months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	interventions included, safety alarms when in bed and in a chair. Physician's Orders, dated 07/29/16, indicated sensor alarm when in bed and sensor pad when up in wheelchair or chair. This Federal Tag relates to complaints IN00240323 and IN00238390. 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) 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-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or			

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	(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to following medication order parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 156) Finding includes: Resident 156's record was reviewed on 9/13/17 at 12:07 p.m. Diagnoses included, but were not limited to,	F 0329	F329 We request desk compliance 1:1: Regarding resident #156, the Physician was notified regarding her BP with no adverse reactions noted. 1:2: Unit Manager/designee reviewed residents requiring parameters for BP medication as well as other ordered medication to ensure accuracy. Any deficiencies noted corrected at that time. 1:3: Director of Staff Development/designee re-inserviced	10/16/2017

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	hypertension and cardiac arrhythmia. The Quarterly Minimum Data Set (MDS) assessment, dated 7/13/17, indicated the resident was cognitively impaired. The September 2017 Physician Orders indicated an order for Propranolol (a blood pressure medication) 40 milligrams (mg) three times daily, hold if systolic blood pressure is < (less than) 110. The order was discontinued on 9/7/17. The August 2017 Medication Administration Record (MAR), indicated the medication was not held on the following dates/times with the corresponding blood pressure (BP) results: 8/9/17 at 1400 - BP 100/64 8/11/17 at 1400 - BP 100/72 8/15/17 at 1000 - BP 102/78 8/15/17 at 1400 - BP 102/70 8/16/17 at 1000 - BP 108/76 The September 2017 MAR, indicated the medication was not held on the following dates/times with the corresponding BP results: 9/2/17 at 1800 - BP 108/66 9/3/17 at 1400 - BP 92/63 9/3/17 at 1800 - BP 98/64 Interview with the Director of Nursing (DON) on 9/1417 at 11:32 a.m. indicated		licensed staff and QMAS regarding following physician's orders for any medication as well as following BP parameters. The Unit Manager/designee will audit 5 residents per unit per week for accuracy of medication administration for 6 months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	she was unable to find documentation the blood pressure medication had been held per the parameters as ordered. 3.1-48(a)(6)			
F 0332 SS=D Bldg. 00	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 9 residents observed during 5 medication pass observations. 2 errors in medications were observed during 25 opportunities for errors in medication administration. This resulted in a medications error rate of 8%. (Resident 184 and 139) Findings include: 1. During a medication administration observation on 9/14/17 at 9:05 a.m., RN 1 prepared Resident 184's medications,	F 0332	F332 We request desk compliance 1:1 regarding resident # 184 & #139 the Physician was updated on the medication. No new orders received. No adverse reactions noted. 1:2: Unit Manager/designee reviewed the medical record for residents receiving Synthroid to ensure accuracy of administration as well as any ordered medication with any deficiencies corrected at that time. 1:3: Director of Staff Development/designee re-inserviced licensed staff & QMAS on	10/16/2017

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	which included Synthroid (levothyroxine sodium, a thyroid medication) 25 micrograms (mcg). RN 1 crushed the medications, put them in applesauce, and administered them to the resident. The resident was in the dining room and had just finished eating her breakfast. Resident 184's record was reviewed on 9/14/17 at 10:00 a.m. Diagnoses included but were not limited to, hypothyroidism. The September 2017 Physician's Orders, indicated an order for levothyroxine sodium 25 mcg daily at 6:00 a.m. Interview with the Director of Nursing (DON) on 9/14/17 at 11:32 a.m., indicated the medication should have been given as ordered. 2. During a medication administration observation on 9/14/17 at 9:11 a.m., RN 1 prepared Resident 139's medications which included Synthroid (levothyroxine sodium, a thyroid medication) 75 micrograms (mcg) and administered them to the resident. The resident had just arrived to the dining room after getting up for the morning. The staff were preparing to serve her breakfast. Resident 139's record was reviewed on		medication administration & following physician's orders. Unit Managers/designee will audit 5 resident records per unit per week to ensure accurate medication administration. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for 6 months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	9/14/17 at 10:00 a.m. Diagnoses included but were not limited to, hypothyroidism. The September 2017 Physician's Orders, indicated an order for levothyroxine sodium 75 mcg daily at 6:00 a.m. Interview with the Director of Nursing (DON) on 9/14/17 at 11:32 a.m. indicated the medication should have been given as ordered. A facility document, titled, "Levothyroxine-oral", received from the DON as the current medication instructions, indicated "...How to use: ...Take this medication by mouth as directed by your doctor, usually once daily on an empty stomach, 30 minutes to 1 hour before breakfast..." 3.1-48(c)(1)			
F 0364 SS=E Bldg. 00	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides-			

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	(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; Based on observation, interview, and record review, the facility failed to serve a resident food that was safe and at a warm temperature, related to puree food and food served cold, for 2 of 6 residents observed at meal time in 1 of 10 dining rooms. (Dining Room 2D, Residents B and 149) Findings include: 1. During an observation of the 2D Dining Room on 09/12/17 at 8:30 a.m. through 9:14 a.m. the following was observed: 8:30 a.m. - Resident 149 was sitting at the table with uncovered breakfast food in front of her. The breakfast meal consisted of puree scrambled eggs, ham, and toast 8:35 a.m. - Dietary Aide 1 obtained temperatures of Resident 149's food, which were eggs at 106.5 F, ham at 83.5 F, and toast at 95.5 F.	F 0364	F 364 Request desk compliance 1:1 regarding Resident “B” and 149 make every effort to ensure food temperatures and food is safe and palatable as required. No residents had a negative outcome as a result. 1:2 Resident orders and tray cards reviewed to ensure accuracy. 1:3 Residents with high risk/specialized diets will have tray card color –coded for ease of identification. Dining as well as nursing staff will be inserviced on color coding. Dining and nursing staff will be inserviced on proper techniques for maintaining proper temperatures of foods while on the steam table and during meal service. Dining staff will be re-inservice related to proper technique for temping foods an thermometer use. Dietitian/designee will audit three high risk/specialized trays and	10/16/2017

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	8:40 a.m., Resident 149 remained with uncovered food and no assistance from staff. 8:43 a.m., the Unit Manager gave Resident 149 a bite of ham. 8:49 a.m., CNA 2 assisted Resident 149 with her meal. 8:57 a.m., the Unit Manager gave Resident 149 a drink of coffee, which had been sitting on the table since 8:39 a.m. 9:09 a.m., the Unit Manager returned to the Dining Room and removed Resident 149's food from the table. The resident had consumed a few bites of ham and one bite of egg. During an interview on 09/13/17 at 8:15 a.m. the Unit Manager indicated they try to assist everyone timely, they are trying to hire a second Dietary Assistant to assist with serving, and she was unaware the resident's food temperature were cool. Resident 149's record was reviewed on 09/13/17 at 2:59 p.m. Diagnoses included, but were not limited to, dementia and the Quarterly MDS assessment, dated 6/13/17, indicated limited assistance was needed for eating.		tray cards five times per week for six weeks then six(6) trays and tray cards for ten (10) weeks. Then one (1) high risk /specialized tray and tray card one time a month for two(2) months. 1:4 Dietitian/dietary manager will report audit findings to the QAPI committee monthly for six(6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	2. During an observation at 8:30 a.m. on 9/13/17, the Unit Manager was assisting Resident B with breakfast, which consisted cranberry juice, coffee, and regular peaches, puree pancakes with blueberry syrup and puree sausage. The Unit Manager stated, " I give her peaches because she likes them" The tray card indicated the resident was ordered a no added salt puree diet with thin liquids. At 8:40 a.m. on 9/13/17, the Unit Manager indicated the resident was on a mechanical soft diet, then read the tray card and stated, "that's what they gave her" and "I think she has had regular peaches before" Resident B's record was reviewed on 09/12/17 at 12:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and the Quarterly MDS assessment, dated 06/13/17 indicated limited assistance with eating was needed. A Physician's Order, dated 08/08/17, indicated Puree diet with thin liquids. A Speech Therapy Progress Note, dated 09/08/17, indicated maximum cues, but no signs or symptoms of aspiration. Diet			

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	downgraded to puree. A Speech Therapy Progress Note, dated 09/12/17, indicated, "...demonstrates fluctuating participation in ST (Speech Therapy) services for dysphagia. Patient discharged on mech (mechanical) soft diet with pureed meats, with recommendation for 1:1 supervision at meals to ensure carryover of aspiration precautions..." An interview on 09/13/17 at 1:49 p.m., the Speech Therapist indicated it was a "mistyping" and the resident note should have said to keep on a puree diet as ordered. 3. In the Main Dining Room on 9/14/17 at 12:37 a.m., after the Main Dining Room had finished serving the last resident, Cook 2 took food temperatures on a test tray that consisted of a pork loin and peas. The Pork loin was 134.6 degrees Fahrenheit and the peas were 116.2 degrees Fahrenheit. Cook 2 indicated the temperatures of the food were cold and should not have been served to the residents. The policy titled,"Steam Table Serving Temperatures for Hot and Cold Foods," was provided by the Administrator on 9/15/17 at 2:30 p.m. This current policy indicated, "...a. Foods will be served at			

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	the following temperatures to ensure a safe and appetizing dining experience... Meat, Casseroles: 135 to 170 degrees Fahrenheit, Vegetables, Potatoes: 135 to 170 degrees Fahrenheit...." 3.1-21(a)(2)			
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and			

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	consumption. Based on observation, interview, and record review, the facility failed to properly sanitize the puree blender for 1 of 1 kitchens, maintain a sanitary environment during meal service related to touching food and non food items and properly sanitize the food thermometer for 2 of 10 dining rooms. This had the potential to affect 9 residents that received pureed meals, 17 residents who are served from the Third Floor D Hall steam table and 35 residents who are served food from the Main Dining Room. (Kitchen,Third Floor D Hall, and Main Dining Room) Findings include: 1. On 9/14/17 at 8:11 a.m., Cook 3 was observed to have pureed noodles, rinsed the puree blender in the sink, washed the blender with soap and water and then rinsed the blender with water. Cook 3 then proceeded to puree cheese ravioli with marinara sauce in the same blender. Interview with Cook 3 at that time, indicated she should have washed the blender through the dishwasher to properly clean it. The policy tilted, "Cleaning of Food Processor," was provided by the Director	F 0371	F 371 Request desk compliance 1:1 No resident experience a negative outcome. 1:2 Had the potential to affect nine(9) resident served Pureed meals, 17 residents served from the third floor D Hall steam table and 35 residents who are served food from the Main Dining Room(Kitchen, Third Floor D hall, and Main Dining Room). None of these residents experience a negative outcome. 1:3 Dietary staff re-inserviced related to food processor cleaning procedure, monitoring and maintaining food temperatures for meal service, proper serving utensils for serving and handwashing/glove usage. Director of Staff development /designee will observe hand washing for three dietary staff weekly for accuracy of technique for six months. Dietary manager/designee will observe five(5) dietary staff weekly for proper technique including proper food temps and proper use of serving utensil including handwashing/glove usage for six months. Dietary manager/designee will observe cleaning procedures for the food processor utilized for pureed foods three(3) days/week for six(6) months. 1:4 Director of Staff development and dietary manager/designee will report audit findings to the QAPI	10/16/2017

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	of Nursing on 9/18/17 at 10:57 a.m. This current policy indicated, "...Procedure: 1. Wash all removable pieces in dishwasher...." 2. During a continuous observation of the Third Floor D Hall lunch services on 9/14/17 from 11:44 a.m.-12:26 p.m., the following was observed by the Dietary Service Aide 2: - 11:54 a.m.: the roasted pork was temped with the food thermometer, then the thermometer was wiped with a napkin from the countertop - the manicotti was temped, then with another napkin, the same food thermometer was wiped off, - the peas were temped and the thermometer wiped with a new napkin - the cauliflower was temped and the same napkin from after the peas was used to wipe off the same thermometer - the ground pork was temped and the same napkin from the peas and cauliflower was used to wipe off the same thermometer - the mushroom pilaf was temped and a new napkin was used to wipe off the same food thermometer - the mashed potatoes were temped and the same napkin used for the mushroom pilaf was used to wipe off the same thermometer,		committee for six (6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	- the gravy was temped, the same napkin was used to wipe off the same food thermometer, - the bow tie pasta was temped and same napkin was still used to wipe off the same food thermometer, - the cake was temped and the same napkin was used to wipe off the same food thermometer, - lastly, the cream of broccoli soup was temped with same food thermometer. - at 12:07 p.m. Dietary Service aide (DSA) 2 changed her gloves and began to plate the food - at 12:17 p.m. she placed the container of cauliflower which had sat on the countertop, into the same serving dish as the peas and continued to plate food. DSA 2 had not changed gloves, then placed a bread stick on to the resident's food with her gloved hand. Interview with the Dietary Service Aide 2 on 9/14/17 at 12:26 p.m., indicated she should have used tongs for the bread sticks, should have made room for the cauliflower on the steam table and did not understand why using a napkin was not sufficient to wipe the food thermometer between foods. 3. During lunch service in the Main Dining Room on 9/14/17 at 12:35 p.m., Dietary Service Aide 1 was observed to			

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	have plated 2 plates of food, then with the same gloved hands, place a bag of hamburger buns on the countertop, reach in and pull out a bun, placed each piece of the bun on a plate, using tongs placed a hamburger patty onto the bun, removed plastic wrap from a plate of tomatoes, removed a tomato slice and place it onto the hamburger patty and then placed the plate on the counter to be served. Interview with the Dietary Service Aide 1 on 9/14/17 at 12:40 p.m., indicate that tongs should have been used and gloves changed. Interview with the Director of Dietary Services on 9/14/2017 at 3:32 p.m., indicated tongs should be used to serve and plate food, alcohol wipes should be used to sanitize the food thermometers, serving dishes should be placed separately on the steam tables and Cook 2 did not temp the pork loin correctly. The policy titled, "Monitoring Food Temperatures for Meal Service, " was provided by the Administrator on 9/15/17 at 2:30 p.m. This current policy indicated, "...3...b. Thermometers are washed, rinsed, sanitized before, and after each meal use. An alcohol swab may be used to sanitize between uses while taking temperatures during the			

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	same meal...." The policy titled, "Food Serving," was provided by the Director of Nursing on 9/18/17 at 10:57 a.m. This current policy indicated, " ...Procedure:...3. Hand-washing should be performed any time the hands are accidentally soiled...4. Avoid food contamination by placing individual serving utensils in each entree...." 3.1-21(i)(2)			
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment			

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	155214	A. BUILDING 00 B. WING	09/18/2017

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	implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the			

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	corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained related to medication administration for 1 of 9 residents observed during the medication administration observation. (Resident 139) Finding includes: During a medication administration observation on 9/14/17 at 9:11 a.m., RN 1 prepared Resident 139's medications, which included Synthroid, Lasix, Seroquel, Metoprolol, Aspirin, Tylenol, and Potassium Chloride. She placed the pills in a plastic medication cup. As RN 1 was reaching to pour a cup of water for the resident she knocked over the medication cup and three of the pills fell on to the top of the medication cart. RN 1 put on a clean glove, picked up the three pills and placed them back in the medication cup with the other pills. She then administered the medications to the resident.	F 0441	F 441 We request desk compliance. 1:1 Regarding Resident #139, no adverse reactions noted after medicationadministration. 1:2 Unit manager/designee educated nursing staff regarding discarding medication which may fall out of medication cup during administration. 1:3 Licensed nursing staff instructed/educated on appropriate infection control procedures related to a medication which may fall on medication cart during medication administration. Director of Staff development/designee will observe three nurses weekly for	10/16/2017

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	Interview with the Director of Nursing (DON) on 9/14/17 at 11:32 a.m. indicated she could not find a policy regarding infection control and medication administration. She indicated good nursing practice would have been for RN 1 to discard the pills that fell on top of the medication cart instead of putting them back into the medication cup. RN 1 should have then replaced those medications. 3.1-18(a)		accurate medication administration on various shifts for six months. Observation will include five residents 1:4 DON/designee will report audit findings to the QAPI committee monthly for six(6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	
F 0465 SS=E Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking			

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	areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to provide a clean, safe, and homelike environment related to discolored ceiling tiles, marred doors, and doorskins coming off the doors for 2 of 3 floors observed. (Second and Third floors) Findings include: During the Environmental Tour on 9/18/17 from 9:10 a.m. - 9:50 a.m. with the Director of Plant Operations, the Plant Operations Assistant, the Environmental Manager and the Coordinator of the Environment, the following was observed: 1. Third Floor, C Hall: a. In Room 373, the cove base at the corner of the bathroom door was loose and coming off. There was one resident who resided in this room. b. In Room 374, the outside bedroom doorskin had peeled off on the bottom corner. There was one resident who resided in this room. 2. Third floor D Hall:	F 0465	F 465 Request Desk compliance 1:1 Corrective measures accomplished for all environmental conditions observed during tour as follows: 1.Room 373 loose cove base was glued 2.Room 222,243,374 bedroom doorskin was repaired to secure it without peeling 3.Room 397 mars on bathroom door were filled. 4.Room 207 and 214, 273 brown/yellow substance removed and thoroughly cleaned. 5.Mar on wall in 222 repaired and re-painted. 6.Room 261 chipped paint removed and re-painted. 7.Room 284, between 282 and 280 ceiling tile to be replaced. 1:2 Plant operations/environmental service manager will identify any other affected areas through regular rounds made by both departments. 1:3 Plant operations/environmental manager will re-inservice their staff regarding the necessity of checking for loose cove base, doorskins marred or loose,	10/16/2017

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	a. In Room 397, the outside of the bathroom door was marred. There was one resident who resided in this room. 3. Second floor A Hall: a. In Room 207, there was a yellow substance on the wall next to the bed. There was one resident who resided in this room. b. In Room 214, there was a yellow substance on the wall next to the bed. There was one resident who resided in this room. c. In Room 222, outside bedroom doorskin had peeled off in the corner and the wall was marred by the telephone outlet. There was one resident who resided in this room. 4. Second floor B Hall: a. In Room 243, outside bedroom doorskin had peeled off and the floor mat corners were coming apart. There was one resident who resided in this room. 5. Second floor C Hall: a. In Room 273, there was a brown discoloration on the ceiling tile and grid above the window. There was one		walls requiring cleaning or repair and painting completing of work order as needed. Plant operations/environmental department will audit five areas per unit weekly to assure ongoing compliance of environment. 1:4 The Plant operations/environmental manager will report audit findings to the QAPI committee monthly for six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	resident who resided in this room. b. In Room 261, the bathroom door frame had chipped paint and blue tape that had peeled. There was also a brown discoloration on top of the air conditioner unit. There was one resident who resided in this room. 6. Second floor D Hall: a. In Room 284, there was a black discoloration on the ceiling tile above the foot of the resident's bed. There was one resident who resided in this room. b. In the Hallway between Rooms 282 and 280, there was a black discoloration on the ceiling tile. Interview with the Director of Plant Operations at the end of the tour on 9/17/17 at 9:50 a.m., indicated all of the above was in need of repair or cleaning. This Federal tag relates to Complaints IN00238074 and IN00238390. 3.1-19 (f)			

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