STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00201162. Complaint IN00201162 - Substantiated. Federal/state deficiencies related to the allegations are cited at F312. Survey dates: June 6, 7, 8, 9, & 10, 2016 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 11 Medicaid: 54 Other: 18 Total: 83 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 6/14/16.	F 0000		

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

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F 0156 SS=E Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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			

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	charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.			

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	The facility must prominently 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. Based on record review and interview, the facility failed to ensure a resident's Power of Attorney (POA) was informed of a list of Medicaid services the resident would and would not be charged for, for 1 of 3 residents reviewed for personal funds. The facility also failed to ensure the residents were informed on how to contact the Ombudsman and the location of the most recent survey results. (Resident #B) Findings include: 1. Interview with Resident #B's POA on 6/7/16 at 10:04 a.m., indicated she was not aware and did not remember ever receiving a list of Medicaid services her Grandmother would or would not be charged for. The admission folder for Resident #B was reviewed on 6/10/16 at 4:25 p.m. The resident's original POA signed the admission agreement indicating what the resident would and would not be charged for on 2/6/07. The resident's POA at that time was her daughter.	F 0156	**F156** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The POA for resident B was provided with a copy of Medicaid	07/10/2016

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	A letter dated 5/15/07, indicated the resident became a Medicaid recipient. The record for Resident #B was reviewed on 6/10/16 at 4:30 p.m. The resident's current POA was not the same POA as indicated on 2/6/07. Interview with the Admissions Director on 6/10/16 at 4:36 p.m., indicated the resident had a different POA than when first admitted to the facility. She further indicated the resident's POA changed on 2/10/11 after the original POA had passed away. The Admissions Director was unaware the admission information regarding the charges with Medicaid needed to be given to the new POA. 2. On 6/10/16 at 10:00 a.m., interview with the Resident Council President indicated the residents were not informed as to where the Ombudsman's contact information was posted, nor were they informed of the location of the results of the State Surveys. Review of the past 6 months Resident Council minutes indicated no documentation indicating the residents were offered information regarding where the Ombudsman's contact information was posted, nor did the minutes include documentation regarding where the		covered charges. The resident Council has been notified of how to contact the Ombudsman and where the current Survey Binder is located. **2) How the facility identified other residents:** All residents have the potential of being affected by these alleged deficient practices. **3) Measures put into place/ System changes:** A mailing was sent to residents with BIMS greater than 13, resident POA's, guardians and responsible parties, with information including Indiana Medicaid covered charges while in a skilled facility, the name of our local Ombudsman, what services he provides and how to contact him and where to find the current Survey results binder in this community. The business office and Social Services will create mailing lists for responsible parties for mailing and hand deliver this information to residents with BIMS at 13 or greater and log the resident's signatures upon receiving. The log will be reviewed by Administrator/designee for 100% completion each month.	

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	results to the State Surveys were located. Interview with the Activity Director on 6/10/16 at 2:57 p.m., indicated she had not informed the residents of the above during the Resident Council meetings. 3.1-4(f)(1)(A) 3.1-4(f)(1)(B) 3.1-3(b)(1) 3.1-3(b)(2)		Information of covered Medicaid charges, how to contact our local Ombudsman and location of the Survey results Binder will be included in the Admission process to inform new admissions. Social Services will provide this same information to any new or changed resident responsible party. Social Services will maintain a log of residents who have a new or change in responsible parties with date of information presented and method of delivery. This log will be presented to the Administrator/designee for review monthly. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	
F 0159 SS=D Bldg. 00	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the			

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	resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other			

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	nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on record review and interview, the facility failed to ensure the residents received a statement of their personal funds at least quarterly and failed to ensure residents were able to access funds for the desired amount of money for 2 of 3 residents reviewed for personal funds. (Residents #11 and #63) Findings include: 1. Interview with Resident #63 on 6/7/16 at 1:22 p.m., indicated she had not received a quarterly statement of her personal funds account. The resident's personal funds account was reviewed on 6/10/16 at 3:00 p.m. Interview with the Business Office Manager on 6/10/16 at 3:04 p.m., indicated she had been sending the quarterly statements to the resident's family and had not personally given the statement to the resident. She indicated last statement was sent out on 4/15/16. 2. Interview with Resident #63 on 6/7/16 at 10:59 a.m., indicted she had asked for $30.00 and was told by facility staff that they could only give her $20.00. She	F 0159	**F159** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #63 was provided with a copy of the 4/15/2016 statement. Resident #11 has been able to access funds requested as she has funds available per the facilities Resident Trust guidelines.	07/10/2016

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	further indicated it had happened at least two times that she was aware of. The resident's personal funds account was reviewed on 6/10/16 at 3:00 p.m. The resident's debits for 2016 were reviewed as follows: debits for May: none debits for April: 4/20/16 $15.00 and 4/28/16 $10.00 debits for March: 3/3/16 $5.00, 3/17/16 $35.00 and 3/23/16 $20.00 debits for February: 2/17/16 $20.00 Interview with the Business Office Manager at that time, indicated the resident should have been able to take $30.00 out of her account at anytime, as long as the resident had money available. She further indicated her previous position at the facility was the receptionist at the front desk and she became the Business Office Manager in March 2016. She indicated she was not aware when the resident would have come down and asked for the $30.00 and was not able to obtain it while she was working. Interview with Receptionist #1 on 6/10/16 at 3:45 p.m., indicated residents could take up to $50.00 from their		**2) How the facility identified other residents:** Residents with a BIMS of 13 or greater have the potential of being affected by not receiving quarterly statements. Residents who have funds in the resident trust have the potential of being affected by not being able to access desired funds from their account. **3) Measures put into place/ System changes:** An audit of current residents with BIMS at 13 or greater with funds in the community trust was completed to determine if any other residents desired to see copies of their statements. Those residents requesting to see this information were provided copies. All residents with BIMS of 13 and greater and responsible parties were provided copies of trust fund withdrawal guidelines. The Management team and receptionists were in-serviced on the guidelines for presenting quarterly statements and resident access to available funds. The Business Office/designee will produce a quarterly log for residents	

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	account if they wanted. 3.1-6(f)(1) 3.1-6(g)		with a BIMS of 13 or greater with funds in the resident trust account. As statements are hand delivered to these residents, they will sign the log verifying receiving the statement. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	
F 0164 SS=D Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.			

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	The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review, and interview, the facility failed to maintain personal privacy during medication administration for 1 of 9 residents observed during medication administration. (Resident #90) Finding includes: On 6/9/16 at 2:02 p.m., LPN #1 was observed pouring and preparing medication for Resident #90's Percutaneous Endoscopic Gastrostomy (PEG) (a tube inserted through the stomach) tube administration. The LPN walked into the resident's room to administer the medication. The resident's bed was located by the window. The curtains were open and outside the window was a driveway in which cars were observed passing by. The room door was also left open. The LPN then began administering the medications. The LPN	F 0164	**F 164** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	07/10/2016

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	did not pull the privacy curtains completely around the resident during the medication administration. Interview with LPN #1 on 6/9/16 at 2:40 p.m., indicated she did not provide privacy for the resident by closing the door, the window curtains, and the privacy curtains during the medication administration. The record for Resident #90 was reviewed on 6/10/16 at 9:24 a.m. The resident's diagnoses included, but were not limited to, respiratory failure, hypoxia, coma, tracheotomy, PEG tube, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment dated 6/1/16, indicated the resident was in a vegetative state. Interview with the Director of Nursing on 6/9/16 at 3:15 p.m., indicated the LPN should have closed the door, privacy curtains and the window curtains before administering the medications. 3.1-3(o)(4)		**1) Immediate actions taken for those residents identified:** Resident #90 is without adverse effect. **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Staff educated on privacy during care. A minimum of 5 residents will be observed weekly at random times and days to ensure that privacy is maintained during care. Any non-compliance observed will be addressed with education/discipline as appropriate. Director of Nursing or designee will be responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be	

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			reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016	
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to the use of self release belts for 3 of 3 residents reviewed for physical restraints. (Residents #C, #32, and #75) Findings include: 1. On 6/8/16 at 8:56 a.m., 10:02 a.m. and 1:45 p.m., Resident #C was observed sitting in a wheelchair in front of the Nurses' station. At those times, she was observed with a seat belt restraint around her waist. The resident was not observed leaning to any side or leaning forward. The resident made no attempts to self	F 0221	**F 221** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	07/10/2016

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	transfer herself or to ambulate by herself. On 6/9/16 at 7:03 a.m., and 9:25 a.m., the resident was observed sitting in a wheelchair in front of the Nurses' station. At those times, she was observed with a seat belt restraint around her waist. The resident was not observed leaning to any side or leaning forward. The resident made no attempts to self transfer herself or ambulate by herself. The record for Resident #C was reviewed on 6/8/16 at 2:16 p.m. The resident's diagnoses included, but were not limited to, palliative care, major depressive disorder, delusional disorder, frontal temporal dementia, anxiety disorder, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment dated 3/28/16, indicated the resident had short and long memory problems and was severely impaired for decision making. The resident needed extensive assist with one person physical assist for bed mobility and transfers. The resident had 2 or more falls since the last assessment with minor injury for one of the falls. The resident was coded as having no physical restraints. The current and updated plan of care dated 3/2016, with an original date of		**1) Immediate actions taken for those residents identified:** Residents #75,32, and C have been reassessed for appropriateness/need for self- releasing seatbelt by the Interdisciplinary Team. Seatbelts have been discontinued for these residents. Families have been educated on the change in treatment. **2) How the facility identified other residents:** All residents that utilize seatbelts have the potential to be affected. Audit was completed with one other seatbelt in use, this was also reviewed by the IDT and is being discontinued. This resident's family has also been educated on the need to discontinue and on what interventions remain in place. **3) Measures put into place/ System changes:** The Interdisciplinary Team has been educated on Restraint Use Guidelines. At time of initiation of a new intervention, the IDT will assess to determine if intervention is a restraint. Devices determined to be restraints will be reviewed monthly x	

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	8/7/15, indicated the resident had a self release belt in the wheelchair per family request to prevent unassisted transfers and falls. The Nursing approaches were to anticipate and intervene for potential causes which have precipitated prior falls or accidents, discuss with the resident's family and caregivers the risks and benefits of the restraint, and evaluate the resident's restraint use. Physician orders with an original date of 8/11/15 and on the current Physician Order Statement (POS), indicated self release alarm belt to wheelchair. Check every shift for fall prevention related to delusional disorder, anxiety state, muscle weakness, and frontal temporal dementia. Use the belt when up in the wheelchair. The most recent restraint evaluation review dated 4/9/16, indicated the reason for the physical restraint was due to an unsteady gait, agitated behavior, frequent falls, unbuckled seatbelt, attempted self transfers, had poor safety awareness, and forgot to get assistance for transfers. The resident was referred to the rehab nurse for staff assists to stand/ambulate and for programmed activity. The seatbelt continued to be a safety intervention. The resident continued to stand. The resident can release the seatbelt at will.		3 months, then quarterly per policy. Any identified restraints will be reviewed by the Quality Assurance Committee to determine if intervention remains appropriate for the resident. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly until restraint is discontinued. **5) Date of compliance:** 7/10/2016	

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	A previous restraint evaluation dated 9/3/15, indicated per family, the best interest for the resident was to use a self releasing belt in the wheelchair. The reasons for the belt was frequent falls and attempts to self transfer. The initial restraint evaluation dated 8/7/15, indicated the family had requested a self release belt. Will evaluate effectiveness. The benefits for the restraint were to prevent injury to self, enhance functional status, and maintain correct positioning. Nursing Progress notes dated 8/6/15 at 5:25 p.m., indicated spoke with daughter in regards to request for self release belt. Informed the daughter that we would try the self release belt per her request. A Hospice Recertification dated 9/17/15, indicated the resident was receiving Hospice services. Nursing Progress notes dated 5/13/16, indicated the resident was moved to the Rehab unit due to Hospice care. A Physical Therapy (PT) evaluation dated 7/30/15, indicated to treat resident secondary to multiple falls and increased weakness. The resident received PT services until 9/3/15. There was no			

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	information or a recommendation to continue the use of the seatbelt restraint. Interview with CNA #3 on 6/8/16 at 1:45 p.m., indicated the resident was not alert and oriented and was not able to express her needs to staff. She further indicated the resident could not remove the seatbelt by herself. Interview with Physical Therapist #1 on 6/9/16 at 8:29 a.m., indicated he did not recommend the seatbelt for an intervention for her previous falls. He further indicated the resident had not received PT services since last year due to Hospice care. Interview with Occupational Therapist #1 on 6/9/16 at 10:13 a.m., indicated he had not been involved in any decision regarding the resident's seatbelt due to the resident being on hospice. Interview with the Restorative Nurse on 6/9/16 at 10:46 a.m., indicated the resident's seatbelt was placed on the resident due to family request. She indicated the resident cannot remove the seatbelt on command, therefore it was a restraint and since being placed on hospice, the resident was no longer in the restorative program.			

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	Interview with the Director of Nursing on 6/9/16 at 1:00 p.m., indicated the resident was wearing a seatbelt restraint per the family's request. She further indicated the resident was not on a therapy case load and therapy had not evaluated her for a different positioning device . 2. On 6/7/16 at 9:59 a.m., Resident #75 was observed seated in a wheelchair with a velcro belt across her lap. The resident was unable to release the velcro belt on command when asked by Activity Aide #1. On 6/8/16 at 9:51 a.m., the resident was observed being taken by staff in her wheelchair from the activity room to another activity room. The velcro belt was in use at this time. During a continuous observation on 6/8/16 from 11:38 a.m. through 11:47 a.m., the resident had the velcro belt in place across her lap. The resident self propelled her wheel chair with her feet throughout the Maple Unit. On 6/9/16 at 9:01 a.m., the resident was unable to self release the velcro lap belt on command when asked by CNA #8. Resident #75's record was reviewed on 6/8/16 at 9:17 a.m. The resident's diagnoses included, but were not limited			

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	to, Alzheimer's disease, depression and osteoarthritis. The Annual MDS (Minimum Data Set) assessment dated 3/10/16, indicated the resident was cognitively impaired and a one person assist with bed mobility, transfers, ambulation (walking), toilet use, dressing and personal hygiene. The "Restraint Evaluation" dated 2/8/16, indicated the reason for the use of the physical restraint was due to frequent falls and sliding out of the chair/wheelchair. The Restraint Evaluation further indicated the decision to restrain the resident was due to the enhanced functional status, the resident was able to self release the lap belt on command and to maintain correct positioning of the resident while in the wheelchair. This was the only restraint evaluation for review. Review of the resident's falls from 11/11/15 through 6/7/16, indicated the resident had fallen one time. The resident was found on her back with her wheelchair nearby on 11/15/15. Review of a Social Service (SS) Note dated 4/5/16 at 2:50 p.m., indicated the resident was in the hallway and upset about the velcro belt being across her lap.			

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Interview with SS #2 on 6/9/16 at 10:25 a.m., indicated she had spoken with the family regarding the 4/5/16 incident. The family indicated they wanted the resident to continue to use the velcro belt.

Interview with the Restorative Nurse on 6/9/16 at 10:45 a.m., indicated the resident did not stand up without assistance. She indicated the resident had not had any falls since 11/15/15, and the Quarterly Restraint Evaluation was not completed in May, 2016. She further indicated the resident was in need of another restraint evaluation and she did not know why the resident was in need of a lap belt restraint.

3. On 6/8/16 at 9:58 a.m., Resident #32 was observed to be able to self release the velcro lap belt restraint on command by staff.

The record was for Resident #32 was reviewed on 6/8/16 at 9:13 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, depression and edema (swelling) of the lower extremities.

The Quarterly MDS (Minimum Data Set) assessment dated 5/9/16, indicated the resident was cognitively impaired and

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	was a one person assist with bed mobility, transfers, ambulation (walking), dressing and toilet use. The MDS further indicated the resident was occasionally incontinent of urine and was not on a toileting program. The most recent restraint evaluation was completed on 2/12/16. The quarterly evaluation indicated the use of the physical restraint was due to unsteady gait, agitated and aggressive behaviors, unbuckled seatbelt and attempted to self transfer. Review of the resident's six falls from 10/10/15 through last the fall on 4/19/16, indicated the root cause of one of the falls had been due to improper footwear, and three of the falls indicated the resident had to use the bathroom. Interview with the Restorative Nurse on 6/9/16 at 9:18 a.m., indicated the May 2016 quarterly restraint evaluation was not completed, and the velcro belt was placed on the resident due to a history of standing when she wanted to go home in the afternoons. Interview with Occupational Therapist (OT) #1 on 6/9/16 at 10:05 a.m., indicated the family wanted the restraint. OT #1 also indicated during the recent			

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	therapy session on 5/12/16, the resident received a new wheelchair cushion for positioning, the leg rests from the wheelchair were removed for self propelling with her feet and it had been difficult to get the resident into a standing position. Interview with Social Service #2 on 6/9/16 at 10:34 a.m., indicated the family originally wanted the velcro belt restraint. The policy titled "Resident Restraints" was provided by the Director of Nursing on 6/10/16 at 2:00 p.m. This current policy indicated, "...Definitions:..also included as restraints are facility practices that meet the definition of a restraint,such as,...Self-Release Belts, if the resident is physically or mentally incapable of releasing the belt...Procedure:..2. The use of restraints will be reviewed by the Interdisciplinary Team periodically and at least Quarterly thereafter...14. The decision to use restraints is never based solely on the resident's representative's request for use...." 3.1-3(w) 3.1-26(o) 3.1-26(r)			

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F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to not serving a table at a time for 1 of 2 meal observations. The facility also failed to ensure dignity was maintained related to a resident voicing the need to use the restroom and expressing embarrassment for 1 of 3 residents reviewed for dignity of the 2 residents who met the criteria for dignity. (Residents #117, #132, and #143) Findings include: 1. On 6/6/16 at 11:58 a.m., the lunch trays were delivered to the Assisted dining room on the Maple Unit. The first tray was served at 12:00 p.m. The second cart was delivered to the Maple dining room at 12:06 p.m. Resident #143 was seated at a table in the Assisted dining room with two other residents. At 12:05 p.m., the resident's	F 0241	**F 241** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for**	07/10/2016

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	tablemates had received their trays. Resident #143 was told her lunch tray was on the other cart. At 12:10 p.m., the resident again was told her tray was on the other cart and she would receive it soon. Staff in the Assisted dining room did not go into the Maple dining room, which was located next to the Assisted dining room, at this time to get the resident's tray. The resident did not receive her tray until 12:20 p.m. At 12:08 p.m., Resident #117's tablemate received her lunch tray. At 12:11 p.m., the resident's other table mate received his tray. The resident was watching her tablemates eat at this time and was overheard asking if she gets anything to eat. At 12:18 p.m., desserts were passed at the table. The resident indicated, "I guess this is all I get to eat." The resident received her lunch tray at 12:19 p.m. At that time, the resident pushed her dessert aside and started to eat her lunch. Interview with the Director of Nursing on 6/10/16 at 8:45 a.m., indicated the residents should have been served in a more timely manner. 2. On 6/6/16 at 3:12 p.m., Resident #132 was observed reclined in a recliner chair in the lounge directly across from the Nurses' station. At that time, the resident stated, "Help me please." LPN #1		**those residents identified:** Resident #143 received her tray and was assisted with eating Resident # 132 was taken to the bathroom and was without incontinence. Resident # 117 received her tray and ate the meal. **2) How the facility identified other residents:** All residents have the potential to be affected. **3) Measures put into place/ System changes:** Staff educated on meal service including the serving of trays, and maintaining dignity and respect for each resident. Nursing staff educated on expectation of providing for ADL assistance in a timely manner. A minimum of five meals per week at various meals and days will be observed to ensure that residents are being served appropriately and are receiving the needed assistance. A minimum of ten residents per week	

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	walked over to the resident and asked him what he wanted. The resident indicated he had to "go pee." The LPN indicated to the resident that someone was going to come and help him. At that time, the LPN left the resident and walked down the hallway. RN #4 was observed sitting behind the Nurses' station. On 6/6/16 at 3:22 p.m., the resident was observed in the same recliner chair and still asking for someone to help him. The resident stated, "I have to go pee and I do not want to go in my pants. LPN #1 indicated to the resident that someone was coming to get him. LPN #1 was observed with a knee brace on one of her knees and indicated she was on light duty. RN #4 was still observed sitting behind the Nurses' station. At 3:24 p.m., the resident was still asking for someone to help him and that he did not want to go in his pants. On 6/6/16 at 3:24 p.m., RN #4 was observed to walk over to the resident and asked the resident what he needed. The resident indicated he had to pee. RN #4 indicated to the resident that she would go and find someone. RN #4 was observed to walk down hall to find someone. CNA #2 walked out of a		will be observed at various times and days to ensure that they are receiving needed assistance for toileting. Director of Nursing is responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016	

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	resident's room and stated "I am coming (Resident's name)." On 6/6/16 at 3:26 p.m., the resident indicated to CNA #4, "I have to go bad and I feel like a fool." The CNA assisted the resident into his wheelchair and pushed him to the shower room. At 3:33 p.m., twenty-one minutes later, the resident was finally assisted to the toilet. Interview with CNA #4 on 6/8/16 at 2:10 p.m., indicated LPN #1 had informed her of Resident's #132's need to use the bathroom. She indicated she was assisting and helping another resident use the bathroom and the resident could not be left alone. The CNA indicated some Nurses will take residents to the bathroom and others will not. The record for Resident #132 was reviewed on 6/10/16 on 9:33 a.m. The resident's diagnoses included, but were not limited to, palliative care, dementia without behavioral disturbance, anxiety disorder, and a history of falling. The Significant Change Minimum Data Set (MDS) assessment dated 4/28/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 indicating the resident was moderately impaired for decision making.			

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	The resident was an extensive assist with 2 person physical assist for transfers, and toilet use. The resident was coded as being always continent of bladder. The current plan of care updated on 4/2016, indicated the resident had episodes of yelling out at times. The Nursing approaches were to anticipate the residents's needs. Interview with the Director of Nursing on 6/10/16, indicated the resident had behaviors of yelling "Help me, Help me all the time. She indicated he did know when he needed to go to the bathroom. 3.1-3(t)			
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure the residents were aware of the visiting hour	F 0242	**F242**	07/10/2016

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	restrictions related to night time visitors for 2 of 3 residents reviewed for choices of the 9 residents who met the criteria for choices. (Residents #11 and #35) Finding includes: 1. Interview with Resident #11 on 6/6/16 at 2:37 p.m., indicated she had never been told what the visiting hour restrictions were and she had never asked if she could have visitors at night. Interview with Resident #35 on 6/7/16 at 10:49 a.m., indicated she did not know the visiting hours for the night time. She indicated she had never asked and did not know the restrictions. Interview with the Admissions Director on 6/10/16 at 11:15 a.m., indicated the policy for visitation hours was an "open door policy" whenever families wanted to visit, they could. She further indicated the admission packet lacked specific information or documentation regarding the visiting hours. She indicated she verbally tells the family members the information regarding the visiting hours but had not followed up with the residents to inform them as well. 3.1-8(a)		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents #11 and #35 were provided with copies of the facility visitation policy. **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged deficient practice.	

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	155277	A. BUILDING 00 B. WING	06/10/2016

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			3) Measures put into place/ System changes: All current residents/responsible parties were provided copies of this community's visitation policy. A copy of the visitation policy is added to the admission package for new residents/responsible parties. Staff were in-serviced on the community policy for visitation and guidelines of reporting any family/responsible party/ family concerns of visitation to a member of the management team. Social Services will log any visitation concerns on the monthly concern log and review at the regular QAPI meeting. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	

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F 0249 SS=C Bldg. 00	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. Based on record review and interview, the facility failed to ensure the Activity Director had the proper qualifications to serve as the director. This had the potential to affect the 83 residents who resided in the facility. Finding includes: The Licensure and Certification book was reviewed on 6/10/16 at 1:30 p.m. There was no documentation to indicate if the Activity Director had completed the Activity Director course. The only certification the Activity Director had was a current QMA and CNA certificate.	F 0249	**F249 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility**	07/10/2016

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	Interview with the Human Resources Director on 6/10/16 at 3:30 p.m., indicated the Activity Director started her position on 11/29/15. She indicated the Activity Director worked as a QMA and CNA prior to that. The Human Resource Director indicated to her knowledge, the Activity Director had not taken the activities certification class. 3.1-33(e)(4)		**identified other residents:** All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** The current Activity Director is able to produce copies of proof of 2 years' experience in a social or recreational program, and certified training and oversight as an activity director by Lacy Beyl and company. Activity Director will be enrolled in the state approved 90 hour activity director course. Copies of this certification will be placed in the Licensure and Certification binder upon completion. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of			

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	the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded related to behaviors and restraint use for 2 of 27 MDS assessments reviewed. (Residents #C and #51) Findings include: 1. The record for Resident #51 was reviewed on 6/9/16 at 1:54 p.m. The resident's diagnoses included, but were not limited to, major depressive disorder and delusional disorder. A Significant Minimum Data Set (MDS) assessment was completed on 3/1/16. Review of Section E Behaviors, indicated the resident did not have any behaviors	F 0278	**F278** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required*	07/10/2016

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	within the past 7 days. The Behavior Detail report for the week ending 2/26/16, indicated the resident had an episode of yelling and screaming. The Quarterly MDS assessment completed on 4/4/16, indicated the resident had not had any behaviors within the past 7 days. The Behavior Detail report for the week ending 4/1/16, indicated the resident had an episode of yelling and screaming. Interview with the Director of Nursing on 6/10/16 at 2:00 p.m., indicated Social Services completes Section E of the MDS. She indicated Social Service staff should run a behavior look behind report to ensure the MDS was being coded accurately. 2. On 6/8/16 at 8:56 a.m., 10:02 a.m. and 1:45 p.m., Resident #C was observed sitting in a wheelchair in front of the Nurses' station. At those times, she was observed with a seat belt restraint around her waist. The resident was not observed leaning to any side or leaning forward. The resident made no attempts to self transfer herself or ambulate by herself. On 6/9/16 at 7:03 a.m., and 9:25 a.m., the resident was observed sitting in a		*by the provisions of federal and state law.* **1). Immediate actions taken for those residents identified:** MDS for resident #51 with assessment reference date 03/01/2016 was corrected to reflect proper coding for section E. MDS for resident #51 with assessment reference date 04/04/2016 was reviewed by the Director of Nursing, MDS Coordinators and Social Service director and found to be accurate for behavior. Behavior Detail Report for the week ending 04/01/2016 indicated the resident had an episode of yelling and screaming although this episode did not occur during the lookback period for the 04/04/2016 MDS. MDS for resident # C with assessment reference date of 03/28/2016 was corrected to reflect the proper coding. **2). How the facility identified other residents:** All residents are at risk for being affected.	

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	wheelchair in front of the Nurses' station. At those times, she was observed with a seat belt restraint around her waist. The resident was not observed leaning to any side or leaning forward. The resident made no attempts to self transfer herself or ambulate by herself. The record for Resident #C was reviewed on 6/8/16 at 2:16 p.m. The resident's diagnoses included, but were not limited to, palliative care, major depressive disorder, delusional disorders, frontal temporal dementia, anxiety disorder, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment dated 3/28/16, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident needed extensive assist with one person physical assist for bed mobility and transfers. The resident had 2 or more falls since the last assessment with one of the falls resulting in a minor injury. The resident was coded as having no physical restraints. Interview with MDS Coordinator #1 on 6/10/16 at 10:35 a.m., indicated the other MDS Coordinator completed the assessment and had just opened up a modification to the assessment yesterday regarding the inaccurate coding of the		**3). Measures put into place/ System changes:** An audit of all MDS assessments dated 06/01/2016 through 06/17/2016 will be completed on or before 07/10/2016 by MDS Coordinators. Any identified errors will be corrected and any interdisciplinary team member associated with the error will complete Point Click Care's Clinical training and tutorials on MDS Data Entry for MDS 3.0. Five (5) MDS assessments will be reviewed each week for four (4 weeks and then ten (10) MDS assessments will be reviewed each month for three (3) months and ongoing as needed. This review will be conducted by available Interdisciplinary Team Members (consisting of Administrator, Director of Nursing, Social Services Director, Restorative Nurse, MDS Coordinators, Dietary Manager, and Activity Coordinator). Identified issues will be corrected. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved	

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	restraint. She indicated the resident should have been coded as having a trunk restraint daily. 3.1-31(i)		x3 consecutive months **5). Date of compliance:** 07/10/2016	
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure residents were invited to a care planning conference as well as being informed of any medication changes for 2 of 2 residents reviewed for care planning decisions of the 2 residents who met the criteria for care planning decisions. (Residents #11 and #35)	F 0280	**F 280** **The facility requests paper compliance for this citation.**	07/10/2016

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	Findings include: 1. Interview with Resident #11 on 6/7/16 at 10:51 a.m., indicated when she asked staff to notify her Physician regarding issues, the Nurses do not come back and let her know what he said. The record for Resident #11 was reviewed on 6/9/16 at 9:09 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, major depressive disorder, chronic pain, and sleep disorder. The Minimum Data Set (MDS) Annual assessment dated 5/19/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was alert and oriented. Nursing Progress notes dated 6/1/16 at 6:41 p.m., indicated the resident's Physician was at the facility to see the resident. New orders were received and the resident's family was aware. On 6/1/16 at 5:39 p.m., Physician Progress Notes indicated the resident was complaining of acid reflux. Physician Orders dated 6/1/16, indicated Prilosec (a medication used for acid		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident # 11 has been notified of medication changes made in the last 30 days as well as a review of established orders. Resident # 35 discharged home. **2) How the facility identified other residents:** All alert and oriented residents (BIMS 13 and higher) have the potential to be affected.	

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	reflux) 40 milligrams (mg) daily. There was no documentation in the Nursing Progress notes to indicate the resident had been notified of the medication change. Interview with the Assistant Director of Nursing on 6/10/16 at 11:25 a.m., indicated there was no documentation regarding the resident being notified of the newly ordered medication. 2. Interview with Resident #35 on 6/6/16 at 2:39 p.m., indicated she had not been invited to a care plan meeting or a care conference. The record for Resident #35 was reviewed on 6/8/16 at 9:17 a.m. The resident's diagnoses included, but were not limited to, fracture of left femur, copd (chronic obstructive pulmonary disease), high blood pressure, pneumonia, history of falling, muscle weakness, and allergic rhinitis. The Admission Minimum Data Set (MDS) assessment dated 3/11/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented.		**3) Measures put into place/ System changes:** Licensed Nurses educated on the need to notify alert and oriented (BIMS 13 or greater) of any order changes. Orders will be reviewed during Clinical Meeting a minimum of three times per week to ensure that alert and oriented residents have been notified. Any non-compliance will be addressed with education/disciplinary action as appropriate. Social Services has been educated on the Care Plan notification process. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016	

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	Social Service Progress Notes for March, April, May, and June 2016, indicated there was no documentation regarding the resident having attended a care conference. Interview with Social Service #1 on 6/9/16 at 10:08 a.m., indicated she has had meetings with the resident regarding discharge planning, however, a meeting with interdisciplinary team members to go over care areas and to discuss resident goals had not been completed. 3.1-35(c)(2)(C)			
F 0281 SS=D Bldg. 00	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were followed related to the administration of medications by licensed staff for 1 of 9 residents observed during medication administration pass. (Resident #90) Finding includes:	F 0281	**F 281** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of*	07/10/2016

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	On 6/9/16 at 2:02 p.m., LPN #1 was observed pouring and preparing medication for Resident #90's Percutaneous Endoscopic Gastrostomy (PEG) tube administration (a tube inserted through the stomach). The LPN poured 0.3 milliliters (ml) of gas relief drops via a syringe into the medication cup. The LPN gathered her supplies and walked down to the resident's room. After obtaining tap water for the container, she drew up 10 cubic centimeters (cc) of water and poured 5 cc into the crushed medication and the rest into the gas drops. While dispensing the water into the gas drops med cup, the water splattered out of the cup and onto the table. The LPN did not know if the medication had splattered out as well so she decided to pour the medication again. The LPN walked back to the medication cart by the Nurses' station. The LPN attempted several times to draw up the 0.3 ml solution but was unsuccessful. The Nurse Supervisor was standing by the Nurses' station and walked over to the medication cart. At that time, the Nurse Supervisor took over the med pass and started to draw up the gas relief drop medication via the syringe. After three attempts she was able to reach 0.3 ml's of the gas drops. The Nurse Supervisor lifted the syringe out of the bottle and held it up and verified she had 0.3 ml's		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #90 is without adverse effects. **2) How the facility identified other residents:** All residents have the potential to be effected. **3) Measures put into place/ System changes:** Licensed Nurses and QMAS educated on the Standards of Practice related to medication administration.	

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	and placed the medication into the medication cup. LPN #1 did not verify the medication dosage. LPN #1 walked back to the resident's room and administered the gas relief drops as well as the other medication. Interview with LPN #1 after the pass at 2:40 p.m., indicated she did not verify with the Nurse Supervisor the 0.3 ml's of the gas relief drops of medication that was poured. The Medication Administration-General Guidelines provided by the Director of Nursing (DON) on 6/10/16 at 9:30 a.m., indicated "The person who prepares the dose for administration is the person who administers the dose." Interview with the DON on 6/9/16 at 2:45 p.m., indicated the Nurse Supervisor should have verified the medication with LPN #1 before it was administered by LPN #1. 3.1-35(g)(1)		Medication administration observations will be done a minimum of three times per week on varied days and times. Anything that is inconsistent with policy will be addressed with education/disciplinary action as appropriate. Director of Nursing/designee will be responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/16	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility			

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	must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to assess, monitor, and document bruises for 3 of 3 residents reviewed for non pressure related skin conditions of the 10 residents who met the criteria for non pressure related skin conditions. (Residents #11, #35, and #102) Findings include: 1. On 6/7/16 at 11:00 a.m., Resident #11 was observed with discolorations to her left forearm, back of the left hand, right forearm and on the back of her right hand. All of the discolorations were red/purple in color. On 6/9/16 at 2:55 p.m., the Nurse Supervisor performed a skin assessment to the resident's arms and hands. At that time, she observed 3 red/purple areas to the resident's right arm. The Nurse Supervisor indicated she was unaware of the bruises to the right arms. She indicated the only documentation of the bruising was for the left forearm. The record for Resident #11 was	F 0309	**F 309** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #11's bruise is resolving. Resident #102's bruise is resolving	07/10/2016

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	155277	A. BUILDING 00 B. WING	06/10/2016

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	reviewed on 6/9/16 at 9:09 a.m. The resident's diagnoses included, but were not limited to, health failure, high blood pressure, and atherosclerotic heart disease. The Minimum Data Set (MDS) Annual assessment dated 5/19/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was alert and oriented. The resident was an extensive assist with 2 person physical assist for transfers. The current and updated plan of care dated 5/2016, indicated the resident had potential for bruising and skin tears related to fragile skin and the use of aspirin. Physician Orders dated 5/29/15 on the current Physician Order Statement dated 6/2016, indicated Aspirin 81 milligrams (mg) daily. The weekly skin observation record dated 6/1/16, indicated there were no skin concerns. Nursing Progress notes dated 6/1/16-6/9/16, indicated there was no documentation regarding any bruising on the resident's right hand and forearm.		Resident # 35 Discharged to home, bruise was healing prior to discharge. **2) How the facility identified other residents:** House wide head to toe skin assessments completed. All identified skin concerns addressed per policy. **3) Measures put into place/ System changes:** Licensed Nurses and CNAS/QMAS educated on Skin assessment Policy and process when skin conditions are identified. A minimum of 10 skin observations will be done weekly at various days and times. Observed areas will be checked against documentation. Any discrepancies will be addressed with education/disciplinary action as appropriate. Director of Nursing will be responsible for the oversight. **How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then	

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	Nurses' notes dated 6/9/16 at 2:59 p.m., indicated the resident had red bruises to the right forearm 1.5 centimeters (cm) by 0.5 cm. A bruise to the right hand 0.5 cm by 0.7 cm and a bruise to the right wrist 0.5 by 2.5 cm from her watch. Interview with LPN #1 on 6/9/16 at 1:37 p.m., indicated during her shift report, she was not given any information regarding any bruising to the resident's right or left arms. 2. On 6/6/16 at 3:01 p.m., Resident #35 was observed with a discoloration to her right hand. The area was red and purple in color. On 6/08/16 at 1:30 p.m., LPN #2 was observed to perform a skin assessment for the resident. LPN #2 identified one red and purple bruise to the resident's right hand. She indicated at that time, she was unaware the resident had a bruise. The LPN indicated no information had been passed on to her during shift report regarding any bruising to the back of the resident's right hand. The record for Resident #35 was reviewed on 6/8/16 at 9:17 a.m. The resident's diagnoses included, but were not limited to, fracture of left femur, high blood pressure, pneumonia, history of		quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/16	

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	falling, muscle weakness, and allergic rhinitis. The Admission Minimum Data Set (MDS) assessment dated 3/11/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented. The resident had no skin problems. The current and updated plan of care dated 3/2016, indicated the resident was at risk for pressure ulcers related to impaired mobility and incontinence. The Nursing approaches were to notify the Nurse of any new areas of skin breakdown, redness, blisters, bruises, and discoloration noted during bathing or daily care. Physician Orders dated 3/4/16, indicated Aspirin 81 milligrams (mg) one time daily. The weekly skin observations dated 6/6/16, indicated the resident's skin was intact with no concerns. Nursing Progress notes dated 6/8/16 at 1:51 p.m., indicated there was a bruise to the back of the right hand that measured 5 centimeters (cm) by 5 cm and red and purple in color.			

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Interview with LPN #2 on 6/8/16 at 2:00 p.m., indicated she was unaware of the resident's bruise and the CNAs who work with the resident most of the time should have let her know.

3. On 6/6/16 at 3:00 p.m., Resident #102 was observed in bed with his eyes closed. On the top of his right hand, between his index finger and thumb, there was a silver dollar sized area of purplish discoloration.

On 6/8/16 at 2:20 p.m., RN #4 was observed performing a skin assessment for the resident. At that time, she indicated the resident had bruising to the top of his right hand between his index finger and thumb. She further indicated the resident had a blood draw approximately 1 week ago and had the bruising as a result. The RN indicated the area should have been assessed, documented, and monitored.

The record for Resident #78 was reviewed on 6/8/16 at 9:47 a.m., his diagnoses included, but were not limed to, heart failure, diabetes, hemiplegia, and atrial fibrillation.

The 4/14/16 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had a Brief Interview for Mental

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	Status (BIMS) score of 7, indicating the resident was severely impaired for decision making. The resident was totally dependent with a physical assist of two people for transfers. The resident had anticoagulant (a blood thinning medication) use during the last 7 days. There was no care plan noted related to skin bruising. The Weekly Skin Observation form dated 6/6/16, indicated the resident's skin was intact with no concerns. There was no documentation indicating the resident had bruising to the top of his right hand. The Nursing progress notes dated 5/1/16 to 6/8/16, indicated no documentation related to bruising. The CNA Care Book indicated the resident's shower days were Monday and Thursday evenings. Review of the CNA Care Charting, indicated no documentation related to bruising. Interview with LPN #1 on 6/8/16 at 2:40 p.m., indicated there was no documentation related to bruising to the top of the resident's right hand.			

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	Interview with the Director of Nursing (DON) on 6/9/16 at 2:38 p.m., indicated the Nursing staff were to perform weekly skin assessments, document any alterations, and monitor the area for 72 hours for changes. The current Monitoring of Bruises policy dated 6/15 provided by the DON on 6/9/16 at 3:00 p.m., indicated "Nurse will monitor the site weekly. At the point of signs of healing, approximately 7-14 days, or when the bruise has turned color to green, yellow, brown, the Wound Care Nurse will make a last entry on the "Skin-Other Skin Condition Progress Report" indicating "the normal healing process has taken place without complications, and no further follow-up will be needed." 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS			

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	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure dependent residents were assisted with showers and oral care for 2 of 2 residents reviewed for activities of daily living. The facility also failed to ensure a dependent resident received assistance with her meal for 1 of 2 meal services observed. (Residents #B, #C, and #D) Findings include: 1. The record for Resident #B was reviewed on 6/9/16 at 9:17 a.m. The resident's diagnoses included, but were not limited to, vascular dementia with behavioral disturbance and muscle weakness. The shower schedule was reviewed on 6/9/16 at 1:46 p.m. The schedule indicated the resident received her showers on the Midnight shift on Monday and Thursday. The Bathing sheet for the past 30 days was reviewed. The sheet indicated the resident preferred a shower or bedbath. Documentation on the bathing sheet indicated the resident received a shower	F 0312	**F 312** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B received her shower. Resident C received needed assistance for eating.	07/10/2016

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	on 5/13/16 at 5:53 a.m., 5/24/16 at 5:59 a.m., and on 5/31/16 at 9:10 p.m. The Quarterly Minimum Data Set (MDS) assessment dated 4/13/16, indicated the resident's Brief Interview for Mental Status (BIMS) score was a 6, indicating cognitive impairment. The resident was identified as being extensive assistance for personal hygiene and bathing. The plan of care dated 8/20/15 and reviewed on 5/25/16, indicated the resident had a self care deficit and required assistance with daily care needs. The interventions included, but were not limited to, required extensive assist of one for bathing needs, dressing needs, and grooming/personal hygiene. Interview with the Director of Nursing (DON) on 6/10/16 at 8:40 a.m., indicated only three showers had been documented as being given. She also indicated "not applicable" had been coded seven times. The DON indicated staff had been counseled related to charting "not applicable" in the computer related to showers being given. She indicated she talked to the CNA yesterday about how to code showers in the computer and instructed the CNA to give the resident a shower before she left. 2. On 6/7/16 at 7:37 a.m., Resident #C		Resident D was provided with oral care, kardex was reviewed and updated to include her denture. **2) How the facility identified other residents:** All residents have the potential to be affected. Shower records reviewed last 30 days. Audit of all residents were reviewed for oral/dental status and care plans updated. Audit of all residents requiring assistance with eating. **3) Measures put into place/ System changes:** Nursing staff educated on Shower guidelines, Dining guidelines and Oral care. A minimum of 10 residents per week will have their showers reviewed to ensure that they have received their scheduled showers. Any discrepancies will be addressed with education/discipline as appropriate. A minimum of three dining rooms will be observed per week on various	

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	was observed sitting at a table in the Rehab dining room waiting for her breakfast. At 7:39 a.m., the resident received her meal tray. The plate of food was placed in front of her. At that time, the resident's eyes were closed. There were two management staff in the dining room, the Administrator and the Admissions Director. At that time, RN #1 was observed standing by her medication cart right outside the dining room passing her morning medications. Interview with RN #1 at that time, indicated she had one CNA and herself on the unit that day. She further indicated the CNA was getting the residents up for breakfast. Continued observation on 6/7/16 at 7:44 a.m. and 7:50 a.m., indicated the resident had not touched any of her food and her eyes remained closed. No staff had helped or cued her to eat. At 7:53 a.m., RN #1 asked the Administrator if everything was ok. The Administrator indicated yes, but Resident #C was not eating. He indicated to RN #1 as soon as she got a chance, could she come in there and help the resident eat her breakfast. RN #1 stated to the Administrator, "Ok, I have an insulin to give and some other meds and I will be in		days and meals to ensure that residents that require assistance with eating receive assistance. Any non-compliance will be addressed with education/disciplinary action as appropriate. A minimum of five residents per week will be observed to ensure that they have received needed assistance with oral care. Any non-compliance will be addressed with education/disciplinary action as appropriate. Director of Nursing/designee is responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **7**/10/16	

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	there to help those two." RN #1 walked into the dining room to assist and feed Resident #C at 8:08 a.m., 29 minutes later. The record for Resident #C was reviewed on 6/8/16 at 2:16 p.m. The resident's diagnoses included, but were not limited to, palliative care, major depressive disorder, delusional disorders, frontal temporal dementia, anxiety disorder, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment dated 3/28/16, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident needed extensive assist with one person physical assist for eating. The current plan of care updated 3/2016, indicated the resident had a self care deficit due to weakness and impaired cognition. The resident required assistance with daily care needs. The Nursing approaches indicated the resident required extensive assist with eating. Interview with the Director of Nursing on 6/10/16 at 9:15 a.m., indicated the resident needed assistance with eating. 3. During a continuous observation on			

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	6/10/16 from 6:35 a.m. through 9:43 a.m., Resident #D was not assisted with oral hygiene. On 6/10/16 at 10:58 a.m., the resident removed the upper full denture and the denture was observed to have a white film on the inside plate with noticeable food debris. The resident also had a noticeable foul odor coming from her mouth. Resident #D's record was reviewed on 6/10/16 at 8:00 a.m. The resident's diagnoses included, but were not limited to, dementia. The Quarterly Minimum Data Set assessment dated 5/12/16, indicated the resident was cognitively impaired, a one person assist with personal hygiene and had full or partial dentures. Interview with Resident #D's family on 6/6/16 at 2:14 p.m., indicated the resident's dentures had not been cleaned due to evidence of food in the top denture and the resident's mouth had a bad odor. Interview with CNA #9 on 6/8/16 at 2:13 p.m., indicated Resident #D needed assistance with oral hygiene. The CNA was not aware the resident had upper dentures that needed to be removed and			

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	cleaned. Interview with CNA #3 on 6/10/16 at 10:59 a.m., indicated the resident was in need of assistance with oral hygiene. The CNA was not aware the resident had upper dentures that needed to be removed and cleaned. CNA #3 referred to the CNA Kardex "Care Tracker", and the Care Tracker did not indicate the resident had upper dentures. Interview with the Assistant Director of Nursing on 6/10/16 at 3:35 p.m., indicated the Care Tracker should have had information indicating the resident had dentures or the CNA should have received that information in report. This Federal tag relates to Complaint IN00201162. 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C)			
F 0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL			

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Bldg. 00	PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to ensure orders for nutritional supplements were obtained in a timely manner for 1 of 2 residents reviewed for pressure ulcers of the 2 residents who met the criteria for pressure ulcers. (Resident #62) Finding includes: The closed record for Resident #62 was reviewed on 6/10/16 at 10:15 a.m. The resident's diagnoses included, but were not limited to, diabetes, muscle weakness, and Parkinsonism. Documentation in the Nursing progress notes on 4/21/16 at 9:31 p.m., indicated the resident had a fluid filled blister to the right heel. The Physician was notified and no new orders were obtained at the time. The Risk Management form provided by the Director of Nursing (DON) on 6/10/16, indicated the area was	F 0314	**F 314** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	07/10/2016

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	a Suspected Deep Tissue Injury and measured 2.2 centimeters (cm) x 1 cm when it was observed on 4/21/16. A Nutrition at Risk (NAR) note dated 4/26/16, indicated the resident had blisters to her bilateral lower extremities and excoriation to her bilateral buttocks. The NAR committee recommended Prostat (a nutritional supplement) 30 milliliters (ml) daily and weekly weights for three more weeks. A Physician's order dated 5/3/16, seven days after the initial recommendation, indicated the resident was to receive Prostat AWC 30 ml's daily to promote wound healing. Interview with the DON on 6/10/16 at 3:50 p.m., indicated the order for the Prostat should have been obtained in a more timely manner. 3.1-40(a)(2)		**1) Immediate actions taken for those residents identified:** Resident #62 was discharged prior to survey. **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged deficient practice. Nutrition at Risk recommendations for the last 30 days reviewed. All residents receiving supplements were reviewed. **3) Measures put into place/ System changes:** Nutrition at Risk Team members educated on protocol for follow up on recommendations. An audit will be done weekly of Nutrition At Risk notes to identify any recommendations made and checking to ensure that orders for items that were recommended have been obtained. Any outstanding recommendations will be addressed after completion of audit. Director of Nursing is responsible for the oversight.	

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	155277	A. BUILDING 00 B. WING	06/10/2016

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			4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/16	
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to comprehensively assess each resident for appropriate treatment and services to prevent a further decrease in range of motion (ROM) for 1 of 1 residents reviewed for ROM of the 1 resident who met the criteria for ROM. (Resident #78) Finding includes: On 6/6/16 at 11:32 a.m., during an	F 0318	**F 318** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	07/10/2016

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	observation with RN #2, Resident #78 was observed in the Linden Dining Room seated in his wheelchair. His right and left hands were contracted. There were no splinting devices in place to his bilateral hands. The RN indicated at that time, the resident was not receiving ROM, nor did the resident wear splinting devices. The record for Resident #78 was reviewed on 6/8/16 at 9:25 a.m. His diagnoses included, but were not limited to, Alzheimer's and contractures. The Quarterly Minimum Data Set Assessment dated 4/8/16, indicated the resident had upper extremity ROM limitations. His active diagnoses included, but were not limited to, contractures and he previously had therapies which ended on 11/7/14. There was no documentation indicating he received Restorative Nursing services for ROM or wore any splint devices. A Care Plan dated 1/11/16, and revised on 4/13/16, indicated the resident was completely dependent. The interventions included, but were not limited to, receives Restorative Nursing for passive range of motion (PROM). There was no documentation related to splinting devices.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #78 is without adverse effect, ROM is at prior level at this time. **2) How the facility identified other residents:** Facility wide joint mobility assessments completed for all current residents. **3) Measures put into place/ System changes:** Restorative Nurse educated on how to answer questions correctly on ROM assessment tool. Nursing staff educated on how to report an observation of a change in	

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	Review of the 5/2016 Physician's Orders, indicated no documentation related to therapies or splint devices. Review of the 6/2016 Physician's Orders dated 6/6/16 indicated, Occupational Therapy (OT) to eval and treat. The Quarterly Restorative Observation dated 4/8/16 indicated, the resident's right and left hands had normal mobility, indicating no contractures. The recommendation was PROM per nursing. There was no documentation related to Restorative Progress notes since 1/7/16. The OT notes indicated the resident's last evaluation was dated 10/2/14. The current OT evaluation dated 6/7/16, indicated the resident was referred to therapy, the resident was observed to be demonstrating a potential for increase in contractures of both hands, while also not consistently having an orthotic device. The Plan of Care included, appropriate orthotic devices based on current needs as well as establishing an appropriate wearing time and staff education and donning of splint device. Interview with CNA #5 on 6/8/16 at 10:14 a.m., indicated the resident seemed to be becoming stiffer by the day and it		range of motion. Any changes in ROM reported will be assessed by the Restorative Nurse. A minimum of 3 resident ROM Assessments will be reviewed weekly to ensure accuracy. These audits will be reviewed by the IDT and results will be presented to the Quality Assurance Committee. Restorative Nurse will be responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016	

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	was getting harder to provide PROM exercises. She and another CNA discussed their concern with the OT Therapist approximately 1 week ago. Interview with the Restorative Nurse on 6/9/16 at 10:02 a.m., indicated the resident was not being seen by Restorative. The Nursing staff were currently providing the resident PROM during morning care (maintenance care). She further indicated during her quarterly assessment completed on 4/8/16, the resident had normal ROM in both his right and left hands and was discharged from the Restorative Program due to reaching his maximum potential. She was unaware of the contractures or splinting devices ordered for this resident. Continued interview indicated, the current system in place when there was a noted decline in mobility/ROM was for the staff to report the concern to her and a comprehensive assessment was then completed. The resident was then assessed quarterly. The decline was not reported to her and staff immediately requested an OT evaluation. Interview with the MDS Coordinator on 6/10/16 at 10:30 a.m., indicated the ROM section on the 4/8/16 Quarterly MDS assessment was completed by the Restorative Nurse.			

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Interview with the Director of Nursing (DON) on 6/9/16 at 2:41 p.m., indicated the Nursing staff were expected to complete an assessment of ROM upon admission. If there were any concerns, a Restorative assessment was completed at that time, then quarterly. If there was a change in condition, the Nursing staff would get a Physician's Order for a joint mobility assessment from OT, and the change in condition and/or treatment would be communicated to the staff by recurrent inservices, shift change report, care charting and the dash board. She further indicated she oversees the overall Restorative assessments, but she was not able to review the resident's assessment for accuracy.

The current PROM Exercises policy provided by the DON on 6/10/16 indicated, "2. If a resident was recommended for a PROM program, trained Nursing staff would provide the ROM exercises as outlined under ROM technique."

3.1-42(a)(2)

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F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was maintained related to the use of heated tray carts on 1 of 4 units in the facility that used heated carts. The facility also failed to ensure 2 of 2 ovens located on the Maple Unit were not functional. The facility also failed to ensure the appropriate fall prevention measures were in place for 1 of 2 residents reviewed for accidents of the 2 residents who met the criteria for accidents. (The Rehab Unit, Maple/Elm Unit, and Resident #3) Findings include: 1. On 6/7/16 at 8:12 a.m., an electric oven was observed in the Maple Unit (a secure Memory Care Unit) dining room. There were no knobs on the stove, however, the clock was functional. At this time, the metal post, where the knob would be placed, was able to be pushed in and turned on. Heat was felt coming from the burner.	F 0323	**F323** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #3 remains in a reclining	07/10/2016

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	Interview with the Unit Director at 8:15 a.m., indicated the Activity department used the oven to bake items with the residents. She indicated the residents were supervised while they were in the dining room. The Unit Director indicated after meals, the doors to the dining room were closed and the residents were not allowed in the dining area unattended. The Unit Director indicated the doors to the dining room were not locked or alarmed. Interview with the Dietary Food Manager at the time, indicated she thought the oven was supposed to be unplugged. At 8:19 a.m., Maintenance Employee #2 came to the dining room and unplugged the oven. On 6/7/16 at 9:20 a.m., interview with Activity Aide #1, indicated that she did not use the oven in the Maple dining room. She indicated she used the oven in the activity room located on the Elm Unit, which also housed cognitively impaired residents. At this time, the oven was observed with 2 knobs in place and 2 knobs removed. The Activity Aide indicated she had just put the knobs on because she was going to make pudding. She indicated she usually turned the knobs in to the office when she left for the day. She indicated the residents were supervised while in the area. She indicated the door was closed to the room		Geri chair without further incident. Resident's Plan of care was reviewed. The regular wheel chair was removed from the resident room. The knobs were removed from the stove after the activity on Linden and both stoves on Linden and Maple were unplugged. The temperature knobs were adjusted from 7 to 5 on the hot carts. This allowed for food to remain within temperature and the outside of cart remained comfortable to touch. **2) How the facility identified other residents:** All residents on the Elm/Maple and Linden units have the potential to be affected by the alleged deficient practices. No other injuries or concerns have been noted related to this citation. Audit of all residents to ensure appropriate devices in place. **3) Measures put into place/ System changes:** Facility will observe 10 residents per week on varied units and times to monitor for safety interventions being in place for 6 weeks, then	

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	when no one was in there, but not locked. She indicated she usually locked the room when she left the facility at 5:00 p.m. daily. Interview with the Restorative Nurse on 6/7/16 at 8:45 a.m., indicated there were 17 ambulatory residents on the Maple and Elm Units as well as 17 residents who could self-propel their wheelchairs. Out of the 17 residents who could self propel their wheelchairs, 9 of the residents could stand up. Further interview with the Restorative Nurse on 6/7/16 at 10:00 a.m., indicated knobs should not be kept on the ovens and the ovens should be unplugged when not in use. 2. The noon meal in the Rehab dining room was observed on 6/6/16 at 12:00 p.m. At that time, there was a heated food cart observed plugged in to the wall by the entrance to the dining room. The cart was observed with plated food for the residents to eat. At that time, the cart's external thermometer indicated the temperature of 178-180 degrees. Both sides of the cart were hot to touch. There was a table observed next to the cart and there was nothing on the other side of the cart. There were no residents who sat at that table.		observe 5 residents per week for a duration determined by the Quality Assurance Committee. Activity staff has been in-serviced on the importance of assuring the stoves on the dementia units have knobs removed and stoves remain unplugged when stove is not in use. Staff have been in-serviced to observe the hot carts when in the dining rooms to assure the temperature setting on the hot cart is at 5. Dining room managers will audit the hot carts on the Rehab, Linden and Elm/Maple units 5 x per week at random meals and locations. Activity Director/designee will audit stoves on the dementia units 5x per week on varied shifts to assure they are unplugged. Audit results will be presented to the Quality Assurance Committee. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months.	

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	At 12:20 p.m., the cart remained at 170 degrees and was hot to touch on both sides. There were 7 residents in the dining room observed eating their lunch and 9 residents residing on the unit. Interview with LPN #2 on 6/6/16 at 2:45 p.m., indicated there were no residents who ambulated by themselves on the unit. There was one alert and oriented resident who was able to propel her own wheelchair and there was one confused resident who was able to self propel her wheelchair with her feet. Interview with the Admissions Director on 6/7/16 at 7:48 a.m., indicated the trays were not hot to touch and if they feel hot, the temperature on the cart had to be adjusted and turned down. On 6/7/16 at 8:00 a.m., the heated cart was observed in the Rehab dining room. The external temperature was 170 degrees and the sides of the cart were hot to touch. Interview with the Dietary Food Manager (DFM) and the Dietary Consultant on 6/7/16 at 1:21 p.m., indicated the heated carts do get hot on the outside if the temperature was above 160 degrees. The DFM further indicated when there were more food trays in the cart, the		**5) Date of compliance:** 7/10/2016	

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	temperature did not get as hot as when there were less trays in them. She indicated the cart was placed in that particular spot in the Rehab dining room due to the location of the outlet. The cart required a three prong plug. The DFM indicated the cart does get very hot on the outside when there were less trays in the cart. She further indicated she had to instruct staff not to turn the temperature up to the "10" setting due to the food drying out and the cart getting very hot on the outside. The Vulcan heated cart manufacture instructions provided by the DFM on 6/7/16 at 1:30 p.m., indicated "The cabinet and its parts are HOT. Be very careful when operating, cleaning, or servicing the cabinet." 3. On 6/8/16 at 2:09 p.m., Resident #3 was observed lying on her back in bed. The resident had blue and purple discolorations to her face and forehead. The resident's bed was in a low position and a long body pillow was observed on the left side. A floor mat was also observed on the left side of the bed and bed bolsters were in use. The record for Resident #3 was reviewed on 6/9/16 at 9:40 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety,			

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	depression and epilepsy (uncontrolled convulsions of the body) and abnormal posture. The Admission Minimum Data Set assessment dated 3/18/16, indicated the resident was moderately impaired for decision making, was a two person assist with bed mobility, transfers, dressing and toilet use, had falls since the prior assessment and was frequently incontinent of urine. Review of the resident's Fall assessments dated 3/11/16, 3/13/16, 3/23/16, 5/23/16, 5/29/16 and 5/30/16, indicated the resident was at risk for falls. The plan of care dated 3/16/16, indicated the resident had a potential for falls. The interventions included, but were not limited to, a reclining gerichair for comfort and positioning. A Fall Investigation for the resident dated 6/5/16, indicated the intervention of a reclining gerichair was not in place at the time of a fall on 6/2/16, which was unwitnessed in the dining room at 7:33 a.m. Interview with the Assistant Director of Nursing on 6/10/16 at 11:58 a.m., indicated the resident had fallen out of			

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	her regular wheelchair on 6/2/16 and should have been in a reclining gerichair due to a history of seizures and recent falls. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0325 SS=G Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to ensure a resident maintained acceptable parameters of nutrition related to monitoring and assessing supplement intake, ensuring weekly weights were completed as well as being assessed by the Registered Dietician (RD) which resulted in further weight loss for 1 of 3 residents reviewed for nutrition of the 10 residents who met the criteria for nutrition. The facility also failed to ensure each resident was assessed by the RD for glycemic control for 1 of 5 residents reviewed for unnecessary	F 0325	**F 325 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	07/10/2016

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	medications. (Residents #35 and #109) Findings include: 1. On 6/6/16 during the noon meal, Resident #35 was served potato soup. At that time, the resident indicated to staff that she would prefer to eat a fruit plate rather than the meal being served. The resident was not offered any super mashed potatoes or other fortified foods during the meal. Interview with the resident on 6/8/16 at 1:45 p.m., indicated she was aware of the recent weight loss she had during her stay at the facility. She indicated she had never been much of a big eater. The resident indicated she does not eat the mashed potatoes all the time, in fact, if she eats a sandwich, then she will not eat the potatoes. She indicated she liked the potatoes but did not want them everyday. The record for Resident #11 was reviewed on 6/8/16 at 9:17 a.m. The resident's diagnoses included, but were not limited to, fracture of left femur, copd (chronic obstructive pulmonary disease), high blood pressure, pneumonia, history of falling, muscle weakness, and allergic rhinitis. The Admission Minimum Data Set		Resident #35 completed all rehabilitation goals and has discharged home Resident #109 will be assessed by the Registered Dietician on her next visit **2) How the facility identified other residents:** Audit completed to identify residents with weight loss, supplements and diabetes. **3) Measures put into place/ System changes:** Licensed Nurses educated on the process for notifying the Registered Dietician of residents that need to be evaluated. Nutrition at Risk Committee members have been educated on NAR Policy. Nutrition at Risk Committee will review consumption of supplements and the need for Registered Dietician assessment during weekly meetings. Dietary Manager will notify the Registered Dietician of any referrals. Concerns identified during NAR meetings will be addressed within 48 hours. NAR documentation will be audited weekly to ensure that all concerns have been addressed. Dietary Manager and Director of Nursing are responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016 IDR, this facility does not agree that there was actual harm to	

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	(MDS) assessment dated 3/11/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented. The resident's weight was 137 pounds with history of weight loss or gain. The resident received a therapeutic diet. The current plan of care dated 3/2016, indicated the resident had potential nutritional problems due to diet restrictions of no added salt and a fracture of the left femur. The Nursing approaches were to monitor food consumption, monitor weight, offer substitutions, honor food preferences, and provide supplements. A Dietary Progress note dated 3/8/16 by the RD, indicated the resident's weight was 135 pounds. The resident indicated she had never been a big eater and her Usual Body Weight (UBW) was 135 pounds. The resident indicated she received enough to eat. The RD indicated the resident's diet meets the estimated needs. The last documented Dietary Progress note by the RD was dated 4/19/16. The RD indicated the resident had a 9% weight loss in one month. Super mashed potatoes were not being served to the		resident #35. Facility will provide documentation of resident #35 edema which had dissipated contributing to weight loss, Registered Dietitian notes that breakdown on nutrition and caloric needs and intake were adequate.	

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	resident at lunch and dinner. The RD indicated the resident's food consumption was between 75-100%. The resident was observed eating lunch and indicated she was eating alright. The RD made no further recommendations. Continued record review indicated there was no initial nutritional assessment completed by the RD for the resident which broke down the resident's estimated needs, caloric intake, labs, and medication review. Nursing Progress notes indicated the resident was being reviewed weekly in the Nutritional at Risk Program (NARP). The NARP progress notes were as follows: 3/8/16 the weekly weight was 137 pounds. The diet was no added salt. Recommendations for weekly weights times 4 weeks. 3/15/16 no documentation of a NARP meeting. 3/23/16 weekly weight was 137 pounds. To follow 3 more weeks. 3/30/16 weekly weight was 137 pounds. To continue with weekly weights.			

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	4/6/16 no documentation of a NARP meeting. 4/12/16 weekly weight was 125 pounds. A 5% loss in one month. Recommend to add super mashed potatoes at lunch and dinner. Weekly weights times 3 more weeks and reweigh the resident. 4/19/16 no documentation of a NARP meeting. 4/26/16 weekly weight was 125 pounds. Continue with super mashed potatoes at lunch and dinner. Weekly weights times 2 more weeks. 5/5/16 weekly weight was 121 pounds. Continue with super mashed potatoes at lunch and dinner. Continue weekly weights one more week. 5/11/16 weekly weight was 119 pounds. Weight down 2.2 pounds in one week and greater than 10% weight loss. Physician made aware. Continue weekly weights times 3 more weeks and current diet. 5/17/16 weekly weight was 120.4 pounds. Continue NARP times 2 more weeks. 5/24/16 weekly weight was 120.4			

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	pounds. Continue NARP times 1 more week. 6/1/16 weekly weight was 120.4 pounds. Transition to monthly weights. Continue with diet and supplements of super mashed potatoes. The weight record was reviewed and documented as followed: 3/7/16 137 pounds 4/12/16 124.5 pounds 4/27/16 121.4 pounds 5/6/16 119.2 pounds 5/12/16 120.4 pounds 6/7/16 118 pounds The super mashed potato food consumption was reviewed for the resident. The information was documented by the CNA staff. The documentation indicated the amount consumed by the resident on certain days was "not applicable". The "not applicable" consumption was noted in April 2016 for the lunch meal on 4/16/16 and 4/30/16. The "not applicable" consumption was documented in April 2016 for the supper meal on 4/13-4/15/16, 4/17/16, 4/20-4/24/16, 4/26/16, and 4/28-4/30/16. The resident had refused the potatoes on 4/15/16, 4/17/16 and 4/25/16 for the lunch meal and 4/18/16 and 4/19/16 for			

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	the supper meal. The 5/2016 supplement consumption was reviewed. The "not applicable" consumption was documented for the supper meal on 5/2/16, 5/4/16, 5/11-5/14/16, 5/16/16, 5/18/16, 5/21-5/24/16, 5/26/16, 5/27/16, and 5/30/16. The resident had refused the potatoes on 5/1/16, 5/2/16, 5/4/16, 5/15/16, 5/17/16, 5/23/16, 5/25/16, 5/28/16, and 5/29/16 for the lunch meal and 5/1/16, 5/6/16, 5/15/16, and 5/17/16 for the supper meal. The 6/2016 supplement consumption was reviewed. The "not applicable" consumption was documented for the supper meal on 6/2/16, 6/4/16, 6/5/16, 6/6/16, and 6/7/16. The resident had refused the potatoes on 6/5/16 for the lunch meal. Interview with the Dietary Food Manager (DFM) on 6/9/16 at 9:32 a.m., indicated she was involved in the NARP meetings which were held one time a week. She indicated the RD was involved in the NARP meetings when she was at the facility. The DFM indicated the last RD progress note for the resident was dated 4/19/16 and was completed by the old RD and the new RD had not seen her. When asked, the DFM indicated she had			

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	personally not interviewed the resident regarding the mashed potato supplement. She indicated she had not reviewed the supplement consumption record and was not aware the resident was not eating the mashed potatoes. The DFM indicated she no longer served health shakes or magic cup ice cream in the facility due a lot of them being wasted. She indicated everyone with weight loss was placed on fortified foods instead. Interview with the Director of Nursing (DON) on 6/9/16 at 9:54 a.m., indicated the NARP meetings were held weekly. She indicated the facility had changed RDs and the new RD was completing training right now. The DON indicated she was unable to find the weekly weights for the resident and questioned the weights documented in the NARP notes, as it was the same for several of the weeks. She further indicated she did not interview the resident regarding the supplement of super mashed potatoes to see if the resident liked them, nor had she reviewed the supplement consumption to see if the resident was eating the potatoes. Continued interview with the DON on 6/9/16 at 2:45 p.m., indicated she was unsure why the supplement consumption of the mashed potatoes were coded as			

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	"not applicable". The DON indicated "not applicable" to her meant they were not served to the resident. She further indicated there was no initial nutritional assessment completed by the RD at the time of admission. Interview with the Administrator on 6/10/16 at 3:30 p.m., indicated the new RD started on 5/17/16 and when the facility gave a 30 day notice to the old RD company, they immediately left and did not finish the 30 days. 2. The record for Resident #109 was reviewed on 6/9/16 at 1:52 p.m. The resident was admitted on 4/2/16 from an acute care hospital. The resident's diagnoses included, but were not limited to, diabetes type 2, congestive heart failure, and anxiety disorder. The Admission Minimum Data Set (MDS) assessment dated 4/8/16, indicated the resident was alert and oriented. The resident received insulin injections daily. Physician orders dated 5/19/16 indicated Lantus (a long acting Insulin) Insulin 85 units at night time. Physician orders dated 5/19/16, indicated an Insulin sliding scale of Humalog (a short action Insulin) Insulin as followed:			

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	101-150=2 units 151-200=4 units 201-250=6 units 251-300=8 units 301-350=10 units 351-400=12 units notify Physician if blood sugar greater than 400. The 5/2016 Medication Administration Record (MAR), indicated to check blood sugar before meals. The resident's blood sugars were as followed: on 5/10/16 at 6:00 a.m. 572, 510 at 12:00 p.m., and 535 at 5:00 p.m. On 5/17/16 at 12:00 p.m., 458, 5/25/16 at 12:00 p.m., 573, 5/20/16 at 5:00 p.m. 425 and 5/25/16 at 5:00 p.m. 600. Nursing Notes dated 5/25/16 at 4:59 p.m., indicated the Physician recommended the resident go to the hospital for better glycemic control. The resident refused. The Nurse explained the detriments of high blood sugar. In addition, the nurse discussed her excessive sugar intake, including ice cream she had eaten at 3:00 p.m., numerous chocolate wrappers in her room, and drinking sugared drinks throughout the day. The resident indicated she would try to make better choices and was agreeable to speak with the Registered Dietitian (RD).			

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The resident was currently on a no added salt and no concentrated sweets diet.

Dietary Progress Notes were reviewed. The last documented dietary progress note was on 4/13/16 regarding the residents concerns with the dietary department. There was an initial dietary note by the Dietary Food Manager on 4/3/16. There was no nutritional assessment or Dietary Progress note completed by the RD.

The current plan of care dated 4/4/16 and updated 6/6/16, indicated the resident had nutritional problems related to diet restrictions and a no added salt and no concentrated sweet diet. The Nursing approaches was for the RD to evaluate and make diet changes and recommendations as needed.

Interview with the Director of Nursing on 6/10/16 at 4:48 p.m., indicated the resident had not been seen or referred to the Registered Dietitian since she had been there.

3.1-46(a)(1)

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F 0329 SS=E Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review, and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary medications related to lack of gradual dose reductions, no indication for the increase in a medication, behavior monitoring, and lack of completion of AIMS (abnormal involuntary movement) scales for 4 of 5 residents reviewed for unnecessary medications. (Residents #42, #51, #56 and #75) Findings include:	F 0329	**F 329** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	07/10/2016

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	1. The record for Resident #42 was reviewed on 6/8/16 at 9:02 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, delusional disorder, dementia without behavior disturbance, and schizophrenia. A Physician's order dated 5/25/16, indicated the resident was to receive Seroquel (an antipsychotic medication) 25 milligrams (mg) at bedtime. Review of the assessment section in the electronic medical record indicated an AIMS (abnormal involuntary movement) scale was not available for review. Interview with the Director of Nursing on 6/10/16 at 2:00 p.m., indicated an AIMS scale should have been completed under the Assessment section in the computer. 2. The record for Resident #51 was reviewed on 6/9/16 at 1:54 p.m. The resident's diagnoses, included, but were not limited to, delusional disorder, anxiety, Alzheimer's disease and depressive disorder. A Physician's order dated 12/2/15, indicated the resident was to receive Seroquel (an antipsychotic medication)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #42 AIMS completed Resident #51 recommendation for GDR pending MD approval Resident #56 AIMS completed Resident #75 discharged **2) How the facility identified other residents:** All residents that receive antipsychotics charts reviewed to ensure that AIMS completed. Those that were identified as missing have been completed. All residents that receive psychotropic medications were reviewed.	

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	200 milligrams (mg) at bedtime. A Physician's order dated 12/3/15, indicated the resident was to receive Paxil (an antidepressant) 20 mg daily. The 12/23/15 Psychiatric progress note indicated the resident was calm and cooperative and Social Services reported an improvement in the resident's behaviors since returning to facility following a Psychiatric hospital stay on 11/30/15. The progress note indicated the resident had no reports of verbal outbursts or aggressive behaviors. Documentation indicated the resident was presently taking Seroquel, Paxil and Ritalin. The Psychiatrist felt it was too soon after the resident's medications were adjusted at the Psychiatric facility to evaluate for a possible dose reduction. A Pharmacy recommendation dated 2/1/16 indicated the resident's sliding scale insulin was addressed. There was no documentation related to the resident's Seroquel. The resident was seen by the Psychiatric Nurse Practitioner on 3/11/16. The progress note indicated the resident had been sleeping and eating well. Documentation indicated the resident was calm and cooperative and she enjoyed		Pharmacy recommendations for past 90 days have been audited. Those recommendations that were not documented with a response from the physician have been resubmitted to the physician to be addressed. **3) Measures put into place/ System changes:** AIMS due will be reviewed weekly to ensure completed. Any identified as incomplete will be completed at the time identified. Pharmacy recommendations for GDRS will be submitted to the physicians for their review. Upon receipt of physician response orders will be transcribed into PCC and the signed recommendations will be given to DON or designee and audit will be conducted 3 times per week until all are completed each month to ensure that a physician's response is documented for each recommendation. Director of Nursing is responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.	

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	staying in her room and watching television. There was no documentation related to the resident's medications and/or a possible gradual dose reduction. The Behavior detail report for the months of March 2016 and April 2016 were reviewed. The resident had no behaviors for the weeks ending 3/4/16, 3/11/16 and 3/25/16. The week ending 3/18/16, indicated the resident had two episodes of kicking, hitting, and yelling and one episode of threatening behavior. The resident had one episode of yelling for the weeks ending 4/1/16 and 4/22/16. The resident had no behaviors for the weeks ending 4/8/16 and 4/15/16. Behavior/Mood Charting was completed on 3/6/16 related to the resident being verbally and physically aggressive. No Behavior/Mood Charting was completed for the month of April 2016. Review of the Assessment section in the electronic medical record indicated no AIMS (abnormal involuntary movement) scale had been completed related to the resident's Seroquel. Interview with Social Service Staff #2 on 6/10/16 at 11:55 a.m., indicated Psychoactive Medication Meetings were		**5) Date of compliance:** 7/10/2016	

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	held to monitor behaviors, medications, and gradual dose reductions. She indicated she kept a log for herself and then a psychoactive medication meeting note was to be completed under the assessment section in the computer. She also indicated behaviors were coded in the computer by the CNAs and if there was a behavior, they were to tell the Nurse and the Nurse was to fill out a Behavior/Occurrence form. She indicated the behaviors should mirror what was input into the computer. The Psychoactive Medication meeting notes were reviewed and indicated the following: 12/23/15 resident with exit seeking behaviors but more easily directed 3/23/16 resident stating roommate stealing from her. Resident has pain from kidney stones. No changes-review next month. Dementia with agitation and aggression. 5/25/16 resident resisting care, has verbal aggression. Psych to review. The last psychoactive medication observation note completed in the computer was on 12/23/15.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the Director of Nursing on 6/10/16 at 2:00 p.m., indicated the resident was due for a gradual dose reduction of her Seroquel in May 2016. She also indicated behaviors should have mirrored what was put in the care tracker and a psychoactive medication note should have been completed in the computer as well as an AIMS scale. 3. The record for resident #56 was reviewed on 6/8/16 at 3:01 p.m. The resident's diagnoses included, but were not limited to, alcohol induced persisting dementia, affective mood disorder, dementia with behaviors, and anxiety. The Quarterly Minimum Data Set (MDS) assessment completed on 5/18/16, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 3 indicating the resident had severe cognitive impairment. The resident's diagnoses included, but were not limited to, anxiety, depression, and unspecified mood disorder. The medications included, but were not limited to, antipsychotics and antidepressants. The current Care Plan indicated the resident was at risk for adverse reactions/side effects related to psychotropic medication use. The interventions included, but were not limited to, attempt and document			

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	non-drug interventions, monitor effectiveness, and observe for adverse reactions. There was no documentation related to an Abnormal Involuntary Movement Scale. The 2/2016 Physician's Orders, indicated Seroquel (an antipsychotic medication) 12.5 milligrams (mg) everyday and 25 mg every evening. The 6/2016 Physician's Orders indicated, Seroquel (an antipsychotic medication) 100 milligrams (mg) every evening dated 3/22/16. The Behavioral Health Visit notes dated 3/2016 to 6/2016 indicated no documentation related to the increased Seroquel from 25 mg every evening to 100 mg every evening. The Nursing Progress notes dated 3/2016 to 6/2016 indicated no documentation related to the rationale for the increase in Seroquel. The Psychoactive Medication Observation notes indicated no documentation related to the rationale for the increase in Seroquel. The observations were completed by the Pharmacist, Psych Nurse, Assistant			

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	Director of Nursing, and Social Services. Interview with Social Service Employee #2 on 6/10/16 at 4:40 p.m., indicated during the 2/24/16 Psychoactive Medication Observation meeting, the discussion included the resident's Seroquel 12.5 mg being discontinued on 2/17/16 and the Gradual Dose Reduction was a failed attempt. Interview with the Director of Nursing on 6/10/16 at 1:59 p.m., indicated there was no documentation related to the increase in Seroquel from 25 mg every evening to 100 mg every evening. 4. Resident #75's record was reviewed on 6/9/16 at 9:49 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, psychosis and depression. The Annual Minimum Data Set assessment dated 3/10/16, indicated the resident had received antipsychotics in the last 7 days, the resident was cognitively impaired and had no behaviors. The June 2016 Physician's Order Summary, indicated the resident was to receive Seroquel (an antipsychotic medication) 37.5 mg (milligrams) at bedtime.			

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The June 2016 Medication Administration Record, indicated the Seroquel was given as ordered and the dose had not changed since 5/21/15.

The Pharmacy Recommendation sheet dated 2/24/16, indicated a recommendation of a trial dose reduction of Seroquel to 25 mg at bedtime.

The plan of care dated 4/6/15 and reviewed in March 2016, indicated the resident was at risk for adverse side effects of psychotropic medications. The interventions included, but were not limited to, GDR (gradual dose reduction) as indicated.

Interview with the Director of Nursing (DON) on 6/9/16 at 2:26 p.m., indicated the Seroquel gradual dose reduction (GDR) did not happen and she was unaware as to how it was missed since it was sent to the Physician for review. The DON further indicated recommendations were monitored monthly by the Assistant Director of Nursing (ADON), Social Services, the Pharmacy and the Psychiatric Nurse Practitioner. She further indicated there was no GDR follow through in the monthly meetings.

The policy titled, "Psychotropic Drug

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	Therapy" was provided by the DON on 6/10/16 at 5:44 p.m. This current policy indicated, "...5. Any resident receiving psychotropic medication will be assessed by a physician and/or psychiatrist for drug reduction program. The staff nurse will receive a physician order for psychotropic medication dosage...6...The pharmacist will report any irregularities to the DON. The DON will notify or direct licensed staff to notify the attending physician as necessary...8. Residents on anti-psychotropic drug therapy will be monitored for tardive dyskinesia side effects every 6 months through the use of the AIMS scale...." The policy titled, "Medication Monitoring" was provided by the DON on 6/10/16 at 5:44 p.m. This current policy indicated, "...b. Comments and recommendations concerning drug therapy are communicated in a timely fashion...c. The consultant pharmacist and the facility follows up on his/her recommendations to verify that appropriate action had been taken...." 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(2)			

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F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post the Scheduled Nurse Staffing sign in a prominent, readily accessible location for	F 0356	**F356**	07/10/2016

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	the residents and failed to include the time frame for actual hours worked for 4 of 5 Units of the 5 units in the facility. (The Rehab, Elm, Maple, and Linden Units) Findings include: 1. On 6/10/16 at 4:20 p.m., the Scheduled Nurse Staffing sign was observed on the counter of the receptionist's desk at the front entrance of the Manor building. The sign was also observed at the front entrance to the Pines North Unit. The two posted signs did not display the time frame for the actual hours worked for each shift. 2. On 6/10/16 at 4:30 p.m., there were no signs observed to be prominently posted for the residents on the Rehab, Elm, Maple, and Linden units. Interview with the Director of Nursing on 6/10/16 at 4:51 p.m., indicated she was not aware the staffing sign was to be posted on the Rehab, Elm, Maple, and Linden Units. She was also not aware the time frame for the actual hours worked was to be indicated on the staffing sign. 3.1-17(a)		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** All residents, families and visitors have the potential to be affected by this alleged deficient practice.	

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			3) Measures put into place/ System changes: This facility had recently implemented an updated nurse staffing information sheet and postings at both main entrances to the community as was reviewed and approved by the State Department of Health on 5/26/2016 and was maintaining that guidance. This community has revised the nurse staff posting sheet to the current recommendations and is posting this posting sheet on each unit of the facility. Audits will continue for monitoring of correct daily posting on all units 3x per week. Results of these audits will be reported to the Administrator/designee weekly for any concerns of non-compliance. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	

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F 0363 SS=E Bldg. 00	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect the 6 residents in the facility who received a puree diet. (The Main Kitchen) Finding includes: On 6/8/16 at 9:27 a.m., during the Chicken Stew puree preparation, the following was observed: Cook #1 placed 5 cups of already prepared Chicken Stew into a blender and then blended the mixture until it was a mashed potato consistency. The Cook then added 20 ml (milliliters) of Thick-it powder to the mixture, blended again, then added an additional 7.5 ml of thick-it powder to the same mixture. Review of the Chicken Stew recipe, indicated the chicken stew was to be placed in the food processor and blended until smooth. The recipe did not indicate	F 0363	**F363** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	07/10/2016

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	Thick-it powder was to be added to the stew. Interview with Cook #1 on 6/8/16 at 10:54 a.m., indicated the Thick-it and the amount she added was due to her experience as a cook. She indicated the Thick-it was not listed on the recipe. Interview with the Dietary Manager on 6/9/16 at 11:35 a.m., indicated the recipe lacked the information on how to thicken the chicken stew. The Dietary Manager further indicated the current policy lacked the amount and which thickening agent to use to thicken recipes. 3.1-20(i)(4)		No residents were identified in this citation. **2) How the facility identified other residents:** Residents who eat soups or stews that require a thickened diet have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Menus are prepared and printed by an outside vendor for this community. Vendor has been contacted about this concern and will address this change in upcoming menu change. The Registered Dietitian has been notified of this concern and will make dietary recommendations to follow until the menus can be reprinted. The Cook staff will be in-serviced on the RD recommendations. Dietary Manager/Registered Dietitian will review all menus for thickening instructions of menu items to ensure instructions are included in the menu guide.	

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			Items found in non-compliance will be reported to the vendor for preparing our menus and to the Quality Assurance Committee for review and recommendations. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to serve and prepare food under sanitary conditions related to the placement of the ice scoop and improperly sanitizing a measuring cup for 1 of 1 kitchens and 1 of 4 dining rooms. (The main kitchen and the Rehab	F 0371	**F371** **The facility requests paper compliance for this citation.**	07/10/2016

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	dining room) Findings include: 1. On 6/6/16 at 11:56 a.m., CNA #4 was observed filling ice into plastic cups for residents in the rehab dining room. After filling the cups with ice, the CNA threw the ice scoop into the ice machine and left it there. On 6/6/16 at 2:13 p.m., the ice scoop was still observed laying directly in the ice machine. Interview with Dietary Food Manager (DFM) on 6/10/16 at 4:00 p.m., indicated the ice scoop was not supposed to be laying directly in the ice machine, but should be stored in the scoop holder. The current and undated Ice Machine Use policy provided by the DFM on 6/10/16 at 4:25 p.m. indicated the ice scoop should never be stored in the ice storage bin. 2. On 6/8/16 at 9:27 a.m., during the puree meal preparation with Cook #1, the following was observed: Cook #1 completed the puree of the Chicken Stew, then placed 4 cups of the stew into a measuring cup and transferred the puree into a serving pan. The Cook		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The ice scoop and factory installed scoop holder were removed from the ice bin in the Rehab dining room. A clean scoop was provided in a separate holder on the wall near the ice machine. Cook #1 was re-educated on the policy of properly using the 3 compartment sink. Resident #4 suffered no harm or voiced no concerns from the 3 uncovered drinks. **2) How the facility identified other residents:**	

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	washed the measuring cup in the first section of the three compartment sink, then dipped the cup into the rinse water, and lastly dipped the cup into the third sink, which was the sanitization sink. The cup was then placed on the drying end of the sink. The Cook retrieved another pan and placed it on the preparation table and returned to the table with the previously washed measuring cup. The Cook then scooped out the remaining cup of puree from the blender to the measuring cup and then transferred the puree into a serving pan. Interview with the Dietary Manager on 6/8/16 at 1:27 p.m., indicated the measuring cup was not properly sanitized in the third compartment sink. The policy titled "Sanitizing for Three Compartment Sink" was provided by the Dietary Manager on 6/8/16 at 1:29 p.m. This current policy indicated, "...5. Immerse utensils in sanitizing solution for at least 60 seconds." 3. On 6/8/16 at 8:31 a.m., a room tray was observed to have three uncovered beverages. The tray was being transported from the Pines Unit serving area down the hallway to Room #4. Interview with CNA #10 on 6/8/16 at		All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Staff were in-serviced on placement of ice scoops in holders and not to be stored in the ice bins and coverage of beverages on room trays being transported out of the dining area. Dietary staff were in-serviced on the proper set up and use of the 3 compartment sink and the sanitation process. Dining room managers will observe ice bins located in their dining areas 5 times per week at varied shifts to assure ice scoops are stored properly. Any findings of non-compliance will be reported to the Administrator or Dietary Manager/designee. Dining room manager/nurse supervisor/designee will observe room trays for covered drinks 5 times per week at varied shifts and times. Any findings of non-compliance will be reported to the Administrator/designee and drinks will be re-served and covered. Dietary manager/designee will observe use of the 3 compartment sink for compliance 5x per week. Audits will be reported to the regular QAPI committee meeting.	

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	8:45 a.m., indicated the beverages should have been covered with plastic. Interview with the Dietary Manager on 6/8/16 at 2:45 p.m., indicated the beverages should have been covered. 3.1-21(i)(3)		**4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and	F 0425	**F 425**	07/10/2016

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	interview, the facility failed to ensure the pharmacy provided labeled medications with the resident's name and dosage for 1 of 3 units. (The Rehab Unit) Finding includes: On 6/9/16 at 7:21 a.m., RN #3 was observed preparing medications for a resident. At that time, she removed the respiratory inhaler from the box. There was no label on the inhaler with the resident's name and dosage. Interview with RN #3 at that time, indicated there was no label on the actual inhaler just on the box it was in. The current 6/8/15 revised Medication Labels policy provided by the Director of Nursing on 6/10/16 at 9:30 a.m., indicated labels were permanently affixed to the outside of the prescription container. If a label does not fit directly onto the product, the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container. 3.1-25(a)		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No resident identified. **2) How the facility identified other residents:** Audit of all medications to ensure proper labels in place.	

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	155277	A. BUILDING 00 B. WING	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			3) Measures put into place/ System changes: Licensed Nurses and QMA's were educated on policy for labeling of medications Pharmacy is now sending an additional label when inhalers are delivered that are to be applied to the inhaler when they are removed from their packaging. Audits of varied medication carts will be done a minimum of three times per week to ensure that medications are properly labeled. Non-compliance will be corrected and will be addressed with education/discipline as appropriate. Director of Nursing/designee is responsible for oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016	

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F 0428 SS=D Bldg. 00	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure Pharmacy recommendations were followed related to gradual dose reductions for antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications. (Residents #51 and #75) Findings include: 1. The record for Resident #51 was reviewed on 6/9/16 at 1:54 p.m. The resident's diagnoses, included, but were not limited to, delusional disorder, anxiety, Alzheimer's disease and depressive disorder. A Physician's order dated 12/2/15, indicated the resident was to receive Seroquel (an antipsychotic medication) 200 milligrams (mg) at bedtime. A Physician's order dated 12/3/15, indicated the resident was to receive Paxil (an antidepressant) 20 mg daily.	F 0428	**F428** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for**	07/10/2016

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	The 12/23/15 Psychiatric progress note indicated the resident was calm and cooperative and Social Services reported an improvement in the resident's behaviors since returning to facility following a Psychiatric hospital stay on 11/30/15. The progress note indicated the resident had no reports of verbal outbursts or aggressive behaviors. Documentation indicated the resident was presently taking Seroquel, Paxil and Ritalin. The Psychiatrist felt it was too soon after the resident's medications were adjusted at the Psychiatric facility to evaluate for a possible reduction. A Pharmacy recommendation dated 2/1/16 indicated the resident's sliding scale insulin was addressed. There was no documentation related to the resident's Seroquel. This was the only Pharmacy recommendation provided for 2016. Interview with the Director of Nursing on 6/10/16 at 2:00 p.m., indicated the resident was due for a gradual dose reduction of her Seroquel in May 2016. She indicated she had no recommendations from the Pharmacy related to gradual dose reductions for 2016. 2. Resident #75's record was reviewed on 6/9/16 at 9:49 a.m. The resident's		**those residents identified:** Resident #51 recommendation received for GDR pending MD approval. Monthly documentation of Pharmacist Medication Regimen Review is documented in the resident's progress notes. Resident #75 Recommendation for GDR has been resubmitted to the physician and awaiting physician response. Monthly documentation of Pharmacist Medication Regimen Review is documented in the resident's progress notes. **2) How the facility identified other residents:** All residents that receive psychotropic medications have the potential to be affected. Pharmacy recommendations for past 90 days have been audited. Those recommendations that were not documented with a response from the physician have been resubmitted to the physician to be addressed. Audit done for GDR compliance **3) Measures put into place/ System changes:** Pharmacy recommendations for	

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	diagnoses included, but were not limited to, Alzheimer's disease, psychosis, and depression. The June 2016 Physician's Order Summary, indicated the resident was receiving Seroquel (an antipsychotic medication) 37.5 mg (milligrams) at bedtime. The June 2016 Medication Administration Record, indicated the Seroquel was given as ordered and the dose had not changed since 5/21/15. The Pharmacy Recommendation sheet dated 2/24/16, indicated a recommendation of a trial dose reduction of the Seroquel to 25 mg at bedtime. Interview with the Director of Nursing (DON) on 6/9/16 at 2:26 p.m., indicated the Seroquel gradual dose reduction (GDR) did not happen and she was unaware as to how it was missed since it was sent to the Physician for review. 3.1-25(i)		GDRS will be submitted to the physicians for their review within 72 hours. Upon receipt of physician response orders will be transcribed into PCC and the signed recommendations will be given to DON /designee and audit will be conducted to ensure that a physician's response is documented for each recommendation. DON/designee will audit recommendations 3 times per week until all have been completed for the current month. Director of Nursing/designee is responsible for the oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016 IDR: Facility is able to provide documentation of Pharmacy completion of Medication Regimen Reviews for residents 51 and 75.	

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F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure glucometer strips were dated after opening for 1 of 3 units. (The Timbre	F 0431	**F 431**	07/10/2016

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	Unit) Finding includes: On 6/8/16 at 11:00 a.m., there was an open bottle of glucometer strips observed in the medication cart on the Timbre Unit. RN #2 indicated at that time, she had worked the previous day and ran out of strips before her shift was over and had borrowed some from another unit. RN #2 proceeded to use a strip to test a resident's blood sugar from the open bottle of strips. The LPN indicated she believed the bottle was opened on the evening shift the night before. The insert from the glucometer test strips bottle indicated "To use test strips within 3 months of opening." Interview with RN #2 on 6/10/16 at 11:20 a.m., indicated there were approximately 50 strips in each unopened bottle. She indicated 9 of those strips were used before the bottle was observed with no date after opening. 3.1-25(k)(6)		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Bottle of glucometer strips dated. **2) How the facility identified other residents:** Medication carts checked to ensure that open multi use medications and supplies, including bottles of glucometer strips were dated.	

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			3) Measures put into place/ System changes: Licensed Nurses and QMAS educated on policy for dating multi use medications and supplies, including bottles of glucometer strips when they are opened. Medication cart audits will be done a minimum of three times per week at random times to ensure that open multi use medications and supplies, including bottles of glucometer strips are dated. Any non-compliance will be corrected and will be addressed with education/disciplinary action as appropriate. Director of Nursing/designee is responsible for oversight **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016	
F 0441 SS=E	483.65 INFECTION CONTROL, PREVENT			

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Bldg. 00	SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to maintain proper infection control procedures related to the storage	F 0441	**F 441**	07/10/2016

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	of wash basins and urine collection devices on 2 of 5 units throughout the facility. (Pines Unit and Elm Unit) Findings include: During the Environmental tour on 6/10/16 from 1:58 p.m. through 3:20 p.m., with the Environmental Supervisor, Maintenance Staff #2 and the Administrator, the following was observed: 1. The Pines Unit: a. A wash basin was observed unlabeled and uncovered on the bathroom floor next to the toilet in Room #7. There were four residents who shared this bathroom. 2. Elm Unit: a. In the shower stall of Room #204, a urine collection device was unlabeled and uncovered on the floor. There were two residents who shared this bathroom. b. In the shower stall of Room #209, a urine collection device was unlabeled and uncovered on the floor. There were two residents who shared this bathroom. Interview with the Director of Nursing on		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Room 7 Wash basin removed and disposed of. Room 204 Urine collection device removed and disposed of Room 209 Urine collection device removed and disposed of. **2) How the facility identified other**	

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	6/10/16 at 4:48 p.m., indicated the facility did not have a policy for wash basins or urine collection devices, but she expected them to be clean and covered. 3.1-18(b)(1)		**residents:** Room observations done to determine if any other such items not stored per policy. **3) Measures put into place/ System changes:** Staff educated on proper handling and storage of wash basins and urine collection devices. A minimum of ten rooms per week will be observed on various days and times to ensure that all devices such as wash basins and urine collection devices are properly stored. Any non-compliance will be corrected and will be addressed with education/disciplinary action as appropriate. Executive Director/designee is responsible for oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:**	

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			7/10/2016	
F 0456 SS=D Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review, and interview the facility failed to ensure resident equipment was in good operating condition related to the bath tub on the Rehab unit for 1 of 2 bath tubs in the facility. (The Rehab unit bath tub) Finding includes: On 6/10/16 at 10:30 a.m., CNA #1 indicated there was a bath tub on the Rehab unit, however, she did not know if it worked. At that time, the bath tub was observed in the shower room. The CNA pressed the "on" button but it did not start up. Interview with Maintenance Staff #2 on 6/10/16 at 10:43 a.m., indicated he had been working at the facility for 3 years and the bath tub on the Rehab unit had not been working during that time. Interview with Maintenance Staff #1 on 6/10/16 at 10:51 a.m., indicated the Maintenance Supervisor was on medical leave. He indicated the bath tub was	F 0456	**F456** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	07/10/2016

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	missing the water valve, which he was holding in his hand. He indicated he had no idea if the part had been ordered. Interview with the Administrator on 6/10/16 at 1:55 p.m., indicated he was unaware the bath tub was not functioning. He further indicated he instructed maintenance to order the part. He indicated it was a nice bath tub and could have been utilized by the residents. 3.1-19(bb)		No residents were identified in this citation. **2) How the facility identified other residents:** Any resident that desires a tub bath has the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** The part for the tub was ordered, installed and the tub is in working order. Nursing staff will be in-serviced on the operation and care of this tub. Maintenance department has been in-serviced on the importance of notifying the Administrator/designee of any equipment that is not working properly in the facility. Maintenance department will add any equipment concerns to the work order log and review weekly with the Administrator/designee. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or	

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			until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain an environment that was safe, clean, and in a state of good repair, related to marred and gouged walls and doors, discolored & cracked floors, marred vents & floor registers, cracked ceiling tile, discolored pull cords, dirty wheelchairs, loose cove base, and urine odors on 5 of 5 units throughout the facility. (Pines, Rehabilitation, Maple, Elm and Linden Units) Findings include: During the Environmental tour on 6/10/16, from 1:58 p.m. through 3:20 p.m., with the Environmental Supervisor, Maintenance Staff #2 and the Administrator, the following was observed:	F 0465	**F465 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 75's wheel chair was cleaned. Pines unit: Rm 1, bathroom door was repaired. Rm 2, bathroom walls were repaired and painted, non-skid floor pads were removed, ceiling tiles were replaced. Rm 5, pull cord was replaced, cover plate placed on outlet box. Rm 7, bathroom	07/10/2016

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	1. Pines Unit: a. Room #1 had a marred bathroom door. There were three residents who shared this bathroom. b. Room #2's bathroom had gouged walls, peeling non-skid pads on the floor, a cracked ceiling tile and a ceiling tile with a hole in it. There were two residents who shared this bathroom. c. Room #5's bathroom had a yellow/brown discolored pull cord. In the room, there was a hole in the wall where an old cable box resided. There were three residents who shared the bathroom and two residents who resided in the room. d. Room #7 had a dusty ceiling vent in the bathroom. There were four residents who shared this bathroom. e. In Room #8's bathroom, the door frame was marred and gouged and the floor register was marred. There were two residents who shared this bathroom. f. Room #14's bathroom had a rust stain under the floor register and the register was marred. There were three residents who shared this bathroom.		ceiling vent was cleaned. Rm 8, bathroom door frame was repainted, bathroom floor register was repainted. Rm 14, bathroom floor had rusted area cleaned, the bathroom register was repainted. Rm 17, bathroom floor had rusted area cleaned, the toilet leak was repaired, the bathroom register was repainted, and the toilet was re-caulked. Rehabilitation unit: Rm 156, bathroom floor tile was repaired, room was deep cleaned, Rm 173, floor tile was cleaned in resident room, bathroom door was repaired. Maple unit: Rm 255, floor tile was cleaned, wall by window was repainted, bathroom door was repaired, and toilet was re-caulked. Rm 256, shower stall floor was cleaned. Rm 257, call light bulb was replaced, window sill was repaired, and the walls were repainted. Rm 258, closet doors were repaired, and walls were repainted. Rm 261, wall by air-conditioner was repainted, bathroom door was repaired. Rm 262, bathroom door was refinished, shower base was repainted. Rm 263, bathroom floor was cleaned, toilet base was cleaned, shower edge was repainted, and bathroom door corner was repaired and repainted. Rm 264, room was repainted. Elm Unit: Rm 203, base board near closet was repaired, bathroom door was repaired, and bathroom tile was cleaned. Rm 204, bathroom floor	

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	g. Room #17's bathroom floor had a rust stain underneath the register. The register was marred and there was water leaking around the toilet bowl base. The floor tile behind the toilet had buckled and there was a black substance along the floor by the toilet bowl base. There were three residents who shared this bathroom. 2. Rehabilitation Unit: a. Room #156's bathroom floor tile had pulled away from the seam and was torn. The floor tile by the door had lifted away from the floor. The resident's room also had a strong urine odor by the window. The urine odor was observed on 6/6/16 at 10:39 a.m., 11:49 a.m., 2:26 p.m. and again on the Environmental Tour on 6/10/16. There were no noted spills on the floor. There was one resident who resided in this room. b. Room #173's floor was discolored yellow by the register in the room and the inside of the bathroom door was marred. There was one resident who resided in this room. 3. Maple Unit: a. Room #255's floor tile was discolored by the register and had a marred wall below the window. The inside of the		was cleaned, toilet was re-caulked, and toilet bolt caps were replaced. Rm 207, room walls were repainted, closet doors were refinished, and cove base was repaired. Rm 208, room walls were repainted, bathroom door and closet doors were repaired, toilet bolt caps were replaced, and bed floor mat was replaced. Rm 209, bathroom floor was cleaned, wall by closet was repaired and painted, and bathroom door was repaired. Rm 213, walls were repainted, toilet was re-caulked. Linden unit: Rm 269, bathroom walls were repaired and repainted. Rm 271, walls were repainted, toilet bolt caps were replaced. Rm 275, walls were repainted, wallpaper was repaired. Rm 276, wall was repaired and repainted, wall paper was removed and wall painted, **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged deficient practice. An audit of all resident rooms was completed. Identified concerns have been scheduled for corrections. Wheelchairs were inspected for cleanliness and corrected as identified. **3) Measures put into place/ System changes:** Staff were in-serviced on importance of completing a maintenance request form when they observe any damage/repairs needed so they can be tracked for completion and reporting of any	

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	bathroom door was marred and gouged, and the caulk at the base of the toilet was discolored. There was one resident who resided in this room. b. Room #256's shower stall floor had a yellow discoloration. There were two residents who resided in this room. c. Room #257's room call light bulb was broken with jagged edges, the window sill had cracked caulk, and the walls were marred. There were two residents who resided in this room. Resident #75's wheelchair wheel spokes and brake levers were also dirty and contained visible spilled food debris. e. Room #258 had marred closet doors and black marks on the walls. There were two residents who resided in this room. f. Room #261's wall by the air conditioning/heat unit had a brown/black substance. There were black marks on the walls and the inside of the bathroom door was marred. There were two residents who resided in this room. g. The inside of the bathroom door in Room #262 was marred and the shower edging had two different paint colors. There were two residents who resided in		wheel chairs needed cleaned. Staff were in-serviced on reporting any dirty wheelchairs for scheduled cleaning Maintenance/Housekeeping will maintain logs of work order repairs and review them weekly with the Administrator/designee. Nursing staff will continue to clean wheelchairs on a scheduled basis or as needed. A minimum of 10 wheelchairs will be observed per week to ensure that they are clean. A minimum of 10 resident rooms will be inspected per week to identify any repairs/cleaning that needs to be completed. Guardian Angels have been in-serviced and an audit tool implemented to include audit of resident rooms and resident wheel chairs. Administrator/designee will be responsible for the oversight of these audits. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 7/10/2016	

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	this room. h. Room #263 had stained floor tiles underneath the pipe behind the toilet, the shower's edge and the toilet bowl base had paint scuffs, and the outside of the bathroom door corner had chipped and marred wood. There were two residents who resided in this room. i. Room #264 had black marks on the walls. There were two residents who resided this room. 4. Elm Unit: a. Room #203 had a loose base board next to the closet. The inside of the bathroom door was marred and there were discolored floor tiles underneath the bathroom sink. There was one resident who resided in this room. b. Room #204's bathroom floor tile and the caulk around the toilet was discolored and the phalange bowl caps were missing on the toilet. There were two residents who resided in this room. c. Room #207's walls and closet doors were marred, the edge of the wall by the closet had chipped paint and a loose cove base. There were two residents who resided in this room.			

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	e. Room #208's walls, bathroom door and closet were marred, the caulk at the base of the toilet bowl was discolored, the phalange bowl caps were missing, and the floor mat was discolored. There was one resident who resided in this room. f. Room #209's bathroom floor tile was discolored underneath the sink, the edge of the wall by the closet had chipped paint and was marred, and the bathroom door was marred. There were two residents who resided in this room. g. Room #213's walls were marred, and the caulk at the base of the toilet was discolored. There was one resident who resided in this room. 5. Linden Unit: a. Room #269's bathroom walls were gouged. There were two residents who resided in this room. b. Room #271's walls were marred and the phalange bowl caps were missing. There were two residents who resided in this room. c. Room #275's walls were marred and had peeled wallpaper at the seams. There			

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	were two residents who resided in this room. e. Room #276 had a large hole in the wall behind the bed frame, marred and peeled wallpaper and a marred wall by the closet. There was one resident who resided in this room. Interview with the Administrator, Maintenance Staff #2, and the Environmental Supervisor at the end of the Environmental Tour at 3:20 p.m., indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)			
F 0520 SS=G Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements			

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	appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to identify non-compliance of the facility's Quality Assessment and Assurance protocol related to lack of identifying concerns pertaining to restraints and bruising, as well as continuing to monitor previous issues related to nutrition, accidents, and activities of daily living. Finding includes: Interview with the Director of Nursing on 6/10/16 at 3:23 p.m., indicated the facility's Quality Assurance (QA) Committee met every month and consisted of herself, the Administrator, the Assistant Director of Nursing, Social Service, Dietary, Activities, Pharmacy, and the Medical Director. The DON indicated at the time, restraints were reviewed in the QA meetings, however, they were being looked at the wrong way and a new system needed to be put in	F 0520	**F 520** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	07/10/2016

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	place. The DON also indicated issues related to nutrition, accidents and activities of daily living had been cited on a previous survey and these issues were currently being monitored in QA. The DON indicated audits were being completed and the system needed to be "tweaked" due to recurring issues. She indicated staff had been inserviced but issues were still being found and inservicing was ongoing. Interview with the Restorative Nurse on 6/9/16 at 10:46 a.m., indicated Resident #C had a seatbelt placed due to family request. She indicated the resident could not remove the seatbelt on command, therefore it was a restraint and, since being placed on hospice, the resident was no longer in the restorative program. Interview with the Director of Nursing on 6/9/16 at 1:00 p.m., indicated Resident #C was wearing a seatbelt restraint per the family's request. She further indicated the resident was not on a therapy case load and therapy had not evaluated her for a different positioning device. On 6/7/16 at 11:00 a.m., Resident #11 was observed with bruises to her left forearm, back of the left hand, right forearm and on the back of her right		**1) Immediate actions taken for those residents identified:** Resident C's seatbelt has been discontinued Resident #11's bruising is resolving Resident #3 is being placed into Geri-chair per plan of care daily. Resident #35 discharged home Resident B received shower Identified concerns have been added to QA Action Log **2) How the facility identified other residents:** All residents have the potential to be effected. **3) Measures put into place/ System changes:** Interdisciplinary Team educated on Restraint Policy and Quality Assurance Program. Nursing staff educated on skin assessments, documentation of new skin concerns, supplement documentation, importance of making sure that positioning and safety devices to be in place,	

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	hand. All of the bruises were red/purple in color. On 6/9/16 at 2:55 p.m., the Nurse Supervisor performed a skin assessment to the resident's arms and hands. At that time, she observed 3 red/purple areas to the resident's right arm. The Nurse Supervisor indicated she was unaware of the bruises to the right arms. She indicated the only documentation of the bruising was for the left forearm. The weekly skin observation record dated 6/1/16, indicated there were no skin concerns. Nursing Progress notes dated 6/1/16-6/9/16, indicated there was no documentation regarding any bruising on the resident's right hand and forearm. Nurses' notes dated 6/9/16 at 2:59 p.m., indicated the resident had red bruises to the right forearm 1.5 centimeters (cm) by 0.5 cm. A bruise to the right hand 0.5 cm by 0.7 cm and a bruise to the right wrist 0.5 by 2.5 cm from her watch. Interview with LPN #1 on 6/9/16 at 1:37 p.m., indicated during her shift report she was not given any information regarding any bruising to the resident's right and left arms.		accessing resident's Kardex to check what interventions are on plan of care and shower protocol. During routine meetings any newly identified concerns or trends will be added to the QA Log and an Action Plan will be developed. All items on the QA Log will be reviewed during Quality Assurance Committee Meetings. . **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** 7/10/2016 IDR, this facility does not agree that there was actual harm to resident #35. Facility will provide documentation of resident #35 edema which had dissipated contributing to weight loss, Registered Dietitian notes that breakdown on nutrition and caloric needs and intake were adequate.	

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	On 6/8/16 at 2:09 p.m., Resident #3 was observed lying on her back in bed. The resident had blue and purple bruises to her face and forehead. The resident's bed was in a low position and a long body pillow was observed on the left side. A floor mat was also observed on the left side of the bed and bed bolsters were in use. Review of the resident's Fall assessments dated 3/11/16, 3/13/16, 3/23/16, 5/23/16, 5/29/16 and 5/30/16, indicated the resident was at risk for falls. The plan of care dated 3/16/16, indicated the resident had a potential for falls. The interventions included, but were not limited to, a reclining gerichair for comfort and positioning. A Fall Investigation for the resident dated 6/5/16, indicated the intervention of a reclining gerichair was not in place at the time of a fall on 6/2/16 which was unwitnessed in the dining room at 7:33 a.m. Interview with the Assistant Director of Nursing on 6/10/16 at 11:58 a.m., indicated the resident had fallen out of her wheelchair on 6/2/16 and should have been in a reclining gerichair due to a			

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	history of seizures and recent falls. On 6/6/16 during the noon meal, Resident #35 was served potato soup. At that time, the resident indicated to staff that she would prefer to eat a fruit plate rather than the meal being served. The resident was not offered any super mashed potatoes or other fortified foods during the meal. Interview with the resident on 6/8/16 at 1:45 p.m., indicated she was aware of the recent weight loss she had during her stay at the facility. She indicated she had never been much of a big eater. The resident indicated she does not eat the mashed potatoes all the time, in fact, if she eats a sandwich then she will not eat the potatoes. She indicated she liked the potatoes but did not want them everyday. The record for Resident #11 was reviewed on 6/8/16 at 9:17 a.m. The resident's diagnoses included, but were not limited to, fracture of left femur, copd (chronic obstructive pulmonary disease), high blood pressure, pneumonia, history of falling, muscle weakness, and allergic rhinitis. The current plan of care dated 3/2016, indicated the resident had potential nutritional problems due to diet			

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	restrictions of no added salt and a fracture of the left femur. The Nursing approaches were to monitor food consumption, monitor weight, offer substitutions, honor food preferences, and provide supplements. A Dietary Progress note dated 3/8/16 by the RD, indicated the resident's weight was 135 pounds. The resident indicated she had never been a big eater and her Usual Body Weight (UBW) was 135 pounds. The resident indicated she received enough to eat. The RD indicated the resident's diet meets the estimated needs. The last documented Dietary Progress note by the RD was dated 4/19/16. The RD indicated the resident had a 9% weight loss in one month. Super mashed potatoes were not being served to the resident at lunch and dinner. The RD indicated the resident's food consumption was between 75-100%. The resident was observed eating lunch and indicated she was eating alright. The RD made no further recommendations. Continued record review indicated there was no initial nutritional assessment completed by the RD for the resident which broke down the resident's estimated needs, caloric intake, labs, and			

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	medication review. Nursing Progress notes indicated the resident was being reviewed weekly in the Nutritional at Risk Program (NARP). The NARP progress notes were as follows: 3/8/16 the weekly weight was 137 pounds. The diet was no added salt. Recommendations for weekly weights times 4 weeks. 3/15/16 no documentation of a NARP meeting. 3/23/16 weekly weight was 137 pounds. To follow 3 more weeks. 3/30/16 weekly weight was 137 pounds. To continue with weekly weights. 4/6/16 no documentation of a NARP meeting. 4/12/16 weekly weight was 125 pounds. A 5% loss in one month. Recommend to add super mashed potatoes at lunch and dinner. Weekly weights times 3 more weeks and reweigh the resident. 4/19/16 no documentation of a NARP meeting.			

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	4/26/16 weekly weight was 125 pounds. Continue with super mashed potatoes at lunch and dinner. Weekly weights times 2 more weeks. 5/5/16 weekly weight was 121 pounds. Continue with super mashed potatoes at lunch and dinner. Continue weekly weights one more week. 5/11/16 weekly weight was 119 pounds. Weight down 2.2 pounds in one week and greater than 10% weight loss. Physician made aware. Continue weekly weights times 3 more weeks and current diet. 5/17/16 weekly weight was 120.4 pounds. Continue NARP times 2 more weeks. 5/24/16 weekly weight was 120.4 pounds. Continue NARP times 1 more week. 6/1/16 weekly weight was 120.4 pounds. Transition to monthly weights. Continue with diet and supplements of super mashed potatoes. The weight record was reviewed and documented as followed: 3/7/16 137 pounds 4/12/16 124.5 pounds			

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	4/27/16 121.4 pounds 5/6/16 119.2 pounds 5/12/16 120.4 pounds 6/7/16 118 pounds The super mashed potato food consumption was reviewed for the resident. The information was documented by the CNA staff. The documentation indicated the amount consumed by the resident on certain days was "not applicable". The not applicable consumption was noted in April 2016 for the lunch meal on 4/16/16 and 4/30/16. The not applicable consumption was documented in April 2016 for the supper meal on 4/13-4/15/16, 4/17/16, 4/20-4/24/16, 4/26/16, and 4/28-4/30/16. The resident had refused the potatoes on 4/15/16, 4/17/16 and 4/25/16 for the lunch meal and 4/18/16 and 4/19/16 for the supper meal. The 5/2016 supplement consumption was reviewed. The not applicable consumption was documented for the supper meal on 5/2/16, 5/4/16, 5/11-5/14/16, 5/16/16, 5/18/16, 5/21-5/24/16, 5/26/16, 5/27/16, and 5/30/16. The resident had refused the potatoes on 5/1/16, 5/2/16, 5/4/16, 5/15/16, 5/17/16, 5/23/16, 5/25/16, 5/28/16, and 5/29/16 for the lunch meal			

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	155277	A. BUILDING 00 B. WING	06/10/2016

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	and 5/1/16, 5/6/16, 5/15/16, and 5/17/16 for the supper meal. The 6/2016 supplement consumption was reviewed. The not applicable consumption was documented for the supper meal on 6/2/16, 6/4/16, 6/5/16, 6/6/16, and 6/7/16. The resident had refused the potatoes on 6/5/16 for the lunch meal. Interview with the Dietary Food Manager (DFM) on 6/9/16 at 9:32 a.m., indicated she was involved in the NARP meetings which were held one time a week. She indicated the RD was involved in the NARP meetings when she was at the facility. The DFM indicated the last RD progress note for the resident was dated 4/19/16 and was completed by the old RD and the new RD had not seen her. When asked, the DFM indicated she had personally not interviewed the resident regarding the mashed potato supplement. She indicated she had not reviewed the supplement consumption record and was not aware the resident was not eating the mashed potatoes. The DFM indicated she no longer served health shakes or magic cup ice cream due to they were wasting a lot of them. She indicated everyone with weight loss was placed on fortified foods.			

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	Interview with the Director of Nursing (DON) on 6/9/16 at 9:54 a.m., indicated the NARP meetings were held weekly. She indicated the facility had changed RD's and the new RD was completing training right now. The DON indicated she was unable to find the weekly weights for the resident and questioned the weight as it was the same for several of the weeks in the NARP notes. She further indicated she did not interview the resident regarding the supplement of super mashed potatoes to see if the resident liked them, nor had she reviewed the supplement consumption to see if the resident was eating the potatoes. Continued interview with the DON on 6/9/16 at 2:45 p.m., indicated the supplement consumption of the mashed potatoes were coded as "not applicable" and she did not know why the supplements were documented that way. The DON indicated "not applicable" to her meant they were not served to the resident. She further indicated there was no initial nutritional assessment completed by the RD at the time of admission. Interview with the Administrator on 6/10/16 at 3:30 p.m., indicated the new RD started on 5/17/16 and when the facility gave a 30 day notice to the old			

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	RD company, they immediately left and did not finish the 30 days. The record for Resident #B was reviewed on 6/9/16 at 9:17 a.m. The resident's diagnoses included, but were not limited to, vascular dementia with behavioral disturbance and muscle weakness. The shower schedule was reviewed on 6/9/16 at 1:46 p.m. The schedule indicated the resident received her showers on the Midnight shift on Monday and Thursday. The Bathing sheet for the past 30 days was reviewed. The sheet indicated the resident preferred a shower or bedbath. Documentation on the bathing sheet indicated the resident received a shower on 5/13/16 at 5:53 a.m., 5/24/16 at 5:59 a.m., and on 5/31/16 at 9:10 p.m. Interview with the Director of Nursing (DON) on 6/10/16 at 8:40 a.m., indicated only three showers had been coded as being given. She also indicated "not applicable" had been coded seven times. The DON indicated staff had been counseled related to charting not applicable in the computer related to showers being given. She indicated she talked to the CNA yesterday about how to code showers in the computer and			

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	instructed the CNA to give the resident a shower before she left. 3.1-52(b)(2)			