STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 00 B. WING	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 30, 31, August 1, 2, 2018 Facility number: 000175 Provider number: 155275 AIM number: 100274440 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 5 Medicaid: 46 Other: 8 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 7, 2018.	F 0000	Preparation and/ or execution of this plan of correction in general,or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws. The facility is requesting paper compliance for all deficiencies in this POC.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview the facility failed to ensure dignity of residents during 2 of 2 dining observations and 1 of 5 residents observed for care. Staff failed to knock and wait to be acknowledged when entering resident rooms, and a resident was observed taking other residents' food and eating with her hands, and was not redirected, given her	F 0550	**F 550 Residents Rights/Dignity** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** **Administrator met with residents:**	09/01/2018

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	own meal, or given silverware, staff was observed yelling across the Main Dining Room to have another staff member to feed a resident, staff was observed leaving a door open during care, and a staff member was observed walking into a resident room while eating a cupcake. (Resident 53, Resident 36, Resident 26, Resident 15, Resident 50, Resident 29, Resident 11, Resident 28, Resident 34 Resident 22, Resident 18, Resident 23, Resident 10, Resident 25, Resident 56, Resident 39, Resident 5, Resident 24) Findings include: 1. On 7/30/18 at 8:45 a.m., CNA 5 was observed to knock on Resident 53's room door and enter the room while eating a cupcake. CNA 5 did not wait to be acknowledged before entering the resident's room. On 7/30/18 at 8:58 a.m., Resident 53 and Resident 36 indicated the staff did not wait to be acknowledged prior to entering their rooms. They further indicated some of the staff did not even knock. During an observation on 7/30/18 from 11:33 a.m. to 11:50 a.m., the following was observed on the West unit: 2. CNA 6 was observed to knock on Resident 36's door and enter the room without waiting to be acknowledged with the resident's lunch tray. 3. LPN 3 was observed to knock on Resident 26's door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 4. CNA 5 was observed to knock on Resident 15's		**53,26,36,15,50,29,11,28,34,22,18, 23,10,25,56,39,5,24 to discuss Residents Rights/Dignity and apologize for any concerns related to such.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **All residents had potential to be affected. In-Service all staff on residents right/dignity on August 22, 2018 by Social Service Director. Any staff who fail to comply with the points of the in service will be further educated and/progressively disciplined as indicated. SSD or designee will meet with each resident to determine if any other residents have had rights or dignity concerns.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **During rounds by department heads 5 X weekly X 4 weeks then 2 days weekly X 4 weeks then weekly times six months to ensure on going compliance. After that routine guarding angel rounds by Department heads will continue on going to monitor any violation of resident rights**	

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	door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 5. CNA 5 was observed to knock on Resident 50's door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 6. CNA 5 was observed to knock on Resident 29's door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 7. CNA 5 was observed to knock on Resident 11's door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 8. CNA 6 was observed to knock on Resident 28's door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 9. CNA 6 was observed to knock on Resident 34's door and enter the room without announcing or waiting to be acknowledged with the resident's lunch tray. 10. On 7/31/18 at 9:11 a.m., CNA 5 was observed to be assisting Resident 36 with a partial bath in the resident's bathroom. The bathroom door was open throughout the bathing procedure. On 8/1/18 at 2:11 p.m., CNA 5 indicated prior to entering a resident's room, you should knock, announce yourself, and wait until the resident acknowledges you to enter. 11. On 7/30/18 at 11:58 a.m., the House Keeping Supervisor was observed serve a lunch tray to		**and will coach staff on site immediately regarding residents rights.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **The results of the monitoring will be presented to the QAPI Committee at the monthly meeting. Any concerns will have been addressed. However, any patterns will be identified and if needed, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	

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	Resident 24 and call across the room to the ADON (Assistant Director of Nursing), "You want to feed her" and gestured to Resident 24. 12. On 7/30/18 at 12:12 p.m., the Activity Aide was observed carry a lunch tray to enter Resident 5's room and enter without knocking. 13. During an observation on 7/30/18 at 11:38 a.m., CNA 2 entered Resident 22's room to serve her meal tray without knocking or waiting to be acknowledged. 14. During an observation on 7/30/18 at 11:41 a.m., CNA 3 walked into Resident 18's room as she was knocking. CNA 3 did not wait to be acknowledged. 15. During an observation on 7/30/18 at 11:47 a.m., CNA 3 walked into Resident 23's room as she was knocking. CNA 3 did not wait to be acknowledged. 16. During an observation on 7/30/18 at 11:50 a.m., CNA 3 walked into Resident 10's room as she knocked. CNA 3 did not wait to be acknowledged. 17. During an observation on 7/30/18 at 11:59 a.m., Residents 25, 56, and 39 were sitting at a table together. Resident 25 received her meal first, and Resident 39 was observed to take her bowl of fruit. Resident 25 attempted to tell staff passing by, but staff ignored Resident 25. Resident 39 continued to eat the bowl of fruit with her fingers. The Activity Director served Resident 56 and noticed Resident 39 eating the fruit with her fingers. She indicated to Resident 25 she would get her a new bowl of fruit, but allowed Resident 39 to continue eating with her fingers. Resident 39 was then observed to grab Resident 56's strawberry shake. The Activity Director notified			

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	the SSD who then brought out Resident 39's meal tray. The SSD gave another strawberry shake to Resident 56, but allowed Resident 39 to continue to drink the one she had taken from Resident 56's meal tray. Resident 39 was then observed to eat her meal with her fingers. The Activity Director and SSD (Social Services Director) were not observed to redirect or offer silverware to Resident 39. During an interview with CNA 3 on 7/30/18 at 12:10 p.m., she indicated staff should knock and wait to be acknowledged before entering resident rooms. During an interview with LPN 4 on 8/2/18 at 8:30 a.m., she indicated if a resident was observed to be impatient during meal service or taking food from another resident, staff should serve that resident first and then move to the first table for future meal services. She further indicated, depending on the resident's diet, allow that resident to keep the food and get the other resident new food, or attempt to remove the food and get the resident their own tray. If a resident was observed eating with their fingers, staff should clean their hands and offer silverware. During a review of the current policy, " Conduct between Staff and Residents, " undated, and provided by the Administrator on 8/1/18 at 11:21 a.m., it indicated, " It is the policy of the facility to ensure that conduct between the staff and the residents promotes growth, development, and as much independence as possible for each individual resident while maintaining safety and comfort and security for the resident....Staff will knock on the resident's door and announce themselves; asking permission to enter...Note: If resident is unable to answer, the staff will still			

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	knock and announce themselves prior to entry." 3.1-3(t)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview the facility failed to ensure a resident, who had not been assessed for self-administration, self administered medication for 3 of 3 residents reviewed for self administration. A resident was found to have eaten topical cream that was left in the resident's private restroom, administer nasal spray, and apply hemorrhoid cream. (Resident 257, Resident 28, Resident 36) Findings include: 1. During an observation on 7/30/18 at 9:15 a.m., Resident 257 was observed pacing the Alzheimer's unit. During an observation on 7/31/18 at 2:35 p.m., Resident 257 was observed pacing the Alzheimer's unit and peering into other resident rooms. During an observation on 8/1/18 at 8:57 a.m., Resident 257 was observed sleeping in his room. During a review of Resident 257's clinical record on 7/31/18 at 9:29 a.m., it indicated Resident 257's diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, schizoaffective disorder,	F 0554	**F 554 Resident Self – Administration Meds-Clinically Appropriate** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice .** **Self- Administration tool will be conducted for Residents who wish to self-administer meds- and if they are capable of self – administration a MD order will be obtained to do so. Any Meds or biologicals that are self-administered will be kept in a safe and secure place.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **Facility wide analysis of resident will be conducted by D.O.N. or designee to determine if any other residents desire to self-administrate. If any residents**	09/01/2018

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	Wenicke's encephalopathy, alcohol induced amnesiac disorder, generalized anxiety disorder, major depressive disorder. The Admission MDS (Minimum Data Set), dated 7/20/18 indicated the resident was severely cognitively impaired. Resident 257 resides on the Alzheimer's locked unit. A review of the progress notes indicated: 7/30/18- Resident was assisted to his room around 0300 and around 0420 came out of resident's room with whitish cream around his face and on clothes. Found a tube of calmoseptine (over the counter topical cream) in the bathroom, called poison control center and was told with the two active ingredients he would be fine, should be asymptomatic but might possibly have diarrhea. Faxed Dr about this and awaiting reply. The clinical record lacked an assessment for self-administration of medications. During an interview with the Administrator on 7/31/18 at 12:07 p.m., she indicated Resident 257 does not have an assessment that allows for medications at his bedside or in his restroom. During an interview with LPN 1, on 8/1/18 at 8:43 a.m., she indicated Resident 257 is in a private room with a private restroom. She indicated Resident 257 wanders and has behaviors, and should not have medications left in his room. 2. On 7/31/18 at 8:20 a.m., LPN 5 was observed to hand Resident 28 his Flonase (nasal allergy spray) to spray in each nostril. On 8/1/18 at 2:32 p.m., the record for Resident 28 was reviewed. The orders indicated, but were not limited to, Flonase Allergy Relief Suspension 2		**are identified they will be given a self- administration evaluation and a MD order will be obtained if criteria met.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **All staff will be educated to report any residents who express desire to self-administrate medications. Those residents will be reported to the DON as having the desire to administer their own meds. Those residents will be evaluated as to the ability and regulations. The protocol for self-administration will be followed.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **QA committee will review and discuss residents whom self-administrate to assure compliance. The residents who have demonstrated the ability and desire to self-administer meds in a safe manner will be observed by the DON/Designee doing this self-administration**	

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	(two) spray in both nostrils one time a day for seasonal allergies. The orders lacked indication that the resident may self administer medications. The record lacked a self administration assessment. On 8/2/18 at 7:25 a.m., LPN 6 indicated a resident can self administer medication if they can identify the medication, the frequency of use, and administer properly. LPN 6 further indicated residents should have an assessment to know if they can self administer. On 8/2/18 at 9:09 a.m., the Administrator provided a Self Medicating Assessment for Resident 28 dated 8/1/18, and a copy of an order dated 8/2/18, indicating Resident 28 may administer Flonase nasal spray. 3. On 7/31/18 at 9:11 a.m., CNA 5 was observed to be assisting Resident 36 with a.m. care. After completing the bathing process, Resident 36 requested her "hemorrhoid" cream. CNA 5 obtained Dubicaine 1% (an anorectal agent) cream and handed the cream to the resident. The resident applied the cream to her rectal area. The clinical record for Resident 36 was reviewed on 7/31/18 at 8:21 a.m. Diagnoses included, but were not limited to, glaucoma, paroxysmal atrial fibrillation, major depressive disorder, and diabetes mellitus type 2. A quarterly MDS (Minimum Data Set) assessment, dated 6/23/18, indicated the resident had slight cognitive impairment. A physician's order, dated 5/27/18 indicated Nupercainal Ointment 1% (Dubicaine), apply to the rectal area topically every 4 (four) hours as needed for hemorrhoids.		**3 days weekly x 4 weeks, then 1 day weekly x 4 weeks, then bi-weekly x 6 months to ensure ongoing ability. After that, random monitoring will occur ongoing. Any concerns will be immediately addressed. Further, any change in the resident's condition will require a new evaluation for the ability to continue to self-administer meds safely. The results of the monitoring for medication self-administration will be submitted to the QAPI committee at the monthly meetings. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	

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	The clinical record lacked documentation of a self-administration assessment of the resident for the ointment. On 7/31/18 at 2:10 p.m., the DON (Director of Nursing) indicated the resident had not been assessed for self-administration of medications. She indicated the resident had a physician's order to keep the cream at her bedside "at one time,." but did not have that order any longer. On 8/1/18 at 8:38 a.m., the DON (Director of Nursing) provided a "Self-Medicating Monitoring Book" form, indicating the resident had been assessed for self-administration. The form was dated 7/31/18. On 8/1/18 at 11:21 a.m., the Administrator provided the current facility policy, Self - Administration of Medications By Residents, updated 6/19/2012. The Policy indicated, but was not limited to a physician order is obtained to self-administer medications... the order is recorded on the MAR (Medication Administration Record). " Self-administration medications will be encouraged if it is desired by the resident, safe for the resident and other residents of the facility, ordered by the attending physician, and approved by the interdisciplinary team...An interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment." 3.1-11(a)			
F 0604 SS=D Bldg. 00	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:			

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	§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review, and interview, the facility failed to ensure a resident was monitored while being restrained for 1 of 1 resident reviewed for restraints. (Resident 33) Findings include: On 7/30/18 at 11:06 a.m., Resident 33 was observed sitting in her broda chair in her room, slightly slid down, with spastic movements. She was observed to have a seat belt in place, resting	F 0604	**F 604 Rights to be Free from Physical Restraints** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice .** **Staff performed a full body check on resident #33 to assure no harm from residents restraint has been documented in point click care system to**	09/01/2018

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	slightly above her waist line. When asked if she could remove it, resident touched the seat belt buckle, but did not open the seat belt buckle. On 8/1/18 at 10:42 a.m., CNA 7 indicated Resident 33 wore a seat belt when up in her broda chair (specialized wheelchair). On 8/1/18 at 10:43 a.m., RN 2 indicated Resident 33 was unable to take off her seat belt and further indicated the nurses didn't document on it. On 8/1/18 at 10:52 a.m., the Administrator indicated Resident 33 was in common areas except when she was in bed and not wearing the seat belt. On 8/1/18 at 12:55 p.m., the record for Resident 33 was reviewed. Diagnoses included, but were not limited to cerebrovascular disease, major depressive disorder, generalized anxiety, unspecified psychosis, unspecified abnormal involuntary movements, pseudobulbar affect, abnormal posture, and mild cognitive impairment. An order dated 7/2/18, indicated Resident 33 may have a seat belt when up in chair. She cannot release belt on her own. To help with holding resident in chair d/t (due to) spastic movements. The care plans indicated, but were not limited to, Resident requires the use of a restraint Type self releasing belt while up in broda chair, dated 7/2/18 Check resident q (every) hour and reposition q 2 hours, dated 7/2/18. Follow MD order, dated 7/2/18. Restraint assessment and quarterly reduction as policy, dated 7/2/18. Therapy screen quarterly and prn (as		**assure staff document and appropriately the monitoring of the restraint.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **No other residents in facility currently utilize restraints. A restraint checklist has been devised to assure any resident whom utilizes a restraint will have all steps completed. Physical restraints are used as a last resort and then the least restrictive physical restraint is used for the shortest amount of time, only after assessment and receipt of a physician's order. Then, follow up and monitoring take place as dictated in the facility's policy as well as per regulation. Nursing staff were in-serviced on the physical restraint Policy and Procedure On August 22,2018 by D.O.N. or designee.** **Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.** **3. What measures will be put into place and what**	

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	needed),dated 7/2/18. A Pre Restraint Assessment, dated 7/2/18, indicated the use of a safety belt when up in chair to keep her from falling out of chair, and met the definition of a restraint. The MAR (Medication Administration Record) and TAR (Treatment Administration Record) were reviewed and lacked documentation of the restraint. On 8/1/18 at 1:11 p.m., the DON (Director of Nursing) indicated the CNA's have a task in the ADL (Activity of Daily Living) system for monitoring the restraint, but she had not put in the computer. On 8/1/18 at 11:21 a.m., the Administrator provided the current facility policy, Physical Restraints/Seclusion, undated. The Policy indicated, but was not limited to, all physical restraints are to [sic] released and the resident is to be repositioned at least every 2 hours. 3.1-26(h)		**systemic changes will be made to ensure that the deficient Practice does not recur:** **Restraint checklist will be utilized to assure all steps are taken.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **If in the future any residents are assessed and receive an order for a physical restraint, they will be reviewed monthly at QAPI meeting for appropriateness of the restraint as being the least restrictive, and being followed up on and monitored as per policy and regulation.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to implement a care plan	F 0656	**F 656 Development/Implement Comprehensive Care Plan** **1. What Corrective actions**	09/01/2018

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	for 1 of 1 resident reviewed for skin assessment and 1 of 6 residents reviewed for unnecessary medications receive weekly skin assessments. A resident with a skin tear to his right arm and abrasions on his knee and a resident with bruising had no skin assessments completed. (Resident 48, Resident 36) Findings include: 1. On 7/30/18 at 9:28 a.m., Resident 48 was observed sitting in his room on his electric scooter. Resident 48 had a red stain on his shorts, a band-aid to his right forearm, and band-aids on his right knee area. The resident indicated he would "bump" his arms and leg when going through the doors at the facility. Resident 48 indicated he had the areas on his right forearm and knee for several days. He indicated the areas would "open" each time he "bumped" into something. He indicated he had bumped the areas earlier that morning and the areas had "opened up" again. The clinical record for Resident 48 was reviewed on 8/1/18 at 9:28 a.m. Diagnoses included, but were not limited to, right hemiplegia, dementia without behavioral disturbance, hypertension, and cerebral infarction. A quarterly MDS (Minimum Data Set) assessment, dated 7/24/18, indicated the resident had slight cognitive impairment. A care plan, dated 6/26/18, indicated the resident had a skin tear to his right arm. Interventions included, but were not limited to, investigate the cause of the skin tear, take necessary precautions to prevent new areas, investigate cause of skin tear, and treatment as ordered.		**will be accomplished for those residents found to have been affected by the deficient practice .** **Residents #48 , #36 have had their Care Plan reviewed and update to reflect any skin issues.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **A facility wide Skin Sweep was performed to ensure that any skin issues were accurately assessed, documented and care planned. All nurses were in-serviced on August 22,2018 by D.O.N. or designee as to the S.W.A.T. Program to include education on Skin Assessments and how to care plan any skin issues. Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **DON/Designee will monitor 10 charts weekly x 4 weeks on a rotating basis to ensure that**	

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	The "Weekly Skin Assessment" form, dated 7/26/18 at 11:27 p.m., indicated the resident had no skin issues. A "Weekly Skin Assessment" form, dated 7/19/18 at 11:38 p.m., indicated the resident had no skin issues and no new areas were noted. The assessment indicated the resident had current treatment orders in place. No further skin assessments were noted. The clinical record lacked documentation of any new skin issues for the resident. On 8/1/18 at 11:05 a.m., the DON (Director of Nursing) indicated the areas should have been documented on the "Weekly Skin Assessment" form. She indicated the assessment form should not be filled out just on a weekly basis, but should be filled out each time a resident has any issue with their skin. 2. On 7/30/18 at 8:39 a.m., Resident 36 indicated she received a blood thinner and had numerous bruises on her lower extremities. On 7/31/18 at 1:34 p.m., Resident 36 was observed to be sitting on the commode in her bathroom. Resident 36 was observed to have numerous discolored areas on her bilateral lower extremities and a discolored area on her right lower quadrant of her abdomen. Resident 36 indicated she bruised easily and no one at the facility was responsible for the bruising. The clinical record for Resident 36 was reviewed on 7/31/18 at 8:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus type 2, paroxysmal atrial fibrillation, glaucoma, and major		**skin assessments are completed and care planned appropriately. After that, 5 charts weekly x 4 weeks and after that 3 charts weekly for a period of not less than 6 months to ensure ongoing compliance.** **After that, random monitoring will occur ongoing. Any concerns will be addressed as discovered.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **The results of the monitoring will be submitted to the QAPI Committee at the monthly meetings. Any concerns will have been addressed. However, any patterns will be identified and any needed Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolved.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	

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	depressive disorder. A quarterly MDS (Minimum Data Set) assessment, dated 6/23/18, indicated the resident had slight cognitive impairment. An anticoagulant use care plan, dated 6/28/18, included, but were not limited to, observe for reactions such as bruising easily, weekly and prn (as needed) skin assessment, and notify the physician and family prn. The "Weekly Skin Assessment" form, dated 7/30/18 at 11:58 p.m., indicated the resident had no skin issues. On 7/31/18 at 1:37 p.m., LPN 3 indicated the person who completed the skin assessment on 7/30/18 at 11:58 p.m., must not have completed a thorough skin assessment. On 8/1/18 at 11:05 a.m. the DON (Director of Nursing) indicated the areas should have been documented on a "Weekly Skin Assessment" form. She indicated she would need to re-educate the staff regarding the skin assessment for wounds. The current facility policy, "Skin Observation/Assessment," dated 2017, and obtained from the Administrator on 8/2/18 at 9:35 a.m., indicated nurses would do skin assessments at least weekly or as indicated. The policy further indicated the nurse in charge would follow up with a documented skin assessment to address the caregiver's skin finding. 3.1-35(b)(1)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans			

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	The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation and record review, the facility failed to ensure medications were administered as ordered for 1 of 1 residents observed. An eye drop ordered for HS (hour of sleep) was given before evening meal. (Resident 36) Findings include: On 7/31/18 at 5:06 p.m., RN 2 provided the pharmacy label of medication that was going to be administered. The label indicated latanoprost 0.005% 1 drop both eyes at HS (hours of sleep) glaucoma. RN 2 was observed to administer latanoprost (eye drop to treat glaucoma) 1 drop in each eye for Resident 36. On 8/1/18 at 9:40 a.m., the record for Resident 36 was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic obstructive pulmonary disease and glaucoma. Orders included latanoprost 0.005% (percent) instill 1 (one) drop in both eyes at bedtime for glaucoma. On 8/1/18 at 12:40 p.m., the Administrator provided the current facility policy, Medication Administration Procedure, last updated 2/11/13. The Policy indicated, remove the medication from the drawer and read the label carefully. 3.1-35(g)(2)	F 0659	**F 659 Qualified Persons** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice .** **Resident #36 currently and going forward receives eye drop medication at bedtime as per the order.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **Residents with an order for eye drops to be administered at bedtime have the potential to be affected by this finding.** **All orders for eye drops were reviewed to ensure that they were listed on the MAR to be given at the ordered time. Any concerns would have been corrected.** **The nursing staff who administer eye drops were in-serviced on August 22,2018 by D.O.N or designee as to the policy on Med Administration with emphasis on eye drop administration in regards to timeliness as well as**	09/01/2018

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			technique. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur: DON/Designee will monitor eye drop medication administration for 3 residents 3 days weekly x 4 weeks for timeliness and proper technique. After that, monitoring will be 3 residents 1 day weekly x 4 weeks. After that, at least one resident weekly will be observed related receiving their eye drops for a period of not less than 6 months to ensure on going compliance. After that, random monitoring will occur ongoing. Any concerns will be corrected as discovered.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **The results of the monitoring will be submitted to the QAPI Committee at the monthly meetings. Any concerns will have been addressed. However, any patterns will be identified. An Action Plan will**	

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			be written as indicated. Any Action Plan will be monitored by the Administrator weekly until resolution. **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to accurately assess a resident for weight loss for 1 of 1 residents	F 0692	**F 692 Nutrition/Hydration Status/Maintenance** **1. What Corrective actions will be accomplished for those**	09/01/2018

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	reviewed for nutrition. A resident's quarterly nutrition assessment failed to utilize the most current weight, a significant weight loss was not identified, and interventions were not put in place to prevent further weight loss. (Resident 51) Findings include: During an observation of Resident 51 on 7/30/18 at 8:45 a.m., she was observed sitting in activities in the dining room. During a review of the clinical record of Resident 51 on 7/31/18 at 10:16 a.m., it indicated diagnoses of, but not limited to: dementia with behavioral disturbance. The Annual MDS (Minimum Data Set), dated 7/11/18 indicated Resident 51 was severely cognitively impaired. It further indicated the resident was not on a prescribed weight loss plan and had a significant weight loss of at least 5% in a month. The clinical record indicated the following weights: 5/4/18 136.3 lbs 6/4/18 126.8 lbs 7/10/18 127.5 lbs A significant weight loss was flagged as -9.4 lbs and a loss of 6.9% from 5/4/18-6/4/18. Resident 51's care plan indicated: Resident is at risk for weight loss related to dementia. A review of the progress notes, dated 6/18/18, indicated, [Name of Attending Physician] was in facility to see resident. New order to start Remeron (appetite stimulant) 7.5 mg (milligrams) daily for appetite.		**residents found to have been affected by the deficient practice .** **Resident #51 had their most current weight reported to the Dietitian and recommendations were made and carried out.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **Residents who reside in the facility have the potential to be affected by this finding.** **All weights were reviewed to be sure that the most recent and accurate weights were reported to the Dietitian. Any recommendations were made and carried out.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **DON/Designee will monitor weights as being timely and accurate and that those weights will be the ones submitted to the Dietitian on their visit. The DON/Designee will monitor weight weekly for accuracy and timeliness as part**	

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	During a review of the physician orders, they indicated a new order for Remeron 7.5 mg for appetite on 6/18/18. During a review of Nutritional Risk Quarterly Review, dated 6/6/18, it indicated a height of 60, weight of 126.8. It further indicated no weight change. Resident is on a regular, mechanical soft diet. It further indicated no current labs were available. It indicated Resident 51's intake was 76-100% of estimated needs. A review of the last 90 days of intake indicated: 25-75% intake of all meals Bedtime snack intake 76-100% During an interview with the Dietician on 7/31/18 at 1:52 p.m., she indicated she did not use the most current weight from 6/4/18 when she did the resident's quarterly review, she used the May weight that was stable. Resident 51 was due for an annual review on 7/11/18, but she was just working on that now. She indicated she was going to request a multivitamin be added along with the Remeron. She had not added bedtime snacks or shakes at this time, but may in the future if the Remeron was not successful. The resident did not have current labs, and did not have them during her quarterly review either. She could request them, but did not intend to do so because they would be done by the physician periodically. During an interview with the DON (Director of Nursing) she indicated the dietician should have used the most current weight when performing the quarterly nutrition review. She indicated the dietician has full access to the clinical chart and the 6/4/18 weight was in the chart when the 6/6/18 assessment was completed.		**of the morning CQI (Clinical) meetings. This will be an ongoing part of the meeting agenda. Weights will also be reviewed at the weekly SWAT meetings going forward.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **The results of the weekly monitoring of weights will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified and any needed Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	

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	During a review of the current policy, " SWAT Program (Skin and Weight Assessment Team), on 8/2/18 at 10:15 a.m., it indicated, " It is the policy of this facility to assess the nutritional status of each resident. SWAT is designed to aggressively review and address those residents exhibiting significant weight change or skin breakdown. These residents will be monitored through this team effort on a weekly basis, involving all applicable disciplines to best cater to the improvement of the resident's nutritional status....This team will appropriately determine clinical and dietary intervention to best address each resident's needs. Any dietary interventions and/or issues in need of review by the Dietician will be listed on the Dietician referral form and addressed at the routine visit...Indicators determining implementation of SWAT monitoring: 5% or more weight change (undesirable) in 30 days...SWAT will meet weekly to discuss residents in need of addressing current health problems to determine appropriate intervention...SWAT will follow protocols...addressing significant weight changes." 3.1-46(g)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to assess for respiratory status during respiratory care for 1 of 1 residents reviewed for respiratory care. (Resident 10) Findings include: On 7/31/18 at 7:56 a.m., LPN 6 was observed to administer budesonide suspension (medication to treat breathing problems) 1 mg (milligram) / 2 ml (milliliter) 1 vial for inhalation per nebulizer. LPN 6 emptied the vial of medication into the medication cup of the nebulizer, attached the inhalation pipe, handed it to Resident 10, turned on the nebulizer, and told Resident 10 she would come back to listen to her. LPN 6 returned to the medication cart parked at the doorway facing Resident 10, performed hand hygiene, and obtained additional oral medications for Resident 10 from the medication cart. LPN 6 then indicated she needed to get a pulse oximeter (devise to measure oxygen levels) and proceeded to the secure unit. LPN 6 returned to Resident 10's room, turned off the nebulizer, obtained an oxygen level of 85%, pulse rate 90, and felt Resident 10's chest for respirations. LPN 6 educated Resident 10 on wearing her oxygen when she goes to the bathroom and Resident 10 indicated she didn't want to. On 8/1/18 at 2:04 p.m., the record for Resident 10 was reviewed. Diagnoses included, but were not limited to heart failure, and chronic obstructive pulmonary disease. The orders indicated, but were not limited to budesonide suspension 1 mg (milligram) / 2 ml (milliliter) 1 vial inhale orally two	F 0695	**F 695 Respiraton/Tracheostomy Care & Suctioning** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice .** **Resident #10 has their lungs assessed before and after their breathing treatment as per policy.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **The facility did an audit to compile a targeted list of resident who receive respiratory treatments. The DON/Designee will monitor 5 treatments a week x 4 weeks to see that lung sounds are taken before and after the treatment and are documented. Then, the monitoring will be done for 3 treatments week x 4 weeks. Afterwards, at least 1 treatment a week will be monitored for not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Any concerns will be corrected as discovered.**	09/01/2018

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	times a day for copd [sic]. On 8/1/18 at 4:48 p.m., the Administrator provided the current facility policy, Administering Nebulizer Therapy, undated. The Policy indicated, but was not limited to, the nurse will obtain pre-treatment lung sounds, pre-treatment pulse rate and pre-treatment respiration rate... the nurse will obtain post- treatment lung sounds.... and the licensed nurse is required to remain with the resident during the nebulization / treatment. On 8/2/18 at 7:26 a.m., LPN 6 indicated she was to stay with the resident when administering a respiratory treatment, set the up medication, obtain a oxygen level, listen to lung sounds before and after the treatment. 3.1-47(a)(6)		**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **At an in-service held August 22,2018 by D.O.N. or designee for nursing staff who administer breathing treatments, the policy for respiratory breathing treatments was reviewed. Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **At the monthly QAPI meetings, the results of the monitoring of respiratory treatments being done by the DON/Designee will be submitted. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolution.** **5. By what Date the systemic changes for each**	

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			deficiency will be completed. **Doc. 9/1/18**	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or			

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	damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to ensure dental services were provided for 1 of 2 residents reviewed for dental services. An edentulous resident had not had a dental consult. (Resident 4) Findings include: On 7/30/18 at 10:50 a.m., Resident 4 was observed with no teeth in his mouth. Resident 4 indicated he would like to see a dentist for possible dentures. Resident 4 indicated he had dentures in the past the dentures no longer fit. The clinical record for Resident 4 was reviewed on 8/1/19 at 11:06 a.m. Diagnoses included, but were not limited to anemia, chronic obstructive pulmonary disease, and hypertension. An annual MDS (Minimum Data Set) assessment indicate the resident had no natural teeth or tooth fragments. A care plan, start date 7/25/18, included, but were not limited to, dental services as needed. On 8/1/18 at 9:36 a.m., SSD (Social Service Director) indicated the facility dentist had not made a routine visit since December 4, 2017. She indicated the dental service would see a resident	F 0791	**F 791 Routine/Emergency Dental Services in NFS CFS** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice .** **Resident # 4 will be seen by Dentist on August 21, 2018** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **Interview able residents were interviewed as to any dental concerns. Any stated were addressed. Non-interview able residents were assessed by DON/Designee for any broken teeth or irritation of their gums. Any concerns will be addressed. Further, at the time that MDSs are done, dental issues will be assessed. Or, upon a resident or a resident's family indicating the possibility of a dental concern, this will be**	09/01/2018

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	for an emergency but the dental service had not scheduled a return visit. She indicated the resident had indicated in May, 2018, that he wanted the dental services. She indicated the resident had not been seen by a dentist. The SSD indicated she had tried to contact the service provider but they had not returned her calls and therefore she did not know when the provider would be coming to the facility. The current facility policy, "Dental Services," undated and obtained from the Administrator on 8/1/18 at 9:35 a.m., indicated the facility would meet any needs for dental/denture care to each resident which included routine as well as emergency indicated services for the residents. The policy indicated the SSD would work with the resident, family, physician, and the dental provider to coordinate timely care, which could include arranging transportation and staff accompaniment as needed. 3.1-24(a)(2)		**addressed. Any concerns will be addressed.** **At the daily CQI (Clinical) meetings, as the 24 Hour Reports are reviewed, any concerns with dental issues will be addressed. This will be an ongoing part of the CQI agenda.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **On August 22, 2018, the nursing staff were in-serviced by Social Service Director on the Dental policy and how to address any complaints or any signs/symptoms to suggest dental concerns. Any staff who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.** **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **The monitoring of the weights weekly at the S.W.A.T. meetings will be submitted to the QAPI committee at the**	

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			monthly meetings. Any concerns will have been addressed. **However, any patterns will be identified. If needed, an Action Plan will be written by the committee.** **Any Action Plan will be monitored weekly by the Administrator until resolution.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a sanitary manner for 2 of 2 kitchen observations and 2 of 2 dining observations. The kitchen had unlabeled and undated food and drinks stored, hand hygiene was not performed, hair nets did not cover earrings, and jewelry was not covered. The staff was observed to handle plates and bowls with their bare hands. The nourishment refrigerators were soiled, had unlabeled and undated foods, and had employee items in them. The nourishment freezers lacked thermometers, had unlabeled and undated food in them, were soiled, and had ice build-up in them. During a dining observation, staff had their thumb in plates while serving, held glasses by the rims, and performed other tasks between serving residents without hand hygiene. (Kitchen, Main Dining Room, Dietary Manager, Cook 1, West Unit, Locked Dementia Unit, East Unit, Resident 22, Resident 18, Resident 23, Resident 10) Findings include: On 7/30/18 from 8:04 a.m. through 8:20 a.m., the following was observed in the kitchen: 1. The free-standing refrigerator was observed to have 2 containers of Kool Aid unlabeled in it. 2. The dry storage area had a bin of rice with no label or date on it and a box of fettuccini noodle was open, unlabeled, and undated.	F 0812	**F 812 Food Procument Store/Prepare/Serve/Sanitary** **1. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice .** **All issues cited in the survey were immediately addressed and corrected.** ***Kool-Aid labeled & dated *Dry storage rice labeled & dated * Fettuccini noodle thrown away * Hamburger buns thrown away * Bowls of cereal labeled & dated * All Staff in-serviced on proper techniques to handle residents meal & untensils. * All staff in-serviced on proper uniform policy. * Dietary Staff in-serviced on proper procedures for pureeing. * Dietary Staff in-serviced on proper handwashing. * Dietary Staff in- serviced on proper procedures for food tempatures & methodology for doing so. * Dietary staff in serviced on proper method of handling residents serving ware. * Nourishment refrigerators – have been defrosted cleaned out & themometers are present.** **2. How other residents having the potential to be**	09/01/2018

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	3. A package of hamburger buns were observed in the walk-in refrigerator opened and undated. On 7/30/18 at 8:23 a.m., the Dietary Manager indicated foods and drinks should be labeled and dated when the items were made or opened. During a dining observation on 7/30/18 between 11:33 a.m. and 12:04 p.m., the following were observed: 4. LPN 4 was observed to be feeding Resident 45 her lunch. LPN 4 was observed to handle the resident's cups by the rims. 5. Activity Aide was observed to handle a bowl of dessert for Resident 33 by the rim and Resident 8's drink cup by the rim. 6. CNA 3 was observed to move a chair between Resident 8 and Resident 7. CNA 3 was observed to begin feeding Resident 8. CNA 3 was observe to place the resident's paper napkin under the resident's chin. CNA 3 was observed to feed Resident 7 her salad, at one point dropping a piece of lettuce on the resident's blouse. CNA 3 removed the piece of lettuce and placed Resident 7's paper napkin under her neck. CNA 3 got out of her chair, knocked on the kitchen door, obtained a fork and knife, returned her chair, cut up Resident 8's food, and began feeding both of the residents. No hand hygiene was observed. 7. On 7/31/18 at 8:04 a.m., three trays with bowls of cereal were observed to be in the kitchen. The bowls had lids on them with no labels or dates. 8. The Dietary Manager had a necklace hanging on the front of her shirt.		**affected by the same deficient practice will be identified and what corrective actions will be taken:** **An in-service was given for the Dietary Staff August 22nd 2018 by Dietary Manager, at which time the following was reviewed:** **a) Storage/Labeling/Dating food and drinks in the dietary department** **b) Hand Hygiene in the Dietary Department** **c) Hair nets/Beard Covers/ Jewelry in the Dietary Department** **d) Handling of bowls/plates/utensils etc., in the Dietary Department** **e) Nourishment refrigerators—cleanliness/what can be stored in these refrigerators** **f) Thermometers in Nourishment Refrigerators/Freezers—require d temps** **g) Proper policy and procedure on pureed foods** **h) Acceptable food temps prior to serving and at time of serving** **An in-service will be held for all staff August 22, 2018 by D.O.N /designee, at which time Hand Hygiene**	

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	9. On 7/31/18 at 10:15 a.m., Cook 1 was observed to have small hoop earrings exposed from under her cap, a plastic bracelet on her right arm, and a necklace hanging in front of her shirt. 10. On 7/31/18 at 10:25 a.m., Cook 1 was observed to puree green beans for the lunch meal. After pureeing the green beans, Cook 1 was observed to wash and rinse the processor bowl, processor blade, and utensils in the 3-compartment sink. Cook 1 was observed to obtain macaroni and cheese to puree, using the same equipment. After pureeing the macaroni and cheese, Cook 1 washed the processor bowl, processor blade, and the utensils in the 3-compartment sink. Cook 1 was observed to obtain black-eyed peas to puree, using the same equipment. After pureeing the black-eyed peas, Cook 1 washed the processor bowl, processor blade, and utensils in the 3-compartment sink. Cook 1 was observed to apply oven mitts, remove a pan of fried chicken from the oven, remove the oven mitts, temp the chicken, reapply the oven mitts, and place the pan of fried chicken back into the oven. Cook 1 was then observed to obtain and puree the cooked chicken. No hand hygiene was observed before, during, or after the process. On 7/31/18 at 11:12 a.m. through 12:10 p.m. the following was observed: 11. Cook 1 was observed to scoop the macaroni and cheese into a pan and place the pan onto the steam table. Cook 1 was observed to apply oven mitts, remove several pans from the oven and place the pans onto the steam table. Cook 1 was observed to remove the oven mitts and vented the foil on the tops of the pans with her bare fingers. No hand hygiene was observed.		**was reviewed with emphasis on Hand Hygiene during tray service.** **Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **The Dietary Manager will monitor the afore mention concerns 3 days weekly x 4 weeks, then 2 days weekly x 4 weeks, then at least weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed as discovered.** **The DON/Designee will monitor meal service for Infection Control concerns 5 meals weekly at various meal times. After that, 3 meals a week x 4 weeks. After that, at least one meal weekly for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be addressed as discovered.**	

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	12. Cook 1 was observed to obtain lids for small bowls, 3 loaves of bread, a pen, alcohol wipes and a log book. Cook 1 was observed to obtain the food temperatures. No hand hygiene was observed prior to obtaining the food temperatures. 13. While obtaining the food temperatures, the gravy was not initially temped. The gravy was lumpy in appearance. Upon query, Cook 1 indicated she had forgot to obtain the temperature of the gravy. 14. While dishing the food for the lunch meal, Cook 1 was observed to handle the plates and bowls with her bare hands, placing her hands inside the plates and bowls. 15. During the lunch meal service, Cook 1 was observed to have a pair of tongs in the bin with the butter packets. Cook 1 was observed to obtain a piece of bread using the tongs, place the tongs into the butter bin, and obtain a packet of butter from the bin with her bare hands. During an observation of the nourishment refrigerators on 8/1/18 from 8:40 a.m. to 9:11 a.m., the following was observed: 16. The west unit freezer had no thermometer in the freezer and had ice build-up in it. A bottle of water was observed in the freezer. LPN 3 indicated the freezer was to be defrosted weekly by the night shift. LPN 3 indicated the freezer had not been defrosted for "quite some time." 17. The locked dementia unit freezer did not have a thermometer. The freezer had a package of a sausage biscuit, an ice cream sundae with no label on it, and an unlabeled, undated 1/2 (one-half)		**4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **At the monthly QAPI meetings, the results of the monitoring by the Dietary Manager as well as the DON/Designee will be submitted. Any concerns will have been addressed. However, any patterns will** be identified. If needed, an Action **Plan will be written by the committee. Any Action plan will be monitored weekly by the Administrator until resolution.**	

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	bottle of flavored water in it. The freezer was soiled with dirt and crumbs. The locking strap was broke on the outside of the freezer. 18. The locked dementia unit refrigerator had an opened jar of dill pickles, an opened jar of mayonnaise, a opened jar of pickled quail eggs, an opened jar of taco sauce, an opened jar of sweet pickle relish, a baggie with shredded lettuce, a baggie with 2 small chunks of cheese, an open can of 2 Cal (a supplement) with a clear plastic cup over the top of the can, and an opened bottle of a yogurt smoothie in it. The items were not labeled with a resident's name or dated. Employee foods were also present in the nourishment refrigerator. The refrigerator was soiled with dirt and crumbs. The refrigerator drawers contained individual packets of mustard, mayonnaise, and ketchup with no expiration dates on them. LPN 1 indicated the employees usually kept their food in the refrigerator as they often took their breaks on the unit. She indicated the employees probably should not place their food in the refrigerator. LPN 1 indicated the refrigerator and freezer needed to be cleaned. LPN 1 indicated the refrigerator would be cleaned immediately. 19. The east unit freezer did not have a thermometer in it. The facility lacked documentation of the refrigerator and freezer temperatures for the month of July, 2018. On 8/1/8 at 9:07 a.m., Cook 1 indicated hands should be washed when going from one task to another and gloves should be used when serving any food. She indicated hands should be washed after removing the gloves. Cook 1 further			

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	indicated dishes should never be handled with bare hands, plates should be handled from the bottom, and cups should be handled by the edges. On 8/1/18 at 9:11 a.m., the Dietary Manager indicated the kitchen staff should not be wearing necklaces or bracelets, and earrings "bigger than a dime" should be covered. On 8/1/18 at 11:40 a.m., the DON (Director of Nursing) indicated she did not know where the thermometers might have went but she had never had a thermometer in the freezer part of the refrigerators. 20. During an observation on 7/30/18 at 11:38 a.m., CNA 2 knocked and entered Resident 22's room to serve her meal tray. No hand hygiene was observed prior to entering or after exiting Resident 22's room. 21. During an observation on 7/30/18 at 11:41 a.m., CNA 3 entered Resident 18's room to serve her meal tray. No hand hygiene was observed prior to entering or after exiting Resident 18's room. 22. During an observation on 7/30/18 at 11:47 a.m., CNA 3 entered Resident 23's room to serve her meal tray. No hand hygiene was observed prior to entering or after exiting Resident 23's room. CNA 3 was observed to touch the food cart, obtain tartar sauce out of a basket, and then reenter Resident 23's room. Again, no hand hygiene was observed. 23. During an observation on 7/30/18 at 11:50 a.m., CNA 3 entered Resident 10's room to serve her meal tray. CNA 3 placed the meal tray on the bedside table, assisted the resident in moving her recliner away from the wall, grabbed a Sprite can from a box on the floor, and poured it into a glass			

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	155275	A. BUILDING 00 B. WING	08/02/2018

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	of ice. CNA 3 then placed the meal tray into Resident 10's lap and removed the lid, as requested. CNA 3 handed silverware to Resident 10. No hand hygiene was observed prior to entering or after exiting Resident 10's room. During an interview with LPN 4 on 8/2/18 at 8:24 a.m., she indicated staff should wash their hands prior to serving trays, after touching the resident or their environment, if their hands are soiled, and before serving the next resident. The facility lacked a written policy regarding hand hygiene with dining. The current facility policy, "Labeling and Dating of Foods," dated 2017, and obtained from the Dietary Manager on 8/1/18 at 9:35 a.m., indicated all foods stored would be properly labeled and dated. The policy indicated once opened, the food would be dated with the dated the item was opened. The current facility policy, "Glove and Handwashing Procedures," dated 2017, and obtained from the Dietary Manager on 8/1/18 at 9:35 a.m., indicated all employees would wash their hands between all tasks and should occur at a minimum of every hour. The policy indicated gloves were to be used whenever direct food contact was required. The current facility policy, "Code of Dress and Personal Appearance," dated 2017, and obtained from the Dietary Manager on 8/1/18 at 9:35 a.m., indicated only a simple wedding band was permitted. The policy indicated personal items should be kept out of the food preparation or service areas.			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;			

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	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to follow their current infection control policy for glucometer (device use to measure blood sugar) decontamination for 1 of	F 0880	**F 880 Infection Prevention & Control** **1. What Corrective actions will be accomplished for those residents found to have been**	09/01/2018

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	1 observations of glucometer use, with potential to affect 3 residents on that hallway. (Resident 8) Findings include: On 7/31/18 at 11:41 a.m., LPN 4 sanitized her hands, applied gloves, and obtained a Sani wipe (disinfecting wipe). LPN 4 proceeded to wipe the front surface of the glucometer across and down in a back and forth motion, turned the glucometer over repeated the procedure. LPN 4 then wrapped the glucometer in a tissue and laid it on the surface of the medication cart "to dry for 2 minutes". On 8/1/18 at 11:21 a.m., the Administrator provided the current facility policy, Cleaning/ Disinfecting/ Maintaining Glucose Meters, revised date 5/4/16. The Policy indicated, but was not limited to, wipe the entire surface of the meter 3 (three) times horizontally and 3 (three) times vertically to remove blood borne pathogens. The meter must be maintained wet for 2 (two) minutes with the Super Sani cloth wipe. During an interview with 8/2/18 at 1:15 p.m., LPN 4 indicated staff should remove the glucometer from the medication cart, don gloves, and wipe the glucometer with a Sani-Wipe, up and down and then back and forth sideways on the front and back for approximately 2 (two) minutes. Staff should then let the glucometer sit wet for 2 minutes. She indicated this was to be done before each resident and after the last resident. After the last resident it was to be wrapped in a clean paper towel after the cleaning and placed into the medication cart. 3.1-18(b) 3.1-18(l)		**affected by the deficient practice .** **Resident #8 has their glucometer cleaned per Policy and Procedure using Infection Control protocols.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **Residents who have their blood sugar level tested per use of a glucometer have the potential to be affected by this finding. Nursing staff who do blood sugar testing were in-serviced on August 22, 2018 by D.O.N. or designee, on the Policy and Procedure on Glucometer Cleaning. Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.** **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice does not recur:** **The DON/Designee will monitor glucometer cleaning on various shifts 10 times weekly x 4 weeks, then 5 x weekly x 4 weeks then at least once**	

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			weekly for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be addressed as discovered. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **At the monthly QAPI meeting, the results of the monitoring by the DON/Designee will be reviewed. Any concerns will be addressed as discovered. Any patterns will be identified. If needed, an Action Plan will be written. Any written Action Plan will be monitored weekly by the Administrator until resolved.** **5. By what Date the systemic changes for each deficiency will be completed.** **Doc. 9/1/18**	