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| | 155621 | A. BUILDING 00<br>B. WING | 08/10/2017 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: August 7, 8, 9, & 10, 2017<br><br>Facility Number: 000442<br>Provider Number: 155621<br>AIM Number: 100266510<br><br>Census bed type:<br>SNF: 19<br>SNF/NF: 70<br>Total: 89<br><br>Census payor type:<br>Medicare: 21<br>Medicaid: 43<br>Private: 14<br>Other: 11<br>Total: 89<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on August 18, 2017. | F 0000 | By submitting the Plan of Correction, the facility is not admitting to the truth or accuracy of the cited deficiencies or allegations. The facility reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance, effective on or before September 6th, 2017, to the cited deficiencies of the Recertification and State Licensure Survey, conducted on August 10th, 2017. The facility respectfully requests paper compliance in relation to the above findings. | |

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

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

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| F 0156 SS=D Bldg. 00 | 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)<br>NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.<br><br>§483.10(g) Information and Communication.<br>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.<br><br>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:<br><br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br><br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br><br>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.<br><br>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational | | | |

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| | agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and<br><br>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] | | | |

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| | (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;<br>[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(v) Contact information for the Medicaid Fraud Control Unit; and<br>[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:<br><br>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and<br><br>(ii) A statement that the resident may file a | | | |

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| | complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.<br><br>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.<br><br>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.<br><br>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.<br><br>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;<br><br>(g)(17) The facility must--<br><br>(i) Inform each Medicaid-eligible resident, in | | | |

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| | writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br><br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br><br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br><br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.<br><br>(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br><br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br><br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br><br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the | | | |

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| | facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br><br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br><br>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br><br>Based on interview and record review, the facility failed to provide residents Notice of Medicare Non Coverage for 2 of 3 residents reviewed. (Residents 12, Resident 5)<br><br>Findings include:<br><br>On 8/9/17 at 2:19 p.m., the SS indicated she was unable to locate the Notice of Medicare Non Coverage for Resident 12 and Resident 5, when requested.<br><br>On 8/9/17 at 3:00 p.m., the record for Resident 5 was reviewed. His payor type changed on 4/27/17 from Medicare A and he remained in the facility. | F 0156 | F 156<br><br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* Resident 5 and Resident 12 were given Notice of Medicare Non Coverage letters upon discovering the error.<br><br>*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents who have been cut from Medicare services | 09/06/2017 |

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| | On 8/9/17 at 3:05 p.m., the record for Resident 12 was reviewed. Her payor type changed on 3/12/17 from Medicare A.<br><br>On 8/10/17 at 11:25 a.m., the Administrator provided the current facility policy, Form Instructions for the Notice of Medicare Non-Coverage, updated/revised 3/1/17. The policy included, but was not limited to: The NOMNC (Notice of Medicare Non-Coverage) must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if a care is not being provided daily.<br><br>3.1-4(f)(3) | | have the potential to be affected by this practice, therefore a house wide audit has been completed on all residents who have been cut from Medicare services in the last 30 days to ensure that all those who required a Notice of Medicare Non Coverage were given proper 48 hour notice prior to the end of Medicare covered services.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service was provided for all staff, including the Social Services Director, to ensure that all residents whose Medicare covered services will be ending are given proper notification of appeal rights within 48 hours prior to end of service, using the Notice of Medicare Non Coverage form. | |

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| | | | *The corrective action taken to monitor to assure compliance is that* the Social Services Director or designee will review 5 random residents whose Medicare covered services has ended weekly times 4 weeks, then monthly times 3 months, then quarterly times 3 quarters, to ensure all residents who require Notice of Medicare Non Coverage are receiving notice timely. This will be reviewed quarterly in Quality Assurance meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/ or their designee prior to the regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |
| F 0241<br>SS=E<br>Bldg. 00 | 483.10(a)(1)<br>DIGNITY AND RESPECT OF INDIVIDUALITY<br>(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 | | | |

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| | resident's individuality. The facility must protect and promote the rights of the resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure dignity was provided for 4 of 5 residents reviewed receiving care. A resident's blood sugar was obtained and their insulin injection was administered while the resident was sitting in the hall, a resident was served her meal after 3 residents were served the meal at another table. and 2 CNAs were observed entering resident rooms without knocking. (Resident 67, Resident 96, Resident 101, Resident 129)<br><br>Findings include:<br><br>1. On 8/7/17 at 7:39 a.m., LPN 1 was observed to be obtaining a blood glucose from Resident 67. Resident 67 was observed to be sitting in a wheelchair in the hall by the nurse's station. LPN 1 was observed to wipe the resident's finger, obtain the specimen, and applied the specimen to the glucometer. After obtaining the result of the blood glucose, LPN 1 was observed to wipe the resident's finger. LPN 1 then placed the glucometer into a plastic bag and placed it into the medication cart. | F 0241 | F – 241<br><br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* LPN 1 was educated related to resident dignity and medication administration practices. Staff who serve resident meals in dining room were immediately educated related to proper serving procedures for residents seated at the table together. Staff was educated related to resident dignity and knocking on doors prior to entering.<br><br>*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this practice, therefore random | 09/06/2017 |

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| | On 8/7/17 at 7:41 a.m., LPN 1 indicated Resident 67's blood glucose result was 165 mg/dl (milligram/deciliter) and was to receive 2 units of Novolog insulin. LPN 1 was observed to administer the insulin into the abdomen of Resident 67. Resident 67 was sitting in a wheelchair in the hall during the administration in view of other residents.<br><br>On 8/9/17 at 8:50 a.m., RN 1 indicated residents should be taken to their rooms prior to obtaining a blood glucose or prior to the administration of any medication or injection.<br><br>2. On 8/7/17 at 8:36 a.m., Resident 77, Resident 75, Resident 11, and Resident 96 were observed sitting at a dining room table. Resident 77, Resident 75, and Resident 11 were observed to be eating their breakfast. Residents 21, Resident 86, and Resident 88, seated at another table, were served their breakfast prior to the staff serving Resident 96. Resident 96 was observed to be looking around the dining room for her breakfast.<br><br>On 8/10/17 at 8:49 a.m., CNA 10 indicated cups should be handled by their handle or from the side. CNA 10 indicated cups should never be handled by the rims. CNA 10 further indicated all the residents seated at the same table | | audits will be conducted on alternating shifts / units per QA schedule and as identified by the Department Director or designee, to ensure that staff are caring for residents with dignity and respect.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* amandatory all staff in-service was provided to educate staff of the importance of caring for all residents with dignity and respect in relation to medication administration, meal service and knocking on doors prior to entering, to ensure that all residents are treated with dignity and respect. | |

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| | should be served before serving the residents at another table.<br><br>3. On 8/7/17 at 8:25 a.m., CNA 3 was observed entering Resident 101 room without knocking to deliver breakfast tray. CNA 3 immediately turned and said she was supposed to knock first before entering the resident's room.<br><br>4. On 8/9/17 at 10:40 a.m., CNA 5 was observed entering Resident 129 room without knocking while answering the call light.<br><br>On 8/9/17 at 10:45 a.m., CNA 5 was observed re-entering Resident 129 room without knocking while bringing back a measuring device.<br><br>During an interview on 8/9/17 at 2:35 p.m., CNA 5 indicated before entering a resident's room you should knock on the door and tell them who you are.<br><br>A policy titled "Quality of Life - Dignity" that was revised on 3/1/17 was provided by the Administrator on 8/10/17 at 1:26 p.m. This policy stated, "Resident's private space and property shall be respected at all times. Staff will knock and request permission before entering residents' room." | | *The corrective action taken to monitor to assure compliance is that* the DON or designee will review 5 random residents / staff members weekly times 4 weeks, monthly times 3 months and quarterly times 3 quarters, to ensure all residents are treated with dignity and respect. This will be reviewed quarterly in Quality Assurance meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/ or their designee prior to the regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |

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| | The current policy, dated 3/1/17, indicated staff should promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.<br><br>3.1-3(t) | | | |
| F 0282<br>SS=D<br>Bldg. 00 | 483.21(b)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Based on observation, record review and interview the facility failed to implement and revise care plans for 1 of 1 residents whose care plan was incomplete to include refusal of care and indicated desires to take his own | F 0282 | F – 282<br><br>*The corrective action taken for those residents found to have been affected by the* | 09/06/2017 |

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| | life. (Resident 49)<br><br>Findings include:<br><br>During a review of Resident 49's clinical record on 8/8/17 at 10:50 a.m., the MDS (Minimum Data Set) indicated Resident 49's BIMS (Brief Interview Mental Status) was a 14, no cognitive impairment. The medical diagnosis listed for the resident were all or in part, but not limited to: pneumonitis, enterocolitis, COPD, chronic kidney disease, chronic respiratory hypoxia, abnormalities of breathing, hypotension.<br><br>During a review of Resident 49's care plans on 8/8/17 at 12:15 p.m., they failed to include care plans for the resident's feeding tube and refusal of feedings, resident's refusal of oxygen, and the resident's suicidal ideation.<br><br>During a review of Resident 49's progress notes on 8/8/17 at 11:52 a.m., the progress notes indicated Resident 49 was refusing to wear his nasal cannula, refusing tube feedings, and had questioned the nurse how long it would take him to die if he left his oxygen off. Resident 49 requested staff to leave him alone and to shut the door so that he could | | *deficient practice is that* Resident 49 is no longer a resident at the facility.<br><br>*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected, therefore a house wide audit of all care plans has been completed to ensure that all resident care plans are reflective of resident individualized care needs, specific requests, and services provided by staff.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory all staff in-service, to include the Care Plan Coordinator was conducted to ensure that any change in resident condition, needs, or specific requests are documented | |

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| | remove his oxygen. Staff refused and placed the resident on 15 (fifteen) minute checks as a nursing measure.<br><br>During an interview with 8/10/17 at 8:02 a.m.. with SS (Social Services), she indicated she would have been the one to add the care plans for the resident's suicidal ideation, refusals of feedings, and the refusal of oxygen. She indicated this should have been done.<br><br>During a review of the current policy, "Care Plans-Comprehensive," revised 3/1/17, on 8/10/17 at 11:25 a.m., it indicated all or in part, but not limited to: develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Review and updating of care plans: When there has been a significant change in the resident's condition; when the desired outcome is not met.<br><br>3.1-35(g)(2) | | on the 24 hour report sheet. The 24 hour report sheet will be reviewed Monday through Friday in clinical meeting to ensure the plan of care and assignment sheets are reflective of the resident's current appropriate needs, specific requests and services provided.<br><br>*The corrective action taken to monitor to assure compliance is that* the MDS Coordinator or designee will conduct audits of 5 random resident care plans weekly times 4 weeks then monthly times 3 months then quarterly times 3 quarters, to ensure that all care plans are reflective of current resident needs, specific requests and services provided. This will be reviewed quarterly in Quality Assurance meetings | |

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| | | | to ensure that compliance is maintained. This review will be conducted by the Administrator and/ or their designee prior to the regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |
| F 0312<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>(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.<br><br>Based on observation, interview, and record review, the facility failed to provide ADL (activities of daily living) care to 2 of 3 residents reviewed for choices. Showers were not provided to residents. (Resident 1, Resident 93)<br><br>Findings include:<br><br>1. On 8/7/17 at 2:02 p.m., Resident 1 was observed to be lying in bed, visiting with her daughter. Resident 1's daughter indicated the resident preferred showers but had not been receiving her showers. | F 0312 | F – 312<br><br>*The corrective action taken for those residents found to have been affected by the deficient practice is that*<br>Resident 312 is no longer a resident at the facility.<br>Resident 92 is now receiving showers 2 times per week per shower schedule. | 09/06/2017 |

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| | Resident 1's daughter indicated the resident was supposed to receive a shower 2 (two) times a week but had not received a shower in a long time.<br><br>The clinical record for Resident 1 was reviewed on 8/8/27 at 1:09 p.m. Resident 1 had diagnoses including, but not limited to, congestive heart failure, osteoarthritis, hypertension, pain, and restless leg syndrome. A quarterly MDS (Minimum Data Set) assessment, dated 7/20/17, indicated Resident 1 had a BIMS (Brief Interview for Mental Status) assessment of 11, indicating moderate cognitive impairment.<br><br>A care plan, initiated 6/25/15 and reviewed on 7/20/17, indicated Resident 1 was to bathed per her preference 2 times a week.<br><br>The "Shower Schedule," obtained from the Adm (Administrator) on 8/8/17 at 2:02 p.m., indicated the resident was to receive a shower 2 times a week on Wednesdays and Saturdays on the evening shift.<br><br>The "ADL - Bathing Task," dated 7/11/17 through 8/7/17, indicated the resident had received only bed baths and had not received a shower. The form further indicated the resident had not | | *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected, therefore a house wide audit of shower sheets and resident shower documentation has been completed to ensure that all residents are receiving showers as scheduled.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory all staff in-service has been conducted to ensure that all staff are aware of the protocol for giving showers per schedule, for documentation of refusal of showers and for communication with outside agencies such as Hospice, who provide care for residents in the facility. | |

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| | refused her showers.<br><br>On 8/10/17 at 8:29 a.m., LPN 3 indicated hospice usually provided the showers for Resident 1 on Tuesdays and Thursdays. LPN 3 indicated he was not aware if the resident was receiving a shower or not.<br>2. During an observation of Resident 92 on 8/8/17 at 11:15 a.m., the resident was in bed resting. Resident 92 was wearing a hospital gown and her hair was unkempt.<br><br>During a review of Resident 92's clinical record on 8/8/17 at 1:19 p.m., the MDS (Minimum Data Set) indicated Resident 92's BIMS (Brief Interview for Mental Status) was unable to be assessed. Resident 92 medical diagnosis included, but were not limited to: dementia, abnormalities of gait and mobility, hemiplegia. Resident 92 is an extensive assist, 2 (two) persons, for bathing, mobility, transfers, dressing, and toileting.<br><br>During a review of the records on 8/8/17 at 2:42 p.m., the records indicated Resident 92 was to receive showers twice a week on Sundays and Wednesdays.<br><br>During a review of the shower task documentation for 7/10-8/8/17 on 8/9/17 at 2:44 p.m., the record did not indicate shower refusals, and indicated as follows: | | *The corrective action taken to monitor to assure compliance is that* the ADON or designee will conduct audits of 5 random resident shower documentation / shower sheets, to ensure that all residents are receiving showers as scheduled. These audits will be conducted weekly times 4 weeks, monthly times 3 months then quarterly times 3 quarters. This review will be conducted by the Administrator and/ or their designee prior to the | |

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| | 7/10/17 Monday- bed bath<br>7/12/17 Wednesday- bed bath<br>7/13/17 Thursday- bed bath<br>7/14/17 Friday- bed bath<br>7/16/17 Sunday- bed bath<br>7/18/17 Tuesday- bed bath<br>7/20/17 Thursday- bed bath<br>7/21/17 Friday- bed bath<br>7/23/17 Sunday- bed bath<br>7/26/17 Wednesday- bed bath<br>7/27/17 Thursday- bed bath<br>7/28/17 Friday- bed bath<br>7/30/17 Sunday- bed bath<br>7/31/17 Monday- bed bath<br>8/03/17 Thursday- bed bath<br>8/04/17 Friday- bed bath<br>8/05/17 Saturday- bed bath<br>8/06/17 Sunday- bed bath<br>8/07/17 Monday- bed bath<br><br>Resident 92 did not receive a bed bath or a shower on her shower days of 7/19/17, 8/2/17, or 8/8/17.<br><br>During an interview on 8/7/17 at 11:19 a.m. with Resident 92's family member, he indicated he did not believe his family member was receiving her showers twice a week.<br><br>During an interview on 8/9/17 at 2:24 p.m. with CNA 9, she indicated the resident is supposed to receive showers | | regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |

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| | twice a week on the night shift. She indicated Resident 92 usually received bed baths due to her decline in condition, but was aware that she was supposed to be receiving showers on Sundays and Wednesdays. She indicated that she or another CNA gave the resident bed baths daily, but when questioned indicated these did not always include washing the resident's hair due to her refusal. She further indicated refusals should have been documented.<br><br>The facility lacked documentation of a policy for ADL's (Activities of Daily Living)<br><br>3.1-38(3)(A) | | | |
| F 0371 SS=E Bldg. 00 | 483.60(i)(1)-(3)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and | | | |

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| | food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br><br>Based on observation, record review, and interview the facility failed to ensure stored food was dated and labeled in 1 of 2 kitchen observations and failed to perform hand hygiene in 1 of 1 dining observations. (Kitchen, Harmony Dining Room, Stocker 1 Dining Room, Resident 20, Resident 66, Resident 95, Resident 101, Resident 132, Resident 133)<br><br>Findings include:<br><br>1. During an observation on 8/7/17 at 7:30 a.m., an opened bag of noodles was on the shelf in dry storage. The bag of noodles was undated and unlabeled.<br><br>2. During an observation on 8/7/17 at 7:32 a.m., 2 (two) opened loaves of bread were on the bread cart. The bread loaves were undated and unlabeled. During a | F 0371 | F 371<br><br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* the undated, open bag of noodles and 2 loaves of bread were discarded. Staff was educated in relation to hand hygiene and use of hand sanitizer between tasks, hand washing protocols prior to meal service and proper handling of dishes during meal service | 09/06/2017 |

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| | second observation on 8/10/17 at 7:52 a.m. the open bread loaves on the bread shelf were labeled with an open date, and the open noodles in dry storage were labeled with an open date.<br><br>3. During an observation on 8/7/17 at 7:51 a.m. in the Harmony Dining Room, LPN 2 left the dining room with a drinking glass and returned with the glass filled with ice at 7:53 a.m. LPN 2 did not perform hand hygiene when reentering the Harmony Dining Room, and proceeded to serve beverages to residents.<br><br>4. During an observation on 8/7/17 at 8:02 a.m., CNA 8 served Resident 133 her meal tray. No hand hygiene was observed prior to entering the resident's room, or after exiting the resident's room.<br><br>5. During an observation on 8/7/17 at 8:03 a.m., CNA 8 served Resident 95 his meal tray. CNA adjusted Resident 95 in his bed and moved his bedside table over the bed. No hand hygiene was observed prior to entering the resident's room or after exiting the resident's room.<br><br>6. During an observation on 8/7/17 at 8:05 a.m., CNA 8 served Resident 66 his meal tray. No hand hygiene was observed prior to entering the resident's room or | | *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this practice, therefore, random audits of sanitary practices will be conducted per QA schedule and as identified by the department director or designee.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory all staff in-service was provided to ensure all staff understand the importance of proper food storage, food labeling, handling of dishes during meal service and hand hygiene. | |

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| | after exiting the resident's room.<br><br>7. During an observation on 8/7/17 at 8:07 a.m., CNA 8 served Resident 132 her meal tray. No hand hygiene was observed prior to entering the resident's room or after exiting the resident's room.<br><br>8. During an observation on 8/7/17 at 8:08 a.m., CNA 8 served Resident 20 her meal tray. CNA 8 assisted the resident with positioning in her bed. CNA 8 moved the bedside table over the bed. No hand hygiene was observed prior to entering the resident's room or after exiting the resident's room.<br><br>During an interview on 8/10/17 at 7:51 a.m. with Dietary 1 she indicated staff should wash or sanitize their hands prior to entering or exiting a resident room and between every 2 (two) trays.<br><br>During an interview on 8/10/17 at 7:55 a.m. with Dietary 2, she indicated staff should date and label bread and noodles upon opening with the open date and also the expiration date. She further indicated staff should label the bread with the expiration date on the original bread label.<br><br>9. On 8/7/17 at 8:30 a.m., CNA 3 was observed lifting the collar of her shirt and | | *The corrective action taken to monitor to assure compliance is that* the Dietary Manager or designee will review all storage areas for proper labeling and will observe for appropriate hand hygiene during meal service, weekly times 4 weeks, then monthly times 3 months, then quarterly times 3 quarters, to ensure sanitary practices are in place. This will be reviewed quarterly in Quality Assurance meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/ or their designee prior to the regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |

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| | wiping her face then proceeded to stir Resident 101 oatmeal with a spoon.<br><br>During an interview on 8/9/17 at 2:57 p.m., CNA 6 indicated you should always wash your hands after coughing, wiping face, and/or sneezing especially while preparing a tray for a resident.<br><br>10. On 8/7/17 at 8:36 a.m., CNA 10 was observed to be serving the resident's in the Stocker 1 dining room. CNA 10 was observed to be handling cups by the rims in the Stocker 1 dining room.<br><br>On 8/10/17 at 8:49 a.m., CNA 10 indicated cups should be handled by their handle or from the side. CNA 10 indicated cups should never be handled by the rims.<br><br>During a review of the current policy, " Food Receiving and Storage," provided by the Administrator on 8/10/17 at 11:25 a.m., indicated all or in part, but not limited to: Foods shall be received and stored in a manner that complies with safe food handling processes.<br><br>During a review of the current policy, " Meal Service, " revised 3/1/17, provided by the Administrator on 8/10/17 at 11:25 a.m., it indicated all or in part, but not limited to: Residents should be served | | | |

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| | their meals in accordance with dignity and acceptable standards of infection control practices. Staff should wash their hands before starting meal service and sanitize hands in between serving each resident.<br><br>An undated policy titled Procedure for Handwashing was provided by the Administrator on 8/10/17 at 2:15 p.m. This policy indicated, "When to Wash Hands (at a minimum) - After touching your hair, face, etc."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F 0441 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(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 | | | |

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| | contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident | | | |

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| | contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 3 of 7 residents. Hand hygiene was not performed with personal care and dirty linens were thrown on the floor. (Residents 43, Resident 93, Resident 67)<br><br>Findings include:<br><br>1. On 8/7/27 at 7:39 a.m., LPN 1 was observed to perform an accucheck on Resident 67. LPN 1 was observed to obtained the glucometer and supplies from a plastic bag in the medication cart, wipe the resident's finger, obtain the blood specimen and place it on the test strip. LPN 1 was observed to obtain the results, discard the test strip and place the glucometer back into the plastic bag. No hand hygiene or gloves were applied prior to obtaining the blood glucose. | F 0441 | F – 441<br><br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* LPN 1 was educated in relation to infection control practices as well as cleaning glucometer after use, glove usage and proper hand hygiene between tasks. CNA 7 was educated in relation to infection control practices as well as proper handling of soiled linens and hand washing procedures.<br><br>*The corrective action taken for the other residents* | 09/06/2017 |

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| | On 8/7/17 at 7:41 a.m., LPN 1 was observed to obtain a vial of insulin for Resident 67 from the medication cart. LPN 1 was observed to place 2 units of the insulin into a syringe, and administer the insulin into Resident 67's abdomen. No hand hygiene was performed or gloves were used during the injection.<br><br>On 8/9/16 at 8:50 a.m., RN 1 indicated hands should be washed and gloves should be applied before obtaining blood glucose or administering injections.<br><br>2. On 8/9/17 at 9:39 a.m., CNA 6 and CNA 7 were observed to take Resident 93 into the shower room. The CNA's entered the shower room and donned gloves without performing hand hygiene first. CNA 7 was observed to give the resident a shower. CNA 7 was observed to drop the used washcloths and towels onto the shower floor when she was done with them. Before CNA 7 left the shower room she was observed to wash her hands a total of 6 seconds.<br><br>On 8/10/17 at 10:08 a.m., CNA 11 indicated that when staff enter the shower room, hands are washed and gloves are donned before giving the resident a shower. | | *having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this practice, therefore random audits of infection control tasks will be conducted per QA schedule and as identified by the Department Director or designee.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* amandatory all staff in-service was conducted to educate staff of the importance of proper infection control practices with linens, cleaning of resident supplies, glove usage and hand washing procedures. | |

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| | On 8/10/17 at 11:25 a.m., the Administrator provided the current policy on handwashing/hand hygiene which indicated employees must wash their hands for at least forty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions, which included, but was not limited to, before and after direct resident care.<br>3. On 8/9/17 at 2:51 p.m., CNA 1 was observed throwing soiled linens on Resident 43's floor.<br><br>During an interview on 8/9/17 at 3:02 p.m., CNA 2 indicated you are not allowed to throw your dirty linens on the floor. CNA 2 indicated dirty linens go in a bag because they are not allowed to carry them down the hall without being in a bag.<br><br>The current policy, Infection Control, revised on 3/1/17, was provided by the Director of Nursing on 8/10/17 at 11:25 a.m. This policy indicated, Breaking the chain of infection controls, the spread of infection. To prevent the spread of infection at work: d. Practice medical asepsis - handle linen properly. The policy further indicated: staff should wear personal protective equipment as necessary to prevent exposure to splashes of blood or bodily spills or other potentially infectious materials. The | | *The corrective action taken to monitor to assure compliance is that* the Administrator or designee will review 5 random staff members to observe for appropriate infection control practices during tasks, weekly times 4 weeks, monthly times 3 months and quarterly times 3 quarters. This will be reviewed quarterly in Quality Assurance meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/ or their designee prior to the regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |

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| | policy further indicated employees should wash their hands before and after direct contact with residents and after contact with blood or body fluids.<br><br>A policy titled "Standard Precautions" revised on 3/1/17 was provided by the Administrator on 8/10/17 at 2:02 p.m. This policy indicated, "Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments."<br><br>3.1-18(b)(i)<br>3.1-18(l)<br>3.1-19(g)(1) | | | |
| F 0465<br>SS=E<br>Bldg. 00 | 483.90(i)(5)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON | | | |

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| | (i) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.<br><br>Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 7 of 29 rooms reviewed during Stage I of the survey, on 3 of 5 units observed during the survey. Ceiling tiles were stained, exposed screws and hooks, dirt and debris buildup, leaking faucet, flooring not affixed to the floor, excess cable pooling on floor, and walls and floors in disrepair. (Rooms 200, 201, 202, 216, 100, 101, and 403)<br><br>Findings include:<br><br>1. On 8/7/17 at 11:53 a.m., Room 200 was observed to have ceiling tiles in the bathroom with brown stains on them, brown stains running down the bathroom wall next to the commode, exposed commode screws, exposed metal hooks on the wall across from the commode, and dirt and debris along the edges and in the corners of the bathroom covebase. | F 0465 | F – 465<br><br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* all identified environmental issues have been resolved. Maintenance and Housekeeping Supervisors have been educated in relation to continued compliance. Items that were noted to be unlabeled in bathrooms have been removed and discarded.<br><br>*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all | 09/06/2017 |

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| | The same was observed on 8/9/17 at 10:17 a.m., as well a white stain in the shower floor.<br><br>2. On 8/7/17 at 11:14 a.m., Room 201 was observed to have dirt and debris along the edge and in the corners of the covebase in the bathroom, exposed screws on the base of the commode, a brown stain in front of the commode on the tile and along the commode caulking. An unlabeled plastic cup was on the back of the commode. The room was shared with one other resident. The same was observed on 8/9/17 at 10:25 a.m.<br><br>3. On 8/7/17 at 4:01 p.m., Room 202 was observed to have dirt and debris in the corners and along the edges of the covebase in the bathroom, exposed screws on the commode base, 4 (four) urinary catheters on the ledge in the bathroom, opened and unlabeled, 2 boxes of catheters with no name on them, and the caulking in front of the commode had a yellow-brown stain on it. The bathroom was shared with 3 (three) other residents. The same was observed on 8/9/15 at 10:22 a.m.<br><br>4. On 8/7/17 at 2:24 p.m., Room 216 was observed to have a hole in the wall next to the resident's bed. The same was observed on 8/9/17 at 10:10 a.m., as well | | residents have the potential to be affected, therefore a house wide audit has been conducted to ensure that all maintenance and housekeeping / environmental issues are in compliance with regulatory standards.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory all staff in-service was conducted to ensure that all staff understand the importance of a clean, safe and sanitary environment, maintenance work order procedures and proper labeling and proper storage of resident personal care items. | |

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| | as the caulking was cracked around the wall sink in the resident's room.<br><br>On 8/9/17 at 10:10 a.m., Housekeeper 1 indicated if they observe an issue that needs to be repaired, they notify either the Housekeeping Manager or the Maintenance person. Housekeeper 1 further indicated rooms are deep-cleaned on a rotating basis daily but the room is never totally cleaned. She indicated floors are only cleaned and waxed if the floor was scratched.<br>5. On 8/7/17 at 11:28 a.m., Room 100 was observed. The hot water faucet in the bathroom was leaking from the stem of the handle when it was turned on.<br><br>On 8/9/17 at 3:17 p.m., the Maintenance Director indicated it needed a new gasket while viewing the faucet.<br><br>6. On 8/7/17 at 2:08 p.m., Room 101 was observed. The linoleum was peeling up in the corner under the sink and was raised. Dark brown build up was observed behind the door in the corner of the baseboards.<br><br>On 8/9/17 at 2:12 p.m., the Maintenance Director indicated the area would be fixed. He further indicated they didn't have a routine maintenance schedule which address these kinds of issues. The | | *The corrective action taken to monitor to assure compliance is that* the DON or designee will review 5 random rooms weekly to ensure they are clean, safe and sanitary and that all personal care items are stored properly, weekly times 4 weeks then monthly times 3 months then quarterly times 3 quarters. This will be reviewed quarterly in Quality Assurance meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/ or their designee prior to the regularly scheduled Quality Assurance meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee. | |

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| | routine maintenance dealt with changing filters, temping water, etc. He further indicated the staff would fill out work orders and items would be fixed the same day of receiving the work order.<br><br>7. On 8/7/17 at 10:44 a.m., Room 403 was observed. The television was observed to have excess cable pooling on the floor next to the resident's wheelchair.<br><br>On 8/10/17 at 1:45 p.m., the Administrator provided the policy, Work Orders, Maintenance, dated 3/1/17. The Policy indicated, but was not limited to: Maintenance work orders shall be completed in order to establish a priority of maintenance service.<br><br>3.1-19(f) | | | |