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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Investigation #1644157/IL87241 - No deficiencies Complaint Investigation #1644227/IL87317 - F425	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

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

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

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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to notify the Physician of a resident's refusal of treatment for more than 5 days for one 1 of 15 residents (R9) in the sample of 15 reviewed for physician notification.

Findings include:

During initial tour of facility on 7/26/17, at 10:00 AM, R9 had a tube feeding bottle hanging at bedside. The tube feeding bottle read "Vital AF 1.2, hung on 7/21, started at 8:00 PM, running at 40 cc (cubic centimeters). The tubing was not hooked up to R9's gastrostomy tube.

On 7/26/17 at 11:00 AM, E13, Registered Nurse (RN) stated the tube feeding was hanging there but he (R9) hasn't gotten it because he is refusing.

R9's Nurses Notes and Physician Order Sheet (POS), from 7/21/16 - 7/26/16 at 11:00 AM, does not document R9's refusal of tube feedings or any notification of R9's Physician about R9 not receiving tube feeding as ordered.

The facility's Policy and Procedure "Notification for Change in Resident Condition or Status, undated, documents in part, "1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: f. Refusal of treatment or

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F 157	Continued From page 2 medications (i.e. three (3) or more consecutive times). " On 7/27/16 at 2:00 PM, E2, Director of Nursing presented a copy of a faxed sheet to Z3, Primary Care Physician, documenting "Receives Vital AF 1.2 cal (calorie) tube feeding at 40cc/hr (hour). Only on from 6pm-6am. Wasting bottles every feeding, it curdles in bottle and he is having loose stools in colostomy. can we change feeding to cans and bolis through the night he eats during the day." E2 verified that there was not documentation of the facility ever receiving a call back from Z3 and no follow up documented.	F 157		
F 241 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to timely answer call lights for 1 of 15 residents (R9) reviewed for call lights in the sample of 15 and 5 residents (R16-R20) in the supplemental sample. Findings include: 1. R9's Physician's Order Sheet for July 2016 documents R9 has diagnoses to include urinary retention, History of a tracheotomy and Methicillin Resistant Staphylococcus Aureus (MRSA) of the	F 241		

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sputum.

R9's Minimum Data Set (MDS) dated 5/21/16, documents R9 has a urinary catheter and communication deficit related to history of tracheotomy. The same MDS documents R9 has a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive defect.

E4, MDS Coordinator, stated on 7/26/16 at 10:10 AM that R9 uses jesters and writing to communicate his needs.

On 7/26/16 at 12:20 PM, R9 stated he had been waiting for over 5 hours for someone to empty his urine bag. R9 stated he puts on the call light and someone will come in and shut it off. R9 pulled back his covers to reveal a bulging urine bag, with brown colored urine, attached to his upper thigh.

The facility Resident Council Minutes for July 2017, document concerns from residents about call lights not being answered.

2. On 7/26/16, R21's call light was on from 10:07 AM until 10:27 AM, with continuous observation.

3. On 07/26/2016 at 1:00 PM during the group meeting R16, R17, R18 and R19 all stated call lights were not answered in a timely manner and they had to wait long periods of time, over 30 minutes, and over an hour for those residents needing a mechanical lift.

4. On 7/26/16 at 12:30 P.M. R20 was sitting in her wheelchair in her room with her call light on. At 12:36 P.M. E2, Director of Nursing (DON) pushed resident down the hall in wheelchair. E2

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F 241	Continued From page 4 passed by R20's room twice and did not answer R20's call light. At 12:42 P.M. R20 wheeled herself to the doorway facing the hall. At 12:44 P.M. E9, CNA answered R20's call light. On 7/28/16 at 2:00 P.M. E1, Administrator, and E2 stated they do not have a policy/procedure for call lights. On 7/29/16 at 10:38 A.M., E2 stated that she woud expect staff to answer call lights.	F 241		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure nails were trimmed and proper timely incontinent care was provided to 3 of 6 residents (R2, R11 and R12) reviewed for hygiene and incontinent care in a sample of 15 and one resident (R22) in the supplemental sample. Findings include: 1. The Minimum Data Set (MDS) dated 6/9/16 documents R22 to have cognitive impairment and require total assist of two staff for hygiene/bathing and toileting. The MDS documents R22 is always incontinent of urine and bowel. The Care Plan	F 312		

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dated 7/17/16 documents R22 to be incontinent and staff are to cleanse peri-area after each incontinent episode.

On 7/26/16 at 1:27 pm, R22's paper incontinent brief was soaked and smelled strongly of urine. R22 had a large bowel movement also. E9, Certified Nurse's Aide (CNA) provided care and used wet hand towels. E9 stated at the time that she only had water on the towels used to cleanse R22. E9 wiped back to front as she cleaned the bowel movement off R22's skin. E9 left the room for more linen and returned with a peri-wash and additional hand towels which she wet with water. R22 was rolled to her back and E9 then wiped her peri-area back to front using the cleanser.

2. The MDS dated 4/18/16 documents R11 as having cognitive impairment and requiring extensive assist of two staff for transfers, ambulating in the corridors, and toileting. The MDS documents R11 is always incontinent of bowel and bladder. The Bowel and Bladder Assessment dated 7/6/16 documents R11 "is aware of the need to void."

On 7/27/16 at 3:25 pm, E8, CNA, assisted R11 as he ambulated into the bathroom. R11's jogging pants were soaked across the entire back of his pants and into the crotch area when he stood up from the sofa to go to the bathroom. E8 removed R11's soaked paper brief. E8 cleansed R11's rectal and buttock area with cleansing cloths but failed to cleanse his inner/upper thighs, peri-area, scrotal area or lower abdomen which would have all been soiled with urine. E8 then applied a new incontinent paper brief and pulled up his pants.

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3. The MDS dated 5/24/16 documents R12 to have no cognitive impairment and be totally dependent on two staff for toileting. The MDS documents R12 to be always incontinent of bowel and bladder. The Bowel/Bladder Assessment dated 5/25/16 documents R12 is "not aware of the need to void." The Diagnosis sheet documents R12 has Hypertonicity of bladder and urinary incontinence in part. The care plan dated 5/9/16 documents R12's incontinence with dependence on staff for all toileting needs. The problems also document a goal to sit on toilet every two hours and as needed when out of bed. Interventions include for staff to contact every two hours about the need to toilet, provide frequent reminders to request toileting and place her on toilet per her request, refer to toileting program, and may wear paper incontinent briefs.

On 7/28/16 at 12:50pm, R12 propelled her wheelchair back to the nurse's station. Her jogging pants were visibly wet throughout her crotch area. R12 positioned herself against the wall and sat watching people in the immediate area. E2, Director of Nurse's, was at the nurse's station along with E13 Registered Nurse (RN.) No one attempted to take R12 to the restroom and provide needed incontinent care until 1:22 pm when a CNA, E10 noticed her as she walked by and took her into the bathroom to change.

The facility's policy entitled "Perineal Cleansing" dated 9/21/10 documents it is the facility's policy to eliminate odor, to prevent irritation or infection and to enhance resident's self-esteem with all nursing personnel responsible to implement. The Procedure documents that all areas soiled be cleansed with a note - "The basic infection control concept for peri-care is to wash from the cleanest

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F 312	Continued From page 7 to the dirtiest area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items. The policy documents that soap and water, cleansing get or Theraworx be used when providing incontinent care. 4. On 07/26/16 at 10:25 AM, E2 and E22, CNA were observed during skin check for R2. R2's toenails were long, thick and dirty. The POS, dated 07/01-31/16, documented R2 had the following diagnoses, in part as, Diffuse Large B-Cell Lymphoma, Weakness and Palliative Care. It documented a standing order for Podiatry Services. There have been no podiatry services rendered since admission and no evidence staff trimmed R2's toenails. The Care Plan, dated 06/18/16, documented R2 required assistance with all ADL's (Activities of Daily Living). On 07/26/16 at 10:00 AM, E2 stated R2 was total care for all ADL's.	F 312		
F 314 SS=E	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.	F 314		

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This REQUIREMENT is not met as evidenced by:
Based on interviews, observations and record review, the facility failed to provide timely repositioning and treatments for 4 of 6 residents (R2, R4, R11) reviewed for pressure ulcer prevention and treatment in a sample of 15 and one resident (R22) in the supplement sample.

Findings include:

1. The Minimum Data Set (MDS) dated 6/9/16 documents R22 to have cognitive impairment and require extensive assist of two staff for bed mobility and transfer.

On 7/26/16 at 1:27 PM, R22 was transferred to bed via a mechanical lift by E9 and E14, Certified Nurse's Aides (CNA's). E9 CNA provided poor incontinent care. E9 stated R22 was up in her wheelchair when they came in at 6 am. R22 had deep red and white creases throughout her buttocks, coccyx and upper thigh areas that remained during the entire observation of care. R22 had an oval shaped dark scab/dry area on her inner right heel. E9 and E14 applied protective boots to bilateral feet prior to leaving the room.

Nurse's Note, dated 6/18/16, documents "New area noted to R (right) heel. S/P (skin prep) q (every) shift + PRN (as needed.) Staff educated to float heels + T/P (turn and reposition.)"

R22's Weekly Summary Wound Documentation, from 7/1 through 7/22/16 documented "heels pink, cont. s/p (Skin prep) + floating. No other areas." This was documented by E13,

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Registered Nurse (RN).

On 7/29/16 at 11:06 am, E5, RN, stated she just measured R22's heel ulcer. E5 agreed that it was a pressure ulcer which she stated just started out as a reddened area. E5 stated the Skin Prep dries it out and now just looks like a calloused area with a little darker center. E5 stated she did not measure it and was sure they hadn't measured it since it just was a red area when it began. E5 agreed that the documentation from 7/22/16 wasn't very descriptive.

The Care Plan, dated 7/17/16, documents R22 require staff assistance to turn/reposition with the goal to be not in the same position for more than two hours in bed or wheelchair. Interventions include approach in calm manner, turn and reposition at least every two hours while in bed, reposition in w/c (wheelchair) if up for more than two hours or does not wish to lie down, monitor for tolerance, and inform nursing if she needs to be repositioned while in activities in part. The Care Plan does not include any documentation for pressure ulcer prevention except turning and repositioning. The Care Plan does not identify R22 to be at risk for pressure ulcers or a current area on her right heel being treated with Skin Prep.

2. The MDS dated 4/18/16 documents R11 as having cognitive impairment and requiring extensive assist of two staff for transfers, ambulating in the corridors, and toileting. The MDS documents R11 is always incontinent of bowel and bladder. The 2016 July POS documents R11 had a newer in house acquired pressure ulcer identified inner right buttocks on

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7/12/16 which was to be treated with a hydrocolloid dressing after cleansing - change every three days and PRN (as needed.)

On 7/27/16 at 3:25 pm, E8 CNA assisted R11 as he ambulated into the bathroom. E8 removed R11's jogging pants which were heavily soaked with urine along with his paper incontinent brief. R11's pressure ulcer was not dressed and no dressing was present in his brief. The area was a small (pea sized) stage II inner right buttocks. R11 stated "Sore" repeatedly when asked if the area was painful. E6 Licensed Practical Nurse (LPN) wiped the area with a protective barrier pad and applied the hydrocolloid dressing. No cleansing to the wound was done as ordered.

3. On 07/26/16 at 10:00 AM, E2, Director of Nurse's, DON and E11, CNA, were observed during a skin check for R2. R2 was in bed on his back with the head of bed elevated 30 degrees. When R2 was rolled to the side lying position, there were two soiled dressings on the sacral/coccyx area and one soiled dressing on the mid back. The incontinent pad on the bed under R2 had brown drainage where R2's wounds were located on the mid back and the sacral/coccyx areas. The dressing near the coccyx area was falling off and the wound bed was exposed. R2's buttocks, especially the coccyx area was reddened and deeply creased. E11 sprayed foam peri wash on a dry wash cloth and wipe from the front to the back across the soiled dressings and peeling back the dressing exposing the open area. E11 asked E2 at this time if she should just remove the dressing and E2 told her no. E11 repeated the wiping in the same manner again and then applied an

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incontinent brief and repositioned R2 in the same position on his back as he was previously. No barrier cream was applied. At 11:30 AM, 12:30 PM, 1:00 PM and 1:20 PM, R2 remained in the same position in bed.

The POS, dated 07/01-31/16, documented R2 had the following diagnoses, in part as, Diffuse Large B-Cell Lymphoma, Weakness, Malnutrition and Palliative Care. On 07/25/16, the POS documented R2's treatment order was to "cleanse all open areas to coccyx and back with wound cleanser, pat dry, apply skin prep to peri wounds and cover with allevyn adhesive, change every three days and as needed when soiled or falls off. Secura Extra Protective Cream to coccyx and inner buttocks as needed. Venelex Ointment 60 (grams) gm to buttocks and coccyx three times per day and as needed if soiled."

The Care Plan, dated 06/18/16, documented R2 was identified as having pressure ulcers and incontinent of bowel. It documented R2 was identified as being high risk for developing pressure ulcers and interventions were listed, in part as, "prevent skin areas from prolonged contact and assist to turn and reposition every two hours and as needed."
On 06/27/16, the Braden Scale for the Development of Pressure Ulcers identified R2 as high risk.

On 07/26/16 at 10:00 AM, E2 stated that R2 was dependent on staff for all ADL's (Activities of Daily Living). E2 also stated that she was aware that R2 had pressure ulcers, but was not sure where and what stage the ulcers were in.

On 07/26/16 at 12:30 PM, E11, CNA stated that

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she had not informed the nurse that the dressing was falling off and was not sure if the dressings had been changed.

4. On 07/26/16 at 9:45 AM, R4 was sitting in her wheelchair at the nurse's station. At 11:50 AM, R4 was sitting in her wheelchair in the dining room. At 12:40 PM, E12, Physical Rehab Assistant, took R4 via wheelchair to the nurse's station. No offer to toilet or check and change was observed. At 1:15 PM, E12 took R4 from the nurse's station to the dining area for an activity. No offer to toilet or check and change was observed. At 2:00 PM, R4 was observed sitting in the same position.

The POS, dated 07/01-31/16, documented R4 had the following diagnoses, in part as, Senile Dementia, Diverticulitis of Colon, Contracture Lower Joints and Urinary Tract Infection.

The Care Plan, dated 06/24/16, documented R4's mental status fluctuates, extensive assist with all ADL's, assist of two with transfers by mechanical lift and will be offered toileting every two hours to improve bladder status for the next 90 days. On 07/01/16, it documented interventions for R4 as "required assistance with turning and repositioning due to being unable to turn and reposition herself, will not be in the same position for more than two hours either in bed or wheelchair each shift 24 hours seven days per week and to encourage to lay down."

The MDS, dated 06/23/16, documented R4 was moderately cognitively impaired requiring total assistance of at least two staff for transfers, bed mobility and toileting. It also documented R4 required total assistance of at least one staff for dressing, hygiene and bathing and is always

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incontinent of both bowel and bladder.

The facility's policy entitled "Pressure Ulcer Prevention Guidelines" dated 4/2006, documents it is the policy to "provide adequate interventions for the prevention of pressure ulcers for residents who are identified as high or moderate risk as determined by the Braden Scale. Interventions will include turning/repositioning, range of motion, special mattress, incontinence care, daily or weekly skin checks, and care plan entry." The policy also documents that any red area that doesn't resolve within 30 minutes as pressure ulcer relief must be documented as a stage I. The policy documents a brief weekly narrative will be completed describing the resident's skin condition on the back of the treatment sheet.

F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER F 315

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 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 interview, observations and record review, the facility failed to provide appropriate catheter care for one of 4 residents (R9) reviewed for urinary catheters in a sample of 15.

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Findings include:

1. R9's Physician Order Sheet for July 2016 documents R9 has diagnoses to include urinary retention, history of a tracheotomy and Methicillin Resistant Staphylococcus Aureus (MRSA) of the sputum.

R9's Minimum Data Set (MDS) dated 5/21/16, documents R9 has a urinary catheter and communication deficit related to history of tracheotomy. The same MDS documents R9 has a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive defect.

E4, MDS Coordinator, stated on 7/26/16 at 10:10 AM that R9 uses jesters and writing to communicate his needs.

On 7/26/16 at 12:20 PM, R9 stated he had been waiting for over 5 hours for someone to empty his urine bag. R9 stated he puts on the call light and someone will come in and shut it off. R9 pulled back his covers to reveal a bulging urine bag, with brown colored urine, attached to his upper thigh. R9 stated his urine bag had not been emptied since during the night. R9 indicated he was unsure of the exact time.

F 322 SS=D 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS F 322

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition

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demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure residents with tube feedings received tube feedings per physician's orders for one of 2 residents (R9) reviewed for tube feedings in the sample of 15.

Findings include:

1. R9's Physician's Order Sheet (POS) dated for July 2016 documents an order for Vital AF 1.2, 40ML (milliliters) per hour from 8PM - 6AM, Flush with 100 ML water TID (three times a day) and 30 ML flush before and after meds and feeding.

During initial tour of facility on 7/26/16, at 10:00 AM, R9 had a tube feeding bottle hanging at bedside. The tube feeding bottle read "Vital AF 1.2, hung on 7/21, started at 8:00 PM, running at 40 cc (cubic centimeters)." The tubing was not hooked up to R9's gastrostomy tube.

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On 7/26/16 at 11:00 AM, E13, Registered Nurse (RN) stated the tube feeding was hanging there but R9 hasn't gotten it because he is refusing.

R9's Nurse's Notes and Physician Order Sheet (POS), from 7/21/16 - 7/26/16 at 11:00 AM, do not document R9's refusal of tube feedings or any notification of R9's Physician about R9 not receiving tube feeding as ordered. R9's Nurses Notes and Progress Notes do not document any notification of the facility's Registered Dietician of R9's refusal of tube feeding.

R9's Food and Fluid Intake Sheet for July 2016 does not document any intake for the supper meal on 7/22/16, 7/27/16 or 7/28/16. The same sheet does not document any meal intake for breakfast, lunch or supper on 7/24/16 and 7/26/16.

R9's Tube Feeding Intake Sheet for July 2016 does not document any tube feeding amounts or flushes for 7/21/16 - 7/26/16.

The facility's Policy and Procedure "Enteral Feeding", dated 2/08, documents in part, "4. The fluid intake for the resident receiving a tube feeding should be equivalent to the fluid needs as assessed by the Dietician. Fluid needs may not be met by product alone in which case water flush ordered may be recommended to meet the needs of the tube fed resident. A record of daily intake of the tube feeding and the flushes for the resident will be kept by the nursing department."

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES F 323

The facility must ensure that the resident

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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 interviews, observations and record review, the facility failed to ensure staff use safe transfer techniques for one of 11 residents (R11) reviewed for transfers and falls prevention in a sample of 15.

Findings include:

1. On 7/26/16 at 11:50 AM, E11, Certified Nurse's Assistant (CNA), was assisting R11 to stand. E11 pulled R11 up by his hands. E11 did not use a gait belt. R11 then held on to his walker shuffling his feet. R11's knees started shaking and R11 started backing up with his walker. E11 then guided R11 to sit down on arm of chair in living area.

R11's Minimum Data Set (MDS), dated 7/5/16, documents that R11 requires limited assistance and one person physical assistance for transfers. R11's MDS documents that R11 has a diagnosis of intellectual disability, depression and Alzheimer's disease.

R11's Care Plan, dated 5/19/16, documents that R11 is to be ambulated with one assist with gait belt and walker.

On 7/29/16 at 11:20 A.M. E2, Director of Nurse's

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F 323	Continued From page 18 (DON) stated that staff are to use gait belts for all transfers unless a resident is independent. The facility Policy Transfer/Gait Belts, dated 4/10/06, documents that to promote safety in transferring and ambulating residents, a gait belt is utilized when deemed appropriate by nursing or therapy staff. The policy documents all certified nursing assistants and licensed nursing personnel engaged in the lifting and transferring of residents will use gait belts. The policy documents gait belts are mandatory.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to provide/offer sufficient fluids at meals and in between meals for 2 of 8 residents (R2 and R5) reviewed for hydration in the sample of 15 and one resident (R22) in the supplemental sample. Findings include: 1. The Minimum Data Set (MDS) dated 5/30/16 identify R5 to have severe cognitive impairment and require total assist of one staff for eating/hydration. The July 2016 Physician's Order Sheet (POS) documents R5 receives nectar thicken liquids.	F 327		

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Labs document Urinary tract infections (UTI) on 2/11/16 and 11/24/15.

The Care Plan documents R5 has the potential for dehydration with interventions for staff to monitor/provide fluids, keep fluids within reach, offer fluids in between meals, encourage fluids with care and activities.

On 7/26/16 at 11:30 AM, R5 was lying down on her left side in a recliner chair at the dining room table. She would reach around and pick up a small glass of water and drink independently. R5's noon meal was served at 12:10 PM and was served with no additional fluids besides the water she was originally given. At 1:40 PM, R5 was provided care after being transferred to bed and was offered no fluids by E9 and E14 Certified Nurse's Aides (CNAs). There was no thickened fluids in her room.

On 7/27/16 at 8:30 AM, R5 was at table for breakfast and was served a small glass of orange juice and 1/2 glass of supplement. R5 consumed no fluids at this meal and was assisted by E15, CNA, who did not offer/encourage and cue R5 to drink more. At 9:30 AM, R5 was in bed with no fluids at bedside.

Calculating R5's minimal daily fluid requirements on 30 cubic centimeters (cc) / kilograms (kg) per day, R5's minimum requirements would be 1782cc/day.

The Food & Fluids Intake Sheet for July 2016 documents R5's fluid intake during mealtimes to be between 420 cc and 600 cc daily.

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2. The MDS, dated 6/9/16, documents R22 to have cognitive impairment and require extensive assist of one staff for eating.

The July 2016 POS documents R22 receives Senexen-S 2 tabs at bedtime and Bisacodyl PRN for constipation.

The Registered Dietician's Note, dated 7/13/16, documents R22's daily minimum fluid requirement as 1745cc/24 hours, fed by staff and drinks an average of 180cc to 480 cc with meals daily.

The Care Plan dated 7/17/16 documents R22 to be at risk for dehydration with the goal to be free of signs/symptoms of dehydration. Interventions include offering fluid in between meals, keep fluids within reach, encourage fluids during cares, meals and activities.

On 7/26/16 at 1:27 PM, R22 was provided care after being transferred to be by E9 and E14, CNAs. No fluids were offered following care.

The Food & Fluid Intake Sheet for July 2016 documents R22's average fluid intake for three meals/day ranges from 300cc to 540cc.

The facility's policy entitled "Hydration Policy" dated 2/2008 documents the policy as: "to assess individual residents who are at risk for dehydration and to provide adequate fluids to all residents to maintain proper fluid balance, prevent skin breakdown, reduce infections and to maintain resident's current level of function." The policy states staff will establish individual interventions to prevent dehydration, record amounts of fluids consumes at meals and any

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other specified times, develop a mechanism to alert nursing staff to residents who are at high risk that will prompt staff to implement these interventions in part.

3. On 07/26/16 at 10:30 AM, E2, Director of Nurse's (DON) and E11, CNA were observed during incontinent care for R2. A full glass of orange juice with a straw in it and a large thermal cup of warm water was sitting on the bedside table out of R2's reach. The urine in R2's catheter bag was dark and tea-like colored. After care was completed, neither E2 nor E11 offered R2 any fluids. At 11:20 AM, both of the cups were still in same position with no fluids taken out and there was no fresh ice water in the thermal cup.

The POS, dated 07/01-31/16, documented R2 had the following diagnoses, in part as, Diffuse Large B-Cell Lymphoma, Weakness, Malnutrition and Palliative Care.

The Care Plan, dated 06/18/16, documented R2 required assistance with all ADL's (Activities of Daily Living). It also documented to offer fluids as needed between meals when cares are provided and observe for signs of poor hydration by decreased output and dark colored urine.

The Food and Fluid Intake Log for 07/26/16 was not filled out and was blank for all meals of the day. On 07/27/16 the log documented R2 had refused breakfast meal and had 120 cc of fluids and at lunch 50% meal intake with 120 cc of fluids. The evening meal was blank. On 07/28/16, it documented R2 ate 0% for the meal and 60 cc of fluids.

On 07/26/16 at 10:00 AM, E2 stated R2 was total

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care and needed assistance with eating.

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 record review and interview, the facility failed to conduct resident specific behavior tracking for 1 of 4 residents (R6) reviewed for antipsychotic medications in the sample of 15.

Findings include:

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R6's Physician Order Sheets (POS) dated July 26, 2016 document R6 is a 60 year old female with a diagnosis in part, of bi-polar and depression. The POS documents R6 medication in part, Risperidone, 3 milligrams (mg) by mouth at bedtime.

R6's Care Plan dated 07/20/2015 does not address R6's antipsychotic medication. There is no black box warning, no problems or need, goals, approach or intervention regarding R6's use of an antipsychotic medication. Under the Depression section, goals dated 07/2015 documents in part, "(R6) will respond to antipsychotic medications in the next 30-90 days with no further behaviors." No other section of the Care Plan addresses antipsychotic medications.

The Behavior Tracking dated July 2016 only documents the self imposed isolation. No behavior tracking is present for the use of any antipsychotic drugs.

E4, Care Plan Coordinator stated she does not have anything else in the Care Plan addressing antipsychotic medication.

On 07/27/2016 at 3:44 PM, E2, Director of Nursing stated "If a resident is on Risperidone or any other psychotropic drug I expect the Care Plan and Behavioral tracking to address and track it. No. I do not see anything in (R6's) Care Plan or Behavior Tracking addressing the Risperidone."

During the survey, E1, Administrator was not able to find a policy addressing Behavior Tracking.

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F 332	Continued From page 24	F 332		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications as ordered. There were 36 opportunities with 3 errors resulting in an 8.33% medication error rate. The errors involved 2 residents (R16 and R25) in the supplemental sample out of 9 residents observed during medication administration. Findings include: 1. On 7/27/16 at 8:00 AM, when giving R16 medications, E5 Registered Nurse (RN) did not administer R16's multiple vitamin. E5 administered one tablet of Senna 8.6 milligrams (mgs) to R16. R16's Medication Administration Record (MAR), dated July 2016, documents that R16 received her multiple vitamin by E5. R16's MAR documents that R16 is to receive Senna 8.6 milligrams (mg) 2 tablets at 8:00 am. E5 administered one tablet at 8:00 am instead of 2. 2. R25's Physician's Order (PO) dated 7/3/16, documents that R25 is to receive Fluticasone nasal spray; one spray each nare at 8:00 a.m. On 7/27/16 at 8:00 A.M. E5 did not administer R25's Fluticasone nasal spray.	F 332		

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F 332	Continued From page 25 On 7/28/16 at 2:54 PM, E2, Director of Nurse's (DON) stated that she would expect nursing staff to administer medications as ordered by the physician. The facility's Policy dated 10/2007, documents that medications must be prepared and administered within one hour of the designated time. The policy documents the complete act of administration entails verifying the dose with the physician's order and promptly recording the time and dose given.	F 332		
F 356 SS=C	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,	F 356		

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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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to post an updated Nursing Staffing Information. This has the potential to affect all of the 59 residents living in the facility.

Findings include:

1. During entrance to the Facility on 07/26/2016 at 9:01 AM, the Facility's Nurse Staffing Information posted near the nurses station did not reflect the current date and documented the date of 07/14/2016 for a total of 12 days past the current staffing schedules.

On 07/28/2016 at 9:07 AM, E2, Director of Nursing (DON) stated "I am the one responsible for the staff posting, I am new to this position here at the facility and I am just trying to figure everything out. I know it was not current when you entered the building."

During the Survey no Policy on Staffing Information was provided.

2. The Resident Census and Conditions of Residents, CMS 672, dated 7/26/16, documents the facility has 59 residents living in the facility.

F 371 SS=F | F 371

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews and record reviews the facility failed to ensure food was cooked in a manner to prevent foodborne illness, store food in manner to prevent potential contamination and ensure kitchen equipment is clean. This has the potential to affect the 59 residents living in this facility.

Findings include:

1. On 07/26/2016 at 9:35 AM, during the tour of the kitchen the large can opener in the kitchen contained small slivers of metal and dried food debris stuck on it.

On 07/26/2016 at 9:38 AM, E3, Dietary Manager (DM), stated "I will make sure the opener is cleaned and it is taken care of right away."

The Can Opener Policy with a date of Revised 10/12 documents in part, "It is the policy of (the Facility) that the can opener is maintained in a sanitary condition. 7) At least every 3 months a. Remove the base from the mounting and clean in

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F 371	Continued From page 28 dishmachine. b. Scrub table where the base is mounted with warm water and soap and rinse with clean, warm water. c. Reattach base to table." 2. On 07/26/2016 at 9:41 AM, in the large refrigerator on the floor were 3 large industrial cans with no lids or covering. The cans were full of an oil substance. On 07/26/2016 at 9:42 AM, E3 stated the cans contained grease and when the grease became hard they would throw it out. 3. On 07/27/2016 at 8:32 AM, R6 and R12 were sitting in the dining room eating breakfast. On each of their plates was a runny egg yolk from the poached eggs. During the tour of the kitchen, on 07/26/2016 at 9:31 AM no pasteurized eggs were present in the refrigerator. On 07/27/2016 at 10:01 AM, E3 stated "No, we do not use pasteurized eggs." On 07/27/2016 at 4:01 PM E3 provided a list of residents in the facility documenting which residents were served poached eggs for breakfast the following residents were documented: R6, R12, R23 and R24. The Shell Egg Policy with a date of Revised 4/15 documents in part, "It is the policy of (Facility) to establish guidelines for using pasteurized eggs in place of unpasteurized shell eggs in meal preparation to eliminate the risk of residents in skilled nursing and nursing facilities contracting Salmonella Enteritidis (SE). 2. Pasteurized eggs	F 371		

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F 371	Continued From page 29 should be used for soft cooked, undercooked, or sunny-side up eggs. 10. Reasonable efforts to respect choices will be made. If a resident requests soft cooked, sunny-side or undercooked eggs, then pasteurized eggs will be used to honor resident food preferences while maintaining health and safety standards." 4. The Resident Census and Conditions of Residents, CMS 672, dated 07/26/2016 documents that the facility has 59 residents living in the facility.	F 371		
F 425 SS=D	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. This REQUIREMENT is not met as evidenced	F 425		

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by:
Based on observation, interview, and record review the facility failed to follow facility policy by ensuring medications are consumed when administered and administered as ordered for 2 residents (R16, R26) in the supplemental sample.

Findings include:

1. On 7/27/16 at 8:00 A.M. E5 Registered Nurse (RN) placed R16's medications in medication cup in front of R16 on table in dining room. R16 stated that she wanted to take her medications with her breakfast. R16's breakfast had not been served at this time. E5 left R16's medication on the table in the dining room. E5 then administered R32's medication to him in the dining room. E5 then left the dining room to pass medication on B hall. R16's medication was still in cup sitting on dining room table when E5 left the dining room.

On 7/28/16 10:38 A.M. E2, Director of Nurse's, DON, stated that nurses are not to leave medications with residents, but to ensure that medications are consumed before leaving the resident.

The facility's Policy Medication Administration dated 10/07, documents the nurse is to observe the resident consume the medication to ensure resident swallows medication. Never leave prepared medications unattended. The policy documents no medications should be left at bedside unless specifically ordered by the physician and then only in limited amounts as described by the physician.

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2. R26's Physician Order Sheet (POS) for July 2016 documents orders for Lisinopril 20mg (milligram) by mouth once daily and Oxybutynin ER 5 mg, take 1 tablet three times a day.

R26's Medication Administration Records (MAR) documents that R26 has received the medications as ordered.

Z1, R26's daughter, stated on 7/28/16 at 2:30PM, that she gets her mom's prescriptions filled at a local pharmacy and has done this for months. Z1 states that both the Lisinopril and Oxybutynin should be refilled at the same time if her mom is taking them as ordered. Z1 states she had always gotten them refilled at the same time. Z1 states she was notified on 7/18/16 that her mom needed a refill of Lisinopril. Z1 states she asked about the Oxybutynin and was told she had plenty. Z1 states she asked to see the bottle of Oxybutynin and it was full.

E2, Director of Nursing, was asked to verify the number of pills in R26's bottles of Lisinopril and Oxybutynin. On 7/28/16 at 2:00 PM, E2 counted 30 pills of Oxybutynin remaining in a pharmacy bottle with a fill date of 6/16/17. E2 verified that there were 24 pills of Lisinopril remaining in a pharmacy package with a fill date of 7/19/16.

On 7/28/16 at 2:30 PM, Z2, Pharmacist, verified that both the Lisinopril and Oxybutynin had been refilled on 5/18/16 and 6/16/16 but only the Lisinopril had been refilled on 7/19/16.

On 7/28/16, at 1:45 PM , R26 states she is unsure if she had been getting her Oxybutynin but states she does receive eye drops but is unsure how often she is suppose to get them.

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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.

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This REQUIREMENT is not met as evidenced by:
Based on interviews, observations and record review, the facility failed to perform hand hygiene to prevent the spread of infection for one of 8 residents (R9) reviewed for infection control in a sample of 15 and 5 residents (R16, R22, R25, R27 and R28) on the supplemental sample.

Findings include:

1. The facility's Policy and Procedure, "Isolation-Universal Precautions", dated 8/03, documents, in part, "(2) Wear gloves upon entrance to room and at all times" and "(3) Wash hands with soap upon leaving the room, taking care not to touch environmental surfaces."

The facility's Policy and Procedure "Cleaning and Transporting of food Trays for Resident in Isolation", dated 04/02, documents in part "2. If entering an isolation room, don appropriate isolation wear before entering the room and deliver the food tray to the resident."

The facility's Policy and Procedure "Leaving the Isolation Room", dated 04/02, documents in part, "8' Wash your hands before leaving the room" and "9. Wash your hands again once you are outside of the room."

R9's Physician Order Sheet (POS) for July 2016 documents diagnoses to include Methicillin Resistant Staphylococcus Aureus (MRSA) of sputum.

On 7/26/16 at 12:45 PM, E9, Certified Nurse's Aide (CNA), entered R9's room without gloves. E9 came out of the room and opened the cabinet

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sitting in the hall, got a trash bag and went back into R9's room. E9 placed R9's lunch tray in the trash bag and carried it out to the call cart. E9 then returned to R9's room and washed her hands, exited the room and proceeded to push the food cart down the hall.

On 7/27/16 at 12:11 PM, E10, CNA, entered R9's room without putting on gloves to deliver his lunch tray. E10 placed the tray on R9's bedside table and moved the table over towards R9. E10 then came out of R9's room without washing her hands and proceeded to push the lunch cart down the hall.

2. On 7/27/16 at 8:00 AM, E5, Registered Nurse (RN) was in the dining room administering medications. E5 did not wash her hands or sanitize her hands with an alcohol base gel prior to dispensing R16's medications or after sitting R16's medication in cup in front of R16 on table in the dining room. E5 then dispensed R28's medication, and handed R28 his medication in cup in the dining room. E5 then pushed the medication cart down B hall. E5 opened the medication cart and pushed out medication from bubble packs into cup and took medication in cup to R25 in his room. During the process of administering medications to these 3 residents, E5 did not wash or sanitize her hands with an alcohol based gel.

On 7/27/15 at 12:15 PM, E5 got insulin pen out of medication cart, walked into R27's room and told R27 it was time for her insulin, pulled up R27's sleeve and administered R27's insulin in right upper arm. E5 did not wash or sanitize her hands prior to or after administering the insulin.

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On 7/28/16 at 2:54 P.M. E2, Director of Nursing (DON) stated she would expect nursing staff to wash their hands or use hand sanitizer during medication administration.

The facility's Policy Medication Administration dated 10/2007, documents that appropriate hand washing or use of an alcohol based gel must be performed throughout the medication pass. The policy documents this should occur before and after medication pass, and after touching any inanimate object possibly contaminated with microorganisms.

3. On 7/26/16 at 1:27pm, R22's paper incontinent brief was soaked and smelled strongly of urine. R22 had a large bowel movement also. E9 CNA provided incontiennt care with gloves on and then without removing the gloves, touched R22's skin, blankets, clean sheets and bed linens with the soiled gloves.

The policy entitled "Handwashing" dated 12/08 documents it to be the policy of the facility that all staff will wash hands, as washing hands promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipement or articles contaminated by them is an important component of the infection control and isolation precautions.