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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Validation for Subpart S	F 000		
F 278 SS=E	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 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. This REQUIREMENT is not met as evidenced by:	F 278		

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

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Based on interview and record review the facility failed to accurately assess for Subpart S on the quarterly Minimum Data Set (MDS) Assessment for seven of 19 residents (R1, R2, R7, R9, and R22 through R24) reviewed for accuracy of assessments in a sample of 22.

Findings include:

The facility's Recommended Actions to assure Compliance with Subpart S. policy, undated, documents "Identify residents who meet the definition of "serious mental illness" as defined under 300.4000b. These are usually residents who have a psychotic or mood disorder who are not substantially impaired by dementia (organic conditions), are not primarily substance abusers and are not impaired by a substantial Physical disability. Utilize a resident roster, especially the type of listing diagnosis provided by the pharmacy."

1.) R1's Medication Resident Profile, dated 8/11/16, documents that R1 has a diagnosis of Traumatic Brain Injury.

R1's MDS Section S State Options, dated 5/2/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements."

2.) R2's Medication Resident Profile, dated 8/11/16, documents that R2 has a diagnosis of Hydrocephalus.

R2's MDS Section S State Options, dated 7/24/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements."

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F 278	Continued From page 2	F 278		

3.) R7's Medication Resident Profile, dated 8/11/16, documents that R7 has a diagnosis of Dementia.

R7's MDS Section S State Options, dated 7/3/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements."

4.) R9's Medication Resident Profile, dated 8/11/16, documents that R9 has a diagnosis of Mental Retardation.

R9's MDS Section S State Options, dated 7/10/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements."

5.) R22's Medication Resident Profile, dated 8/11/16, documents a diagnosis of dementia.

R22's MDS Section S State Options, dated 5/25/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements."

6.) R23's Medication Resident Profile, dated 8/11/16, documents a diagnosis of early onset Alzheimer's with behavior disturbance.

R23's MDS Section S State Options, dated 5/24/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements."

7.) R24's Medication Resident Profile, dated 8/11/16, documents a diagnosis of Mental Retardation.

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F 278	Continued From page 3 R24's MDS Section S State Options, dated 7/3/16, documents, "Resident has met the criteria identified and is eligible for enhanced Medicaid Reimbursements." On 8/10/16 at 4:30 p.m., E1 (Administrator), E2 (Director of Nurses/DON), E3 (Assistant Director of Nurses/ADON), and E4 (Care Plan Coordinator) verified that the MDS should not document eligibility for Subpart S if the residents' diagnoses do not meet the applicability requirements for Subpart S.	F 278		
F 280 SS=D	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.	F 280		

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F 280	Continued From page 4	F 280		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to revise the resident care plan to reflect a significant weight loss for two of 22 residents (R8 and R11) reviewed for care plans in a sample of 22.

Finding include:

The Facility Comprehensive Care Planning Policy, undated, documents "(1.e.), CarePlan-Plan of care describing a need/problem, and indicating approaches/interventions to be instituted to assist the Resident in maintaining/receiving care in relation to the need/problem."

1. R11's Dietary Services Communication, dated 7/27/2016, documents "1.) Observation/Comments:Poor intake at meals, and significant weight loss x 3 months, decrease 8.4%."

R11's Careplan with a current date of 7/14/2016 does not document the significant weight loss of 8.4% in 3 months.

On 8/7/2016 at 12:30 P.M., E5 (Dietary Manager) stated, "R11's CarePlan does not reflect the recent 8.4% weight loss, it should have been updated to show weight loss."

2. R8's Physician Notification of Weight Change dated 7-19-16, states R8 is receiving a regular pureed diet and has had significant weight loss of 8 % in the last 30 days.

R8's care plan dated 7-21-16 documents

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F 280	Continued From page 5 "Potential risk for altered nutritional status and/or weight gain. Resident will not gain 5% of body weight for next 90 days." The care plan does not contain interventions related to R8's weight loss. On 8-11-16 at 9:30 am, E5 (Food Service Supervisor) stated she is responsible for updating the nutrition section of the care plan. E5 confirmed she did not update R8's care plan for weight loss.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to perform hand washing during a dressing change of a pressure sore for one of one resident (R2) reviewed for pressure sores in a sample of 22. Findings include: The facility's Aseptic Wound and Skin Treatment Procedure revised 01/02 documents the following: "Wash your hands, put on gloves, clean the wounds as ordered...remove gloves	F 314		

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F 314	Continued From page 6 and place in plastic bag, wash your hands, put on clean gloves, and apply clean dressing as ordered, using gloves or no-touch technique." On 8/8/16 at 10:20 a.m., E6 (RN/Registered Nurse) completed the following during a dressing change: E6 washed hands and put on gloves, rolled R2 over, pulled down R2's incontinence brief, touched R2's gluteal area, took off gloves, opened R2's door and went to the treatment cart for supplies. E6 returned to R2's room, put gloves on and cleansed R2's pressure sore without washing her hands. E6 continued on with R2's treatment and applied the dressing without changing her gloves and washing her hands after cleansing R2's pressure sore wound. On 8/10/16 at 10:50 a.m., E6 stated she would have taken her gloves off and washed her hands if she had been taking an old dressing off, but not for just cleansing the wound. On 8/10/16 at 11:00 a.m., E2 (DON/Director of Nursing) stated R2 has a healing stage IV pressure sore to R2's gluteal fold. E2 stated R6 should have washed her hands and changed her gloves before she left R2's room and in between cleansing R2's wound and completing R2's treatment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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F 315	Continued From page 7 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to keep a urinary catheter bag off the floor for one of three residents (R9) reviewed with urinary catheters in a sample of 22. Findings include: 1. On 8/9/16 at 9:25 a.m., E10 (CNA/Certified Nursing Assistant) emptied R9's urinary catheter bag and then placed the uncovered catheter bag on the floor while assisting to transfer R9 from the bed to the wheelchair. R9's MDS (Minimum Data Set), dated 7/10/16, documents R9 has a urinary catheter with a history of UTIs (Urinary Tract Infections). On 8/10/16 at 11:00 a.m., E2 (DON/Director of Nursing) stated E10 should not have placed R9's urinary catheter on the floor for infection control purposes/risk of infection.	F 315		
F 329 SS=D	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	F 329		

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F 329	Continued From page 8	F 329		

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.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to accurately monitor a medication according to a physician order for two of 19 residents (R11, R23) reviewed for medication monitoring in the sample of 22.

Findings include:

The facility's policy "Diagnostic Services", undated, documents, "All diagnostic tests must be ordered by the attending physician or the Medical Director...Physician orders will be carried out promptly as ordered."

1. R11's Current Physician's Order Sheet (POS),

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F 329	Continued From page 9 dated 8/1/16 through 8/31/16, has the following diagnoses: Schizoaffective Disorder, Bi-Polar Type, Anxiety and Depression. R11's POS, dated 2/24/2016 thru 2/29/2016, documents to increase Depakote (Mood Stabilizer) to 500 MG (Milligrams) every morning and Depakote 500 mg two tablets every night, and test Depakote level on 3/2/2016. R11's Nurse's notes, dated 2/24/2016 at 10:00 A.M., documents a new order to increase Depakote. R11's clinical record contained no documentation that R11's Depakote level was tested on 3/2/16 as ordered. On 8/9/2016 at 12:20 P.M., E2 (DON/Director of Nurses), stated "The lab for (R11's) Depakote level that was ordered to be drawn for 3/2/2016 was not drawn." 2. R23's Physician Order Sheet (POS), dated 8/1/16 to 8/31/16, documents that R23 is on Depakote 500mg for a diagnosis of Bipolar disease. On this same POS, R23's physician ordered "Depakote level every 3 months." The lab results in R23's clinical record documents the Depakote level (Valproic acid) was tested on 12/11/15 and 6/9/16. On 8/11/16 at 10:05 a.m., E2 (DON/Director of Nursing) confirmed that R23's Depakote level was to be drawn every three months and stated "There are no more labs for (R23)."	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 10 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to perform hand washing and glove use in a manner that prevents food contamination; failed to date potentially hazardous food items stored in the coolers and freezers; failed to keep food items covered and off the floor in the dry storage room; and failed to keep kitchen counters and shelves free from crumbs and food debris. These failures have the potential to affect all 110 residents living in the facility. Findings include: 1. The facility Hand Washing Policy, revised 10/09, states, "Hand washing is to be done: After contact with soiled or contaminated articles...After handling soiled equipment or utensils...During the food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks." On 8/9/16 at 12:00 p.m., E12 (Dietary Cook) was plating the resident lunch meal with gloved hands.	F 371		

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E12 stepped away from the serving line and opened a drawer to get a scoop wearing the same gloves. Without removing gloves, E12 resumed plating resident lunches, using E12's fingers to assist scoop the noodles out of the serving utensil and pressing the food with E12's finger to spread the food out on the plate.

On 8/9/16 at 12:00 p.m., after witnessing E12 touch the food, E5 (Dietary Manager) stated, "After (E12) stepped away with gloved hands to open the drawer for a new scoop, (E12) should've removed his/her gloves, washed hands, and applied new gloves if she/he was going to keep directly touching food to scrap it out of the scoops."

2. The facility Refrigerator and Freezer Storage Policy, revised 10/09, states, "2.) Mark container with name of item. Mark the date that the original container is opened or date of preparation. 3.) Label refrigerated, potentially hazardous food prepared and held for more than 24 hours with the day/date by which the food shall be consumed or discarded (maximum of seven days from time of preparation)."

On 8/8/16 at 6:30 a.m., during initial tour with E5 (Dietary Manager), the walk-in cooler had a full, deep pan of cheesy rice covered with foil, unlabeled and undated, and a rack holding full sheet pans of various desserts that were uncovered, undated and unlabeled; the reach-in freezer had an open bag of pre-formed and pre-cooked pizza crusts, undated and unlabeled; and, the reach-in cooler had an uncooked roll of sausage wrapped in foil, unlabeled and undated, and a quarter-sized, deep pan of mechanically altered hot dogs, unlabeled and undated.

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On 8/8/16 at 6:30 a.m., E5 (Dietary Manager) stated, "Everything in the coolers and freezers should be covered, labeled and dated."

3. The facility Storage Policy, revised 6/06, states, "3. Shelves in all areas shall be kept at least six inches off the floor...6. When using only part of a product, the remaining product should be in the original package or air tight container, and labeled and dated."

On 8/8/16 at 6:30 a.m., during initial tour with E5 (Dietary Manager), the dry storage room had three boxes of bread sitting directly on the floor and an open five gallon bucket of rice, uncovered, sitting directly on the floor.

On 8/8/16 at 6:30 a.m., E5 (Dietary Manager) stated, "Nothing should be on the floor in the dry storage room. I've been looking all morning for the rice bucket lid. I'm not sure where it is at, but the rice shouldn't be left open on the floor."

4. On 8/8/16 at 6:30 a.m., during initial tour with E5 (Dietary Manager), the following areas had excessive crumb and debris on the surfaces of food preparation areas and/or areas where ready-to-use cooking equipment/supplies were stored: the shelf below the cooks' counter where clean, ready-to-use pans were kept for cooking, the table next to the oven where the open foil container was located, and the shelf under the steam table where clean, ready-to-use pan lids were stored. The shelf above the stove top had crumbs, debris and grease build-up and there was a hard, crusted reddish-brown substance dripping down the front of the oven door. The can opener had red debris on the blade and near

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F 371	Continued From page 13 the crank component of the can opener. On 8/8/16 at 6:30 a.m., E5 (Dietary Manager) stated, "It looks like the weekend shifts didn't complete their cleaning responsibilities/tasks this weekend...The can opener should be cleaned after use and on an as needed basis." The Kitchen Cleaning Schedule, undated, provided by E5 (Dietary Manager), guides staff to clean stove top and shelf and shelves under cooks counter on Saturday(s), and shelf where foil sits on Sunday(s). The Centers for Medicare and Medicaid Services "Resident Census and Conditions of Resident", form 672, completed by the Facility on 8/8/16 lists 110 residents are living in the facility.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT 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	F 441		

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	146097	A. BUILDING _____ B. WING _____	08/11/2016

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(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.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to perform hand hygiene and proper glove use during resident cares for five of eight residents (R2, R8, R11, R23, and R24) reviewed for infection control in the sample of 22, and one resident (R28) on the supplement sample.

Findings include:

1. The facility's policy "Perineal Cleansing", dated 9/21/10, documents "The basic infection control concept for peri-care is to wash from the cleanest to the dirtiest area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items."

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On 8/10/16, at 9:30 a.m., E8 and E9 (both Certified Nursing Assistants/CNA's) provided incontinence care for R23. With gloved hands, E8 lowered R23's soiled incontinence brief then cleansed R23's perineal area. R23 wiped the meatus and then the outer labia using the same area of the soapy washcloth when cleansing and the same area of the rinse washcloth. With the same soiled gloves, E8 touched R23's skin to assist to turn, removed soiled brief, and cleansed R23's rectal area. With the same soiled gloves, E8 assisted R23 to turn onto R23's back, dried R23's perineal area, and put R23's pants and shoes on R23. With the same soiled gloves, E8 then touched R23's bare hands to assist R23 to standing position, applied a gait belt, and adjusted R23's gown. E8 and E9 placed a clean incontinent brief on R23 and assisted R23 to a wheelchair. With the same soiled gloves, E8 removed the gait belt and R23's gown, then cleansed R23's armpits and applied deodorant. E8 emptied the bath basin in sink and then removed E8's soiled gloves.

On 8/10/16, at 9:45 a.m., E8 stated that E8 normally performs incontinence care in this manner and stated "If there is a lot of (stool) I would change my gloves."

2. The Facility Policy named Aseptic Wound And Skin Treatment Procedure, revised 01/02, documents the following: "To prevent contamination of the wound and to protect wound from mechanical injury. To stimulate, restore, and promote circulation and healing. To prevent further deterioration of skin tissue, to prevent necrosis of deeper body structures, and to promote resident comfort. Procedure: 10.) Remove gloves and place in plastic bag. 11.)

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Wash your hands. 12.) Put on clean gloves. 13.)Clean the wound as ordered. Clean from center outward, never going back over area, which has been cleaned. 14.) Place soiled sponges used for cleaning wound in the plastic bag. 15.) Remove gloves and place in plastic bag. 16.) Wash your hands. 17.) Put on clean gloves. 18.) Apply clean dressing as ordered, using gloves or no-touch technique. 19.) Remove gloves and discard in plastic bag."

R11's PCP (Primary Care Physician) Chronic Care Note, dated 8/1/2016, documents, "Neck Wound, R11 did have surgery for a wound on her neck that was debrided."

R11's Treatment Record, dated 8/1/2016 thru 8/31/2016, documents, "Change dressing on neck daily. Cleanse with wound cleaner and apply specialized dressing cover with gauze."

On 8/9/2016 at 12:30 P.M., E15 (LPN/Licensed Practical Nurse) performed wound care to R11's back of neck by removing soiled dressing. R11 had a 2 x 3 CM (Centimeter) oval wound with small amount of dark yellow drainage noted on dressing, periwound is red, no odor noted. E15 cleansed the wound and removed excessive dry drainage from wound, then proceeded to apply specialized dressing to wound using the same gloves that E15 used for cleansing wound.

On 8/9/2016 at 12:50 P.M., E15 (LPN) stated, "Yes, I used the same gloves to apply clean dressing to R11's wound, that I used to clean the wound. The gloves were not changed."

On 8/10/2016 11:50 P.M., E2 (DON/Director of Nurses) stated, "I expect the nurses to change

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the gloves after cleansing a wound, prior to applying a clean dressing."

3. The facility's Medication Administration Policy, dated revised 10/07, documents "Avoid touching medication. If contact with the medication is likely, prepare medications using gloves...Appropriate hand washing or use of an alcohol based gel must be performed throughout the medication pass...After touching an oral medication during administration...After touching any inanimate object possibly contaminated with microorganisms. Handwashing between every resident is not required according to the CDC guidelines. It is acceptable to use an antiseptic gel type solution between residents."

On 8/8/16 at 7:34 a.m., E6 (Registered Nurse) prepared R8's crushed medications. E6 fed R8's medication to R8 in pudding. E6 then prepared and gave R24's medication. E6 did not perform hand hygiene during the medication pass.

On 8/8/16 at 7:45 a.m., E6, verified that E6 did not perform hand hygiene during medication pass. E6 stated that E6 did not know what the hand hygiene policy was for medication pass.

On 8/9/16 at 3:30 p.m., E7 (Registered Nurse) was preparing R28's medication. E7 dropped R28's Lorazepam 2 milligram tablet onto the top of the medication cart. E7 picked up R28's tablet with E7's bare hands, placed it back into the medication cup, and gave the medications to R28.

On 8/9/16 at 3:35 p.m., E7 verified that E7 should have disposed of the medication and retrieved a new tablet from R28's medication card.

On 8/10/16 at 3:30 p.m., E2 (Director of Nursing) verified that hand hygiene should be performed in between residents during medication pass. E2 also verified that E7 should have disposed of the

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F 441	Continued From page 18 dropped tablet and given a new one. 4. The facility's Handwashing policy revised 12/08 states "All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions." On 8/9/16 at 1:30 p.m., E11 (CNA/Certified Nursing Assistant) emptied R2's urostomy bag, repositioned R2 in bed, pulled up R2's covers, took off her gloves, and touched R2's doorknob before washing her hands. On 8/10/16 at 11:00 a.m., E2 (DON/Director of Nursing) stated E11 (CNA) should have removed her gloves and washed her hands after emptying the urostomy bag and before she touched anything else.	F 441		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all employees were trained for proper use of fire extinguishers. This has the potential to affect all 110 residents residing in the	F 518		

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facility.

Findings include:

The facility's Fire Extinguisher Inservice Attendance sheet, dated 11/25/15 at 2:00 .m., documents 47 employee signatures for attendance, including E16 (Maintenance Director).

On 8/11/16 at 12:50 p.m., E1 (Administrator) stated that there were 70 staff members employed at the time of the Fire Extinguisher Inservice on 11/25/15 and that 47 of the 70 staff attended.

On 8/9/16 at 10:55 a.m., E16 (Maintenance Director) stated "Fire extinguisher drills are done every year. Corporate won't let us make it mandatory."

On 8/9/16 at 11:00 a.m., E1 (Administrator), stated that the fire extinguisher drill on 11/25/15 should have covered all staff. E1 stated "We need to offer a second opportunity and encourage it."

The Centers for Medicare and Medicaid Services "Resident Census and Conditions of Resident", form 672, completed by the Facility on 8/8/16 lists 110 residents are living in the facility.