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F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	Annual Licensure and Certification Survey 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement preventative fall interventions and failed to implement post fall interventions to prevent fall reoccurrence for two of four residents (R1, R15) reviewed for falls in a sample of 11. Findings include: 1. On 9/15/15, at 10:20am, R15 sat in a wheelchair with an orthopedic boot to the left lower foot. On 9/15/15, at 10:20am, R15 stated the boot was applied on 9/14/15 because of an injury incurred after a fall. R15 stated he fell in the bathroom when transferring independently from the toilet back to the wheelchair because the wheelchair wasn't close enough. R15 stated he didn't require staff assistance to transfer until the last fall. The Minimum Data Set dated 8/10/15 documents R15 as cognitively intact and requiring extensive	F 323		

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

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F 323	Continued From page 1 assistance of one staff person for transfers. The Fall Analysis Log October 2014 documents R1 with an incident on 10/29/14. The Fall Analysis Log June 2015 documents R15 with an incident on 6/8/15. On 9/16/15 at 10:10am, E2 (Director of Nursing) stated on 10/29/14 R15 was found on the floor of the bathroom by the toilet. E2 stated the root cause of R15's fall on 10/29/14 was weakness and not asking for staff assistance; R15 was re-educated and a physical therapy evaluation was completed. E2 stated on 6/8/15 R15 was found sitting on the bathroom floor after transferring without assistance and missed the wheelchair. E2 stated the root cause of the fall was R15 refusing to ask for help; R15 was re-educated on safety. The SBAR (Situation, Assessment, Background, Request) form, dated 9/2/15 at 7:55pm, documents R15 fell and was found sitting on the floor in front of the toilet; the assessment documents R15 slipped while transferring. The SBAR form, dated 9/5/15 at 3pm, documents R15 fell in the bathroom attempting to transfer without assistance from the toilet to the wheelchair; the assessment documents R15 with decreased strength to get up from toilet and low blood pressure. The SBAR form, dated 9/6/15 at 6:30pm, documents R15 was found yelling for help and R15 was found on the floor in the bathroom and reported to have hit head on the floor. The SBAR documents the things that make the condition worse are "R15 doesn't ask for assistance". The SBAR documents a physician order to send R15 to the hospital for evaluation and treatment of	F 323		

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three recent falls and low blood pressure. The Nurse's Notes document R15 returned to the facility on 9/9/15. The hospital Discharge Summary, dated 9/9/15, documents R15's hospital diagnoses to include Congestive Heart Failure, Hypertension, and Urinary Tract Infection.

The SBAR form, dated 9/12/15 at 12:45pm, documents R15 as transferring without assistance from the toilet and became weak and unable to support self incurring a fall; R15 was reinforced to ask for assistance to bathroom.

The Nurse's Notes 9/13/15 at 8:30am document "(R15) states no pain from fall yesterday...this am woke up with pain to the left foot and ankle. Hurts to put weight on it and not able to transfer self without pain and required more help. No discoloration....MD (physician) contacted....X-Ray of LLE (left lower extremity)."

The Left Tibia and Fibula Radiology Report, 9/13/15, documents R15 with a recent hairline fracture of the proximal fibula.

The Nurse's Notes, dated 9/14/15, document R15 returning from physicians office with a orthopedic boot and to assist with transfers.

The Nurse's Notes, dated 9/14/15, completed by E2 (DON), documents the interdisciplinary review of the 9/12/15 fall was completed and the root cause was determined to be R15 transferring without assist; interventions to use a mechanical lift to transfer and a pressure pad alarm was added to the wheelchair.

On 9/16/15 at 10:10am, E2 stated R15 doesn't want to wait for help and doesn't want to ask for

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it. E2 stated that on 9/2/15 at 7:55pm R15 transferred self without assistance to the bathroom and when transferring back to the wheelchair R15 missed the wheelchair and was found sitting on the floor; the root cause was refusing to ask for staff assistance with an intervention to re-educate on safety. E2 stated that on 9/5/15 at 3pm, R15 transferred to the toilet from the wheelchair without assistance and was found sitting on the floor; the root cause of the fall was low blood pressure and transferring without assistance. E2 stated the interventions implemented after R15's fall on 9/5/15 were to notify the physician, medication was changed and the blood pressure was monitored. E2 confirmed no interventions were implemented to address R15 transferring without staff assistance. E2 stated that on 9/6/15 at 6:30pm, R15 transferred without assistance from the toilet to the wheelchair and was found sitting on the bathroom floor. E2 stated the root case was weakness and low blood pressure with interventions to send R15 to the hospital for evaluation. E2 stated that on 9/12/15 at 12:45pm, R15 transferred without staff assistance from the toilet to the wheelchair and was found on the floor in the bathroom. E2 stated that R15 didn't complain of pain until 9/13/15 in which a X-Ray was ordered and a fracture of the proximal fibula was found. E2 stated the root case of R15's fall on 9/12/15 was transferring without assistance of staff, weakness and refusing to ask for help with interventions added to use a mechanical left for transfers and a sensor pad was added to R15's wheelchair. E2 stated R15 had a pattern of falls in September and an overall pattern of transferring without assistance from the toilet to the wheelchair. E2 stated R15 was re-educated multiple times to call for assistance prior to transferring. E2 confirmed

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R15 was a 2 person transfer per the care plan. E2 stated R15's falls were a re-education issue and, "this shouldn't be a problem but obviously it was." E2 confirmed no interventions were placed in September prior to R15's fall on 9/12/15 to address R15's compliance with safety and safe transfers related to weakness except re-education after the 9/2/15 fall.

The Fall Risk Assessments, completed 6/8/15, 9/2/15 and 9/9/15, all document R15 at risk for falls.

The Care Plan dated 8/19/15 documents R15 with self care deficits requiring assist of two due to senile dementia, impulse control disorder and "frequently incontinent of urine and tries to take self to the toilet." R15 is documented with interventions of an assist of two staff to transfer R15.

The Care Plan dated 8/19/15 documents R15 at high risk for falls due to a history of falls, poor balance, frequently incontinent of bladder and bowel with interventions to include encourage resident to ask for assistance which was added to as an intervention on 8/11/13; the last intervention added to this fall care plan is dated 5/18/15 to use the sit to stand lift as needed.

The facility policy Fall Prevention, undated, documents the policy is to provide for resident safety and to minimize injuries related to falls. All falls will be discussed and any new interventions will be written on the care plan.

2. The Physician Order Sheet (POS), dated 9-1-15 to 9-30-15, documents R1 with diagnoses of Psychosis, Agitation, and Alzheimer's with

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Dementia. R1's same POS documents "Safety Devices: tab alarm on bed/chair. Treatment Orders: Pressure alarmed chair".

R1's Treatment Administration Record (TAR), dated 9-1-15 to 9-30-15, documents "7-1-15, Tab alarm to bed."

R1's Care Plan, dated 8-3-15, documents "Resident has risk factors that require monitoring and intervention to reduce potential for self injury...A) pressure pad alarm to bed and chair."

On 9-16-15, periodically from 8:10 am to 1:25 pm, R1 was seated in a wheelchair in various areas of the facility with no alarm device.

On 9-16-15, at 1:35 pm, R1 sat in a wheelchair; an unattached sensor alarm cord was dangling from R1's wheelchair seat. On 9-16-15, at 1:37 pm, E7, Registered Nurse (RN) removed R1's alarm device from R1's bed and attached it to the dangling sensor pad cord and stated "(E7) should have a sensor pad hooked up."

On 9-16-15, at 1:40 pm, E7 reviewed R1's Treatment Administration Record (TAR) and stated "(R1) only needs it while in bed" and removed the alarm from his wheelchair.

On 9-16-15, at 3:55 pm, R1 received cares by E8 and E9, Certified Nursing Assistants (CNA) and had been placed into a wheelchair. E8 attached an alarm to the dangling sensor pad cord on R1's wheelchair and stated "(R1) is supposed to have the sensor pad on (R1's) wheelchair. I also like to use the personal alarm", as E8 attached a personal alarm device to the back of R1's shirt.

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F 323	Continued From page 6 On 9-16-15, at 4:00 pm, E9 stated "(R1) has the sensor pad alarm on all the time on his wheelchair."	F 323		
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 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 observation, interview, and record review the facility failed to identify target behaviors, to ensure implementation of gradual dose reduction, and to assess, monitor and	F 329		

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evaluate the continued need for psychotropic medication usage for one of three residents (R21) reviewed for psychotropic medication usage in a sample of 11.

Findings include:

The facility Face Profile Sheet documents R21 was admitted to the facility on 4/9/2012.

The Physicians Order Sheet (POS), dated September 2015, documents R21 has diagnoses of Huntington's Disease, Schizophrenia, Anxiety, Depression, and Mood Disorder. The POS documents R21 receives Depakote ER 1000 mg every evening for Mood Disorder, initiated 7/18/2013; and Seroquel 50 mg every evening for Schizophrenia, initiated 8/8/2013.

The Psychotropic Medication Quarterly Evaluation, dated 8/3/2015, documents Seroquel is used for a target behavior of criminal history, refusal of assist, non compliance with safety; Depokote is used for a target behavior of mood swings. Both medications document that R21 appears controlled.

The Behavioral Monitoring Records, dated March 2015 through September 2015, document the Target Behavior monitored by staff are "History of Suicidal Ideation and Unhappy with diagnosis of Huntington's Disease." There were three behaviors documented for R21: 9/9/2015 - yelled /grabbed nurse, 9/10/2015- refused to participate in activities, and 9/11/2015 - refused to get out of bed. No other behaviors were documented for the six month period.

R21's Progress Notes, dated 5/15/2015 through

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9/7/2015, document one behavior on 9/6/2015 at 6:00 AM, "(R21) cursing at staff", with no other behaviors documented.

On 9/17/2015 E2, Director of Nursing (DON) stated " all behaviors are documented on the Behavior Monitoring Record or in the progress notes. The staff should be looking for crying and sadness for behaviors. The current target behaviors documented on the Behavior Monitoring Record are diagnoses not behaviors. I'm not sure staff know what needs to be documented."

On 9/15/2015 at 10:00AM and 1:50PM, 9/16/2015 at 10:30AM and 1:00PM and 9/17/2015 at 1:50PM, R21 was lying on the bed watching television. R21 was in the dining room for lunch at 12:00PM on 9/15/2015 and 9/16/2015. R21 did not display any behaviors during the survey.

On 9/17/2015 at 9:45AM, E6 (Registered Nurse) stated "(R21) has never hit anyone nor is (R21) aggressive that I know of. (R21) cooperates with staff as much as possible, but it is difficult due to (R21's) continued spastic movements. The only thing I have ever seen (R21) do is try to walk behind (R21's) wheelchair and become frustrated that (R21) can't do it any more."

On 9/17/2015 at 9:45AM, E2 (DON) stated "(R21) isolates (R21's) self in the room, becomes frustrated, and never becomes aggressive."

There are no documented psychiatrist or psychologist visits or gradual dose reduction attempts in R21's clinical record.

R21's medical doctor did not document a reason

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F 329	Continued From page 9 for the continued use of Depakote or Seroquel on monthly visit progress notes from May 2015 through August 2015. On 8/17/2015 at 9:45AM, E2 (DON) confirmed there were no psychiatrist or psychologist visits and the medical doctor did not address the continued use of psychotropic medications in R21's clinical record. E2 also stated "I don't know when or if (R21) has ever seen a psychiatrist or psychologist. I don't see any gradual dose reduction attempts for Depokote or Seroquel in the last year." R21's clinical record does not provide evidence the facility is monitoring and tracking behavioral episodes consistently, or evidence the facility has adequate indications for continued use of the psychotropic medications for R21. The facility "Psychotropic Medication Policy", dated 5/30/2014, documents "#7. Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive of property, or emotional problems exist which can cause the resident frightful distress. #8. The behavioral tracking sheet of the facility will be implemented to ensure behaviors are being monitored. #9. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs."	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 10 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. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 11	F 441		

Based on observation, interview, and record review, the facility failed to disinfect a multi-use blood glucose meter between resident use to prevent cross contamination and failed to prevent cross contamination during medication administration. This failure applies to one of 10 residents (R20)reviewed for medication administration in a sample of 11 and two residents (R9, R23) in the supplemental sample.

Findings include:

1. The facility's policy Cleaning and Disinfecting of Glucometer (dated 6-9-10), documents "The blood glucose meters will be cleaned between each resident test to avoid cross-contamination issues. 1. Cleaning and disinfecting with a Germicidal Disposable Wipe will be completed each time the blood glucose meter is used with a pre-moistened towelette."

On 9-16-15, at 11:04 am and 11:08 am respectively, E7, Registered Nurse (RN) performed blood glucose testing for R9 and R23. E7 did not sanitize the glucose meter in between R9 and R23's testing.

On 9-16-15, at 11:35 am, E7, RN, stated "I should have wiped it between residents. I usually use alcohol swabs. Sometimes we have other wipes. I don't know what they are called."

On 9-16-15, at 11:30 am, E6, RN, stated "I typically would wipe (the glucose meter) pre and post with sani-cloth germicidal wipes."

2. The facility's policy Medication Administration (dated 10-27-10), documents "11. Avoid touching medication. If contact with the medication is likely,

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F 441	Continued From page 12 prepare medication using gloves." On 9-16-15, at 7:58 am, E6, RN, dropped R20's Torsemide 5mg tablet on the top of E6's medication cart. E6 picked the pill up with E6's bare hand, placed it in R20's medicine cup, and administered it to R20. On 9-17-15, at 1:37 pm, E2, Director of Nursing (DON), stated "It is not acceptable for a nurse to touch a pill with bare hands and give it to the resident."	F 441		