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	14E897	A. BUILDING ______ B. WING ______	07/12/2016

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F 000	INITIAL COMMENTS Annual Certification Survey Federal Oversight and Support Survey Complaint #1643667/IL86672-F323	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to identify and complete a significant change in condition assessment for one of 12 residents (R5) reviewed for a significant change in a sample of 12. Findings include: 1. R5's Minimum Data Set, MDS, dated 5/3/16, documents R5 has severe cognitive impairment. R5 was documented to have a general decline	F 274		

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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F 274	Continued From page 1 from his MDS dated 2/1/16 to 5/3/16 that should have been identified as a significant change. R5's MDS dated 2/1/15 to 5/3/16 document R5 to have gone from extensive assist of one staff to total assist for bed mobility, transfers, ambulation in and off the unit, and dressing. R5 also had a decline in eating from a set/supervision to minimal assist of one staff. R5 also began using a reclining chair in May 2016. On 6/21/16 at 12:15 PM, R5 was assisted with eating by E7, Certified Rehab Aide, CRA, after he fed himself a portion of the meal. At the breakfast meal, on 6/22/16, R5 was totally fed by E7. On 6/21/16 at 11:34 AM, E3 and E4, Certified Nurse's Aides transferred R5 from his bed into a reclining chair. R5 minimally assisted with the pivot transfer. On 6/22/16 at 9:45 AM, E11 and E16, CNAs, transferred R5 from his reclining chair to his bed utilizing a mechanical sit to stand lift. R5 was pulled up into a standing position and moved to the bed safely. On 6/23/16 at 8:15 AM, E2 Director of Nurse's, DON agreed that R5 has had an overall decline and that MDS should have identified the significant decline. E2 stated the prior nurse completing the MDS failed to correctly identify and complete the assessment dated 5/3/16 as a significant change.	F 274		
F 280 SS=E	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	F 280		

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F 280 Continued From page 2 F 280

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to review and revise Care Plans and allow residents to participate in their care plan meetings for three of 12 residents (R4, R9 and R11) reviewed for care plans in the sample of 12 and two residents (R14 and R16) in the supplemental sample.

Findings include:

1. R14's Care Plan, dated 4/18/16, documents R14 to be at high risk for falls due to vision problems, decreased mobility and cognition. The Goal documents "Is to be free of injury through next review with interventions being - anti-tippers on w/c (wheelchair), anticipate and meet needs, call light within reach, bring to nursing station if

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F 280	Continued From page 3 unable to redirect or not ready for bed, education resident/family/caregivers about safety reminders and what to do if fall occurs, follow policy, (laptop cushion) while up in w/c - release every two hours and PRN (as needed) for toileting, Review information on past falls and attempt to determine cause of fall, record possible root causes, schedule toileting between 3-4am, bed/chair alarm - ensure in place, verbal reminders to not lean forward too far for items out of reach, wedge cushion." On 6/28/16 at 8:15 AM, R14 was in the front hallway in her wheelchair. She had her purse open and dropped items from her purse onto the floor in front of her. R14 made several attempts at leaning over to pick them up off the floor and then unhooked the right side of her laptop cushion before staff reached her. She had a chair alarm clipped onto her shirt with a long cord to the unit. She had no wedge in her chair and no anti-tippers. On 6/29/16 at 10:15 AM, E2, Director of Nurse, DON, acknowledged that R14 frequently removes her laptop cushion and "quite often, which is okay because it gives staff a little more time to get to her." E2 stated CNA's know how to care for R14 from the Kardex available on the floor. E2 also stated R14 doesn't have the front anti-tippers any longer because they were problematic from the start. On 6/30/16 at 9:45 AM, E11 and E9, Certified Nurse's Aides, CNAs, stated R14 does not use a wedge in her wheelchair but had a laptop cushion and a chair alarm. E11 stated R14 will get "fidgety" when having to use the bathroom so you need to watch her for that. Both CNA's stated	F 280		

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F 280	Continued From page 4 R14 can remove the laptop cushion and does so many times on some days. E11 stated R14 is unable to use her call light due to her confusion. On 6/30/16 at 10:10 AM, E16, Licensed Practical Nurse, LPN, stated R14 is not able to use call light due to cognitive impairment but will tell you when she has to toilet, then off comes the laptop cushion. E16 stated you would not be able to remind R14 of safety measures either. R14's Care Plan hasn't been revised since 4/18/16 even though she's had 4 additional falls, two on 4/22/16, one on 5/21/16 and one on 5/30/16. R14's Care Plan still includes the anti-tipper and the wedge cushion which she no longer has on her wheelchair and fails to identify that R14 frequently removes her lap buddy and does so at times when she has to use the toilet. The Care Plan includes ineffective interventions given R14's severe cognitive impairment such as call light in reach, educate resident about safety measures, verbal reminders to not lean forward too far for items that are out of reach. 2. R16's Nurse's Note, dated 03/03/16, documented E13 and E14, CNAs, were transferring R16 from the shower chair to the wheelchair. R16's Nurse's Note documented "(E13) stated that the (mechanical lift) would not fit into the bathroom, so one aide got on each side to transfer resident. (E13) heard a pop and (R16) was not able to perform Range Of Motion (ROM) on right arm." It further documented, "(R16) sent to emergency department for evaluation." E13's Witness statement, dated 3/03.16, documents "We were getting the resident (R16)	F 280		

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F 280	Continued From page 5	F 280		

out of the shower chair and there was not no room." E13 documented, "I had her right arm and leg and (E14) had her left arm and leg. It was very up close and personal, but as we sat her bottom down she was just to the chair and I'm sure I heard a crack in her arm or something. She said it didn't hurt but she couldn't move it."

On 03/04/16, a Cat Scan (CT) report documented, "Anterior displacement of the humeral component of the right reverse shoulder arthroplasty. There does appear to be superior subluxation of the clavicle relative to the acromion." Also, a post reduction to surgically restore the dislocation to the correct alignment was performed on R16 03/04/16.

The Care Plan, dated 02/07/16, documented R16 required mechanical lift transfers with two staff. It also documented R16 was a high risk for falls related to Parkinson's Disease and Cerebral Palsy and the intervention listed was to follow the fall protocol. On 02/24/16, the Care Plan documented under Transfer "The resident requires (mechanical lift) (dependent on resident mobility at time of transfer) with two staff for transfers." The Care Plan had not been updated to show that an incident had occurred with R16 on 3/3/16 during an unsafe transfer or that an assessment had been done to verify what was the safest transfer method for R16.

On 06/29/16 at 3:25 PM, E2, Director of Nurse's, DON, stated that the Care Plan was updated on 02/24/16 because E18, MDS/Care Plan Coordinator had talked with R16 regarding being discharged back to an assisted living. E18 told R16 that she could not go to an assisted living until she could be transferred by some other

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F 280	Continued From page 6 method than a mechanical lift. E2 stated that at that time as a courtesy to R16, E18 put that she could be a sit to stand transfer if able to do so at the time of the transfer. E2 further stated that this would be decided by the staff if she could be transferred via sit to stand. 3. On 05/23/16, an Interim Care Plan was established that identified the following focus issues for R11, in part as, assistance with Activities of Daily Living,ADL's, such as dressing, hygiene and toilet use, independent with bed mobility, transfers, eating and ambulation, continent of bowel and bladder, and antipsychotic. The due date for the completion of the comprehensive Care Plan was dated 06/11/16. The POS, dated 06/01-30/16, documented R11 had an order for Seroquel 200 mg at bedtime and Lexapro 40 mg daily and has a diagnosis of Personality Disorder. There was no documentation of comprehensive assessments or indications for use for the antipsychotics as of 07/07/16. 4. On 6/21/2016, at 11:40 AM, R4 was asked if she was invited or attended her care plan meetings. R4 stated she knew nothing about being invited to a meeting about her. On 7/5/2016, at 11:40 AM, E2 stated there was no documentation in R4's medical record as to who was invited or attended R4's Care Plan Meeting. R4's Care Plan file had no documentation of signatures that anyone, including R4, was invited or attended the Care Plan meeting.	F 280		

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5. On 6/22/16 at 1:30 PM, during the group meeting, R9 stated that she had not been invited to her care plan meeting.

R9's Care Plan, dated May 2015 does not have a sign in sheet documenting that R9 was in attendance at her Care Plan meeting.

On 7/5/16 2:00 PM, E2 stated that she may have not called it a Care Plan meeting when she met with R9, but that she did meet with her and go over her plan of care.

F 309 SS=E — 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to identify, assess, monitor, and treat wounds to promote healing for 3 of 12 residents (R6, R5 and R8) reviewed for wounds in the sample of 12.

Findings include:

1. R5's Minimum Data Set, MDS, dated 5/3/16, documents R5 has severe cognitive impairment and is totally dependent on staff for all activities of daily living (ADL's) except eating. The MDS

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F 309	Continued From page 8 documents R5 is always incontinent of bowel and bladder. R5's Care Plan, dated 5/10/16, documents R5 has a potential for impairment to skin integrity r/t (related to) fragile skin and diabetes. The goal is to be free from injury through the next review with interventions documented "Follow facility protocols for treatment, identify/document potential causative factors and eliminate/resolve where possible." Under Incontinence, the Care Plan interventions include "Clean peri-area with each incontinence episode, wash/rinse/dry perineum, change clothing PRN (as needed) after incontinent episode, monitor/document for s/sx (signs/symptoms) UTI (urinary Tract Infection)." R5's Care Plan does not include any interventions to staff for keeping his skin clean and dry to assist in lessening irritation and aid in healing. The Care Plan does not address R5 scratching his buttocks. On 6/22/16 at 8:10 AM, R5 was in the dining room in his wheelchair. R5 remained in his wheelchair until 9:45 AM. At 9:45 AM, E17 and E11, Certified Nurse's Aides, CNAs, transferred R5 to bed and E17 removed his wet incontinent brief. E17 stated R5 had been up in his wheelchair and R5 still had the severe excoriation present in between his buttocks. As E17 wiped the excoriated area with a dampened wash cloth, R5 moaned and flinched as E17 wiped the area. E17 stated she had no soap on the cloth since R5's skin was tender from the excoriation and didn't want to aggravate it. E10 Registered Nurse, RN observed E11 and E17 provide R5 incomplete incontinent care and then applied Clotrimazole AF 1% to the excoriated area without first cleansing the treated area.	F 309		

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R5's Physician's Orders document on 4/6/16, R5 was given a regiment of Diflucan 150 milligrams (mg) every day for 7 days for a fungal infection of the periarea.

The June 2016 Treatment Administration Record (TAR) documents the Clortrimazole AF 1% being applied twice daily from 6/1/16 through 6/22/16. There is no assessment of R5's wound or current wound status in the weekly wound report or progress notes until 6/23/16 when E8, Licensed Practical Nurse, LPN, documented "2 small abrasions noted to resident left buttock." E8 documented one wound measuring 2 centimeters (cm) by (x) .7 cm and the second wound as 1.3 cm x .5 cm and "appears to be self inflicted from scratching." There is nothing documented regarding the severe excoriation that surrounded the actual open areas or as to when it began or if the wounds were from the fungal infection treated in April 2016.

On 7/1/16 at 11:20 AM, E7, Certified Rehab Aide (CRA), stated R5 scratches at his buttocks and rectal area often.

Weekly Skin Reports documented 6/24/16 document two areas on R5's left buttocks that measures 2 cm x 0.7 cm x 0 cm and 1.3 cm x 0.5 cm x 0 cm described as abrasions, self inflicted with a partial full thickness tissue loss.

2. R6's Care Plan, dated 1/17/16, documents that R6 has diagnoses of Alzheimer's disease and unspecified Dementia with Behavioral Disturbance.

R6's Care Plan, dated 1/17/16, documents that

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R6 has potential skin impairment to skin integrity related to fragile skin. R6's Care Plan documents that staff are to "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to the physician." R6's Care Plan documents that staff are to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.

R6's MDS, dated 4/5/16, documents that R6 is totally dependent and requires two plus physical assistance for bed mobility. R6's MDS documents that R6 is totally dependent and requires one person physical assistance for transfers.

On 6/22/16 at 11:05 A.M., E11 and E17 transferred R6 to the toilet. R6 had an open circular area to right inner knee. There was no drainage present and no dressing in place. R6 also had numerous scabbed areas to her right anterior lower leg.

On 6/23/16, at 9:25 A.M., E2 stated that she was not aware of any open areas on R6's right lower leg. E2 stated R6 had no open areas on Friday when she did skin checks. E2 stated that she expects the Certified Nursing Assistants (CNA'S) to report any skin changes to the nurse. E2 stated the nurse would then be responsible to report any changes to her.

3. Facility Wound Report dated 08/2016, for R8's surgical wound documents "#1 right shin lower medical/inferior location with measurements as 4.5 cm by 3.9 cm by 0.4 cm and full thickness." The Wound report dated

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06/17/2016-06/28/2016documebnts R8's surgical wound as "#1 right shin lower medial/inferior measurements as 4.5 cm by 2.3 cm by 0.2 cm and full thickness. #2 right lower leg right side measuring 4.9 cm by 2.2 cm by unable to determine (UTD)."

On 6/23/2016 at 11:00 AM, E16, LPN, entered R8's isolation room with gown and gloves on and supplies to do R8's dressing change. E16 removed R8's shoe, sock and tan/gray drainage soaked sockett from right extremity. E16 took bandage scissors and cut up through the tan/gray drainage on kerlix wrap starting at ankle and upwards to mid leg. E16 cleansed all R8's open areas to right shin lower medial/inferior wounds with wound cleanser and gauze pads. E16 took the soiled scissors from removing prior drainage soaked dressing and cut clean silver alginate pad into smaller pieces to fit R8's open areas to right shin lower medial/inferior areas and secured with kerlix wrap and tape. At 11:10 AM, E16 was asked what kind of drainage was on R8's soiled dressing. E16 stated R8 has Methicillin Resistant Staphylococcus Aureus (MRSA) drainage. E16 was asked about cleaning and disinfecting soiled scissors. E16 stated "We clean and disinfect scissors when isolation is discontinued." E2 stated R8 went to wound clinic on 6/16/2016 and the facility received a call that R8 had a wound culture done. There and has MRSA and isolation was started.

R8's Care Plan, revised on 05/15/2016, documents "Impairment to non-healing surgical sites."

Isolation-Categories of Transmission-Based Precautions dated 2001 MED-PASS, Inc (Revised

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April 2010). F. documents (2) The facility will also ensure that the residents' care plan specialist communication system indicates the type of precautions implemented for the resident.

Undated WOUND CARE policy under Procedure: documents "#21 Wipe reusable supplies with alcohol as indicated (i.e. outside of containers that were touch by unclean hands, scissors blades, etc.). Return reusable supplies to resident's drawer in treatment cart."

B. Based on interview and record review, the facility failed to implement a care plan to coordinate Hospice services for one of one resident (R10) reviewed for Hospice services in the sample of 12.

Findings include:

On 6/21/16, at 9:18 AM, E8, Licensed Practical Nurse, LPN, stated R10 was on hospice care.

R10's Physician Order (PO), dated 3/13/2016, documented she was to receive Hospice.

The Comprehensive Hospice Agency contract, dated 10/5/2015, documents under 2.2 Plan of Care "Where feasible, a resident's Plan of Care will be jointly directed, coordinated and monitored by the Parties. The patients's applicable Plan of Care will identify the Hospice Services the Patient requires and will specify the responsible provider to perform the respective functions encompassed by the Plan of Care."

R10's Care Plan, revision date 04/01/2016, has no documentation of R8 being on hospice.

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on interviews, observations and record review, the facility failed to identify, assess and develop appropriate treatment to include services to maintain or improve Activities of Daily Living (ADLs) for residents with decline for 2 of 9 residents (R5 and R3) reviewed for ADL's in a sample of 12 and one resident (R13) in the supplemental. This failure resulted in R5's decline in ambulation/mobility, dressing, eating and transfers abilities.

Findings include:

1. The Minimum Data Set, MDS, dated 5/3/16, documents R5 has severe cognitive impairment. R5's MDS dated 2/1/15 to 5/3/16 document R5 to have gone from requiring extensive assist of one staff to total assist for bed mobility, transfers, ambulation in and off the unit, and dressing. R5 also had a decline in eating from a set/supervision to minimal assist of one staff.

R5's Care Plan, dated 1/10/16, documents R5 to have a self care performance deficit due to dementia with a restorative program for eating/swallowing program with the intervention being to serve R5's meal in a divided plate.

The Restorative List provided by E7, Certified

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F 311	Continued From page 14 Rehabilitation Aide,CRA, did not include R5 for any services addressing decline in any of the identified ADL's even though the Care Plan documented a need for a restorative eating program. On 6/21/16, at 11:34 AM, E3 and E4, Certified Nurse's Aides, CNAs, assisted R5 to transfer from bed to wheelchair with extensive assist when E3 grabbed R5 by the back of the neck and E4 swung his feet off the bed to side on the edge of the bed. After they applied a gait belt around his waist and then E3 and E4 grabbed the gait belt under his arm and pulled him to a standing position as they swung him toward the reclining chair dropping him in the seat. R5 did not participate in the transfer. R5 was assisted with eating by E7 at the noon meal on 6/21/16 after he fed himself a portion of the meal. At breakfast, on 6/22/16, R5 was totally fed breakfast by E7 without giving the opportunity to feed himself. On 6/23/16, at 8:15 AM, E2, Director of Nurses (DON), agreed that R5 has had an overall decline and that MDS should have identified the significant decline. When asked if an assessment was done to determine what the decline was from, E2 stated no assessment was done but the decline was attributed to the progression of his disease. E2 confirmed that no restorative programs or services have been implemented in response to R5's decline since they were identified. 2. On 06/21/16 at 12:20 PM, R13 was served the lunch meal. R13 was served a pureed meal in separate bowls with built up utensils and had	F 311		

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thickened liquids. E9, CNA was sitting with R13 and fed her with the built up utensil. At 1:10 PM, E9 pushed the bowls in toward the center of the table and left to start helping other residents back to the halls. At that time, R13 picked up the built up spoon and began to feed herself. R13 was able to keep food on the spoon to her mouth without difficulty. R13 also was able to pick up the thickened red juice and drink it. At 1:20 PM, E9 saw R13 feeding herself and walked up and stated "I'll help you" and removed the utensil from R13's hand and began to feed her again. At 1:25 PM, E9 took R13 down the hall to her room. At no time did E9 allow R13 to feed herself while sitting with her.

On 06/22/16, at 8:00 AM, E9 was again feeding R13. When E9 got up to assist other residents, R13 again began to feed herself without difficulty.

R13's Physician's Order Sheet (POS), dated 06/01-30/16, documented R13 had the following diagnoses, in part as, muscle weakness, ataxia and dysphagia.

The MDS, dated 05/16/16, documented R13 was moderately cognitively impaired and required limited assistance of one staff for eating. It also documented R13 was not on a restorative program for eating.

On 06/22/16, a Dietary Note documented "spoon with foam handle and partial assistance needed with eating. Staff assist resident at meals when unable to feed self due to resident becomes upset and tearful if feeding self and unable to do so. Foam handled spoon given to help aid resident feed self as able."

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The Care Plan, dated 02/11/16, documented R13 required assistance with all ADL's. It documented R13 required limited assist by one staff for eating. It documented "Provide resident with adaptive spoon at meals to increase independence with eating."

3. The 6/23/2016, at 9:10 AM, E17, CNA, propelled R3 in her wheelchair from the dining room to R3's room. E17 placed a gait belt around R3's trunk and assisted R3 to the bathroom. R3's knees were not fully extended as she ambulated into the bathroom.

On 6/24/2016, at 11:10 AM, E7 was asked about R3 walking. E7 stated R3 walks 100 to 120 feet for lunch and supper and no one in the facility receives range of motion.

On 6/24/2016, 12:10 PM, E11, CNA went into R3's room and assisted R3 to the sitting position on the left side of bed. E11 placed a gait belt around R3's trunk and assisted her to stand and walked into the bathroom. R3's knees were not fully extended while she ambulated into the bathroom. Upon coming out of bathroom, E11 placed R3 in a wheelchair, removed the gait belt, and propelled R3 into the dining room.

On 6/24/2016, at 12:20 PM, E11 was asked if R3 walks to the dining room for lunch. E11 stated, "No." E11 stated R3 would get up too much and would go by herself.

On 6/24/2016, at 1:50 PM, E3, CNA, was asked if R3 walked to lunch or was in wheelchair and propelled to dining room. E3 stated R3 went to lunch in a wheelchair.

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R3's Care Plan Intervention/Tasks, revised on 2/1/16, documents "NURSING REHAB/RESTORATIVE: Transfer and walk resident to Lunch and Supper to maintain mobility."

R3's MDS, dated 10/20/15, documents she had no impairments in range of motion. R3's MDS, dated 2/1/16, documents R3 has had a decline in range of motion for both sides of her upper and lower extremities.

F 314 SS=G — F 314

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, record review and interview, the facility failed to identify, assess, monitor, treat and provide repositioning to prevent pressure ulcers for 4 of 9 residents (R1, R2, R5 and R10) reviewed for pressure ulcers in the sample of 12, and one resident (R13) in the supplemental sample. This failure resulted in R2 developing three facility acquired Stage II pressure ulcers on the buttocks and R1 having a decline in a Stage IV pressure ulcer.

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Findings include:

1. On 06/21/16, at 9:15 AM, R2 was sitting in a wheelchair in the TV room during an activity. At 11:15 AM, R2 was sitting in the wheelchair at the 200 hall nurse's station. At 11:30 AM, R2 was taken via wheelchair by E26, Certified Nurse's Aide, CNA, to the dining room for the lunch meal service. R2 remained in her wheelchair in the dining room from 11:30 AM to 1:30 PM without benefit of repositioning based on 15 minutes or less observation intervals. At 1:30 PM, E2, Director of Nurse's, DON, and E23, Licensed Practical Nurse, LPN, transferred R2 from the wheelchair to toilet, from toilet to wheelchair and from the wheelchair to bed. R2's buttocks were reddened with deep creases, as were the back of her thighs with a foul smell of urine. Observation of R2's entire buttocks was not possible due to multiple areas of skin folding over and R2 was very agitated. There was no dressing present when incontinent brief was removed. E2 stated R2 had no open areas on R2's bottom. R2 was very agitated and anxious and would not allow a complete skin check to be done.

On 06/22/16 at 8:00 AM, R2 was sitting in her wheelchair at the dining room table. At 8:50 AM, E25, Activity Aide, took R2 in her wheelchair to the TV room adjacent to the dining room. At 9:10 AM, E26 took R2 via wheelchair to R2's room for podiatry appointment. E26 did not offer to toilet R2, did not check R2 for incontinence or reposition R2. At 10:15 AM and 10:30 AM, R2 remained in the same position in her wheelchair. At 11:00 AM, E12, CNA, and E26 gave R2 incontinent care. R2 was saturated with urine through the incontinent brief, through her pants and onto the wheelchair cushion. There was no

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F 314	Continued From page 19 dressing present when the incontinent brief was removed. There were small pieces of the saturated incontinent brief observed throughout the front perineal area and the buttocks. E26 performed perineal care with wet wash cloth sprayed with peri wash with one wipe on each outer side of the labia, folding the cloth over between each wipe and then down the middle between the labia. R2's labia was deeply reddened with deep creases. R2 was then rolled to the right side and an additional wet wash cloth was used to wipe down between the buttocks and folded over wiping each buttocks with back and forth method due to small pieces of the incontinent brief remaining stuck to R2's buttocks. During this time, R2's buttocks remained deeply reddened with deep creases. There were two open areas identified on the right buttocks, one approximately 2.0 centimeters (cm) x (by) 3.0 cm and the second approximately 1.0 cm x 1.0 cm. Another open area identified on the left buttocks in between the gluteal fold approximately 1.0 cm x 2.0 cm. Both E12 and E26 stated that they had not seen these open areas before. E29, LPN was present in the room during this time but did not assist with care. E29 stated that she was not aware of any open areas on R2, and stated they looked to be staged at a level II. E29 did not assess these areas and stated to put some barrier cream on them. E26 pulled out the nightstand drawer an open cup of barrier cream, no lid or cover, and applied to R2's bilateral buttocks . R2 was then transferred back to the wheelchair. At that time, E12 and E26, both stated that R2 had been up since the night shift, because she was already in her wheelchair when they got to work around 6:00 AM. They both denied toileting her or repositioning her until 11:00 AM.	F 314		

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On 06/23/16 at 1:30 PM, E16, LPN, was observed during dressing change, however when surveyor entered R2's room, R2's pants and incontinent brief had already been removed. No dressing was present. E16 stated that barrier cream had been applied to R2's bottom. E16 then stated she had already cleaned R2's bottom with wound cleanser and had cut the gel-filled dressings (Duoderm) and dated them prior to the surveyor entering the room. E16 did not take any measurements, applied the dressings to each open area and covered R2 with a blanket. No incontinent brief was applied.

R2's Physician's Order Sheet, POS, dated June 2016, documented R2 had the following diagnoses, in part as, Muscle Weakness, Alzheimer's disease, Dementia with behavioral disturbances, Diabetes Mellitus, Anxiety Disorder and Pseudobulbar Affect. The POS, dated 06/14/16, documented an order for R2 for two areas one on the left buttock, measuring 2.0 cm x 3.0 cm x 0.1 cm and one area on the right gluteal fold, measuring 2.0 cm x 1.8 cm x 0.1 cm. It documented areas cleansed with wound wash, pat dry and apply Duoderm to be changed every three days and as needed until healed. The POS, dated 06/16/16, documented R2 had an order for a special gel-filled dressing (Duoderm) to left buttock and right gluteal fold wound.

The Wound log, dated 06/14/16, documented the same measurements as listed above and those are the only measurements documented by the facility regarding R2's pressure ulcers. It also documented that these wounds were caused by R2 scratching herself and were acquired in house.

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R2's MDS, dated 04/27/16, documented R2 was severely cognitively impaired with a BIMS score of zero and short and long term memory deficit. R2's MDS documented she had no pressure ulcers. It documented R2 required total assistance of at least one staff for bed mobility, transfers, locomotion in wheelchair, dressing, eating, hygiene and bathing. It also documented R2 required total assistance of two staff for toileting, was frequently incontinent of both bowel and bladder and had limitations of ROM of both upper and lower extremities.

The Care Plan, dated 04/14/16, documented R2 was dependent on staff for all Activities of Daily Living (ADL's) and totally dependent on staff for turning and repositioning, bathing, bed mobility, dressing, hygiene and transfers. It documented R2 was incontinent of both bowel and bladder and was identified as being moderately at risk for developing pressure ulcers.

The Braden Scale for the Development of Pressure Ulcers, dated 05/05/16, documented R2 scored 12 indicating high risk.

On 06/23/16 at 10:50 AM, E12 stated that she had provided care to resident that morning and there was no dressing present on R2's bottom only barrier cream. E12 stated that R2's open areas may not have required a dressing.

On 06/23/16 at 10:56 AM, E16 stated that she did not know if R2 had a dressing on or not. E16 stated that E2 would know more because she does all of the measurements and keeps a log.

2. On 06/21/16 at 11:00 AM, R13 was sitting in a

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wheelchair in the TV room at an activity. At 11:35 AM, E9, CNA too R13 from the TV room directly to the dining room for the lunch meal service. E9 did not offer to toilet or reposition R13. R13 was in the dining room in her wheelchair until 1:30 PM when E9, CNA took her to her room and left her sitting in the wheelchair.

R13's POS, dated June 2016, documented R13 had the following diagnoses, in part as, muscle weakness, ataxic gait, cerebral infarction, urinary incontinence, colitis and gastroenteritis.

The MDS, dated 05/16/16, documented R13 was moderately cognitively impaired and required total assistance of one staff for bed mobility, transfers, locomotion, ambulation, bathing and toilet use. It documented R13 had ROM limitations in both the upper and lower extremities and was frequently incontinent of the bladder.

The Care Plan, dated 02/11/16, documented R13 was identified as being aphasic and incontinent of both bowel and bladder.

3. R1's MDS, dated 5/5/16, documents R1 as being admitted to the facility on 4/22/16 with bilateral unstageable heel pressure ulcers.

R1's Care Plan, dated 5/10/16, documents R1's heel ulcers are due to decreased mobility with the goal being to show signs of healing and have no new ulcers develop. Interventions include "Administer treatments as ordered and monitor for effectiveness, educate resident/family/caregivers as to causes of skin breakdown including transfer/positioning requirement; importance of taking care during ambulating/mobility, good nutrition and frequent

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F 314	Continued From page 23 repositioning, following policies/procedures for prevention and treatment of pressure ulcers, monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (Sign/symptoms) of infection, wound size (length x width x depth), stage. Cushion to wheelchair and recliner, and layover on bed." R1's Braden Scale, dated 4/29/16, documents R1 at moderate risk for pressure ulcers even though she was admitted with two unstageable ulcers of her heels. R1's Laboratory results, dated 6/2/16, document low levels of Total Protein at 5.3 (normal 6-8.3) and Albumin 3.4 (normal 3.5-5.5). R1's POS documents an order, dated 5/26/16, to "wash wounds, pat dry et (and) apply thin (hydrocolloid) every 3 days to Right buttock wound." The first documentation of R1's heels on the Facility's Weekly Wound log is dated 4/30/16, 8 days after admission. Measurements being: right heel - 2 cm x 1.9 cm, unstageable, necrotic tissue 100% treated with skin Prep TID (three times daily), left heel - 3.8 cm x 3cm, unstageable, necrotic 100%, Skin Prep TID. The Weekly Wound Log Assessment on 5/7/16 lists the same measurements and status for both heels. On 5/14/16, R1's right heel appears slightly larger at 3.0 cm x 1.9c, necrotic tissue 100% with Skin Prep tid with no status/documentation on the left heel. On 5/21/16, R1's right heel measures 2.0 cm x 1.0 cm with less necrotic tissue at 25%, and left heel 3.8cm x 2.9cm 100% necrotic tissue again with	F 314		

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both heels treated with skin prep TID. On 5/28/16, R1's right heel measured slightly larger at 2.0cm x 1.9cm again with 100% necrotic tissue treated with Skin Prep TID and the left heel 3.8cm x 3.0cm 100% necrotic with a treatment change to a hydrocolloid dressing every three days.

R1's May 2016 TAR does not include the Skin Prep to R1's heels.

Progress Notes documented by E10, Registered Nurse, RN, dated 5/26/16 at 16:14 (4:14pm) document "Staff brought to writers attention an open area to Rt (right) buttock during PM cares in res (resident) room. Measured it to be 1.5cm x .5cm - wound cleaned with wound cleanser and dry gauze applied until further notice." At 4:45 PM, a Physician's Order for a hydrocolloid dressing was given to be changed every three days.

On 5/28/16, two days later, on the Weekly Wound Log, R1's right buttock measured 5.2 cm x 3.8 cm x 0.1 cm depth, stage III with granulation and 50% slough/attached with a hydrocolloid dressing every three days. There is no documentation justifying this decline or why it wasn't identified earlier than the weekly assessment.

On 6/4/16, the weekly pressure ulcer log documented the right buttock as 2.2 cm x 2.0 cm x 0.1cm stage II, with granulation. The left heel measurements remained the same and the right heel showed some improvement with a slight decrease in size to 2.0 cm x 1.6cm with granulation and no necrosis documented for either heel wound.

On 6/18/16, R1 was documented as having

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another new pressure ulcer on her coccyx that measured 2.0 cm x 1.5 cm x 0.1 cm 90% slough no stage, right buttock back to stage III measuring 2.4 cm x 1.8 cm x 0.1 cm. Order for both was hydrocolloid dressing every three days. R1's left heel measured 3.8cm x 3.0cm x unstageable and right heel 2.0 cm x 2.4 cm unstageable, both with necrosis 100% which is inconsistent with the previous week.

On 6/21/16 at 3:05 PM, E3 and E9, CNAs, transferred R1 to her bed from the recliner. R1's hydrocolloid dressing dated 6/20 that was on her buttocks was loose on three sides, exposing the wound base which appeared very sloughy. There were two separate pressure ulcers, one on her left center buttocks and one on her right buttocks. E2 pulled the dressing off and after E3 and E9 cleansed R1's buttock/rectal area with a wash cloth, applied a new hydrocolloid dressing on the areas without first cleansing them.

Treatment Administration Records (TAR) for June 2016 document R1's dressing was initialed as changed on 6/19/16, not the 20th as documented on the dressing and no initials as done on 6/21/16 as observed by E2.

On 6/23/16 at 10:31 AM, E10 was asked if he had checked R1's coccyx dressing yet and stated "No." E4, CNA, was standing next to R10 and was asked if she had noticed if the dressing was intact when she last care for R1 and replied "It probably needs to be changed." R1's dressing was crumpled up and loose, hanging by a corner with the entire two wound bases exposed. Both wound beds were sloughy and larger than when observed on 6/21/16. E10 replaced the dressing.

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F 314	Continued From page 26 As of 6/28/16, the June 2016 TAR did not have E10's initials as the treatment being done on 6/23/16. The facility's policy entitled "Pressure Ulcer, Care and Prevention of," undated, documents the purpose of the policy is to provide a "systematic approach in the prevention and healing of pressure ulcers" and "to prevent and treat further breakdown of pressure areas." The definition of pressure ulcer is "area of skin redness or breakdown caused by pressure to the area." The statement documents "All residents admitted to this facility will have a complete skin assessment with documentation of any known or potential risks that will place residents in danger of skin breakdown. Skin assessment weekly for the first 4 weeks, then quarterly and at time of significant change of condition." The policy documents "An individualized treatment plan for the prevention of skin breakdown and/or treatment for any existing pressure areas will be developed. When a pressure area is identified, an aggressive treatment program will be instituted and closely monitored to promote healing." Under procedure, staff are document ulcers upon identification and assessment. The policy documents all areas will be charted on daily. Nursing measures to be implemented include avoid friction/shearing when moving resident in bed, inspect sites of breakdowns as least during each nursing shift, cleanse skin at time of soiling, frequently change positions of immobile resident at least every two hours or as needed, and use pressure ulcer reducing devices in part. The policy includes a Skin Check Worksheet for the nurse and a CNA's Skin Assessment. 4. R5's MDS, dated 5/3/16, documents R5 has	F 314		

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severe cognitive impairment and is totally dependent on staff for all activities of daily living (ADL's) except eating. The MDS documents R5 is always incontinent of bowel and bladder.

R5's Care Plan, dated 5/10/16, documents R5 has a potential for impairment to skin integrity r/t (related to) fragile skin and diabetes. The goal is to be free from injury through the next review with interventions being follow facility protocols for treatment, identify/document potential causative factors and eliminate/resolve where possible. Under Incontinence, the care plan interventions include clean peri-area with each incontinence episode, Wash/rinse/dry perineum, change clothing PRN (as needed) after incontinent episode in part.

On 6/22/16 at 9:45 AM, R5 was transferred to bed from his wheelchair by E17 and E11 CNAs. R5's incontinent paper brief was wet with urine and he had severe excoriation along with deep creases throughout his hips, buttocks and upper thighs. E17 provided poor incontinent care. E17 was asked how long R5 was in his wheelchair and replied he was up at 6:50 AM.

A Progress Note, dated 7/6/16 documents R1 was seen by Z1, Medical Director. The note documents Ulcer Left Buttocks Stage IV, refusing to eat/drink, Hospice services recommended. The Note also documents family agrees for wound care.

5. 6/21/2016 at 9:18 AM E8, LPN, stated R10 had a Duoderm film dressing on left hip for protection as R10's pressure area was healed.

On 6/22/2016, from 9:15 AM until 12:23 PM, R10

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F 314	Continued From page 28 was lying on her left side in bed based on 15 minutes or less observation intervals. At 12:23 PM, E11 and E17 was going to get R10 up for lunch. When E17 repositioned R10 to change her adult diaper, R10 had a duoderm film over her left hip dated 6/21/16. The Duoderm appeared dry with scar tissue under. Facility Ulcer List, dated 6/17/2016-6/18/2016 documents the date R10's pressure ulcer was first observed as 06/26/2016. R10's Stage II pressure ulcer measured 1.0 cm by 1.4 cm by 0.1 cm. On 7/4//2016 at 3:10 PM E2 brought in Pressure Ulcer List, dated 7/4/2016, with R10 current pressure ulcer measurements of 2.5 centimeter (cm) by 0.9 cm by 0.1 cm. R10's Kardex , updated on 11/25/15 documents "stay off left hip turn and reposition every one hour." PRESSURE ULCER, CARE AND PREVENTION OF; undated policy. POLICY STATEMENT documents "An individualized treatment plan for the prevention of skin breakdown and /or treatment for any existing pressure areas will be developed."	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 catheterization was necessary; and a resident	F 315		

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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, observation and record review, the facility failed to provide incontinent care to prevent urinary tract infections (UTI) and toileting to restore normal bladder function for 3 of 10 residents (R2, R5 and R6) reviewed for urinary tract infections and toileting in a sample of 12.

Findings include:

1. R5's Minimum Data Set (MDS), dated 5/3/16, documents R5 has severe cognitive impairment. The MDS, dated 2/1/16, documents R5 to require extensive assist of one staff for toileting and R5 is frequently incontinent of bowel and bladder. The MDS, dated 5/3/16, documents R5 requires total assist of two staff for toilet use and R5 is always incontinent of urine.

The Bowel and Bladder Assessment, dated 5/2/16, documents R5 to "sometimes be aware of the need to toilet" and documents he is on a timed toilet schedule.

R5's Care Plan, dated 5/2/16, documents R5's incontinence is due to confusion, physical limitations, Dementia, impaired mobility with the goal to be "free of skin breakdown and brief use. Interventions include clean peri-area with each incontinence episode, check per facility protocol for incontinence, Wash/rinse/dry perineum,

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change clothing PRN (as needed) after incontinent episode, monitor/document for s/sx (signs/symptoms) UTI (Urinary Tract Infection)."

On 6/21/16 at 11:24 AM , R5 was transferred from bed to his wheelchair after receiving incontinent care from E3 and E4, Certified Nurse Aides, CNAs. R5 had a bright red rash (excoriation) that extended from his scrotum to his coccyx inner buttocks. E3 and E4 did not offer the toilet to R5 after transferring him to the wheelchair before going to the dining room for lunch.

On 6/22/16 at 9:45 AM, R5 was transferred to bed from his wheelchair by E17 and E11 CNAs. No opportunity to toilet was offered prior to assisting him to bed. R5's wet incontinent paper brief was removed. R5 had the severe excoriation present in between his buttocks and rectal area that extended to his scrotum. E17 wiped the excoriated area with a dampened wash cloth as R5 moaned and flinched as she wiped the area. E17 stated she had no soap on the cloth since R5's skin was tender from the excoriation and didn't want to aggravate the area. No cleansing was done with soap or cleanser.

2. On 06/21/16 at 1:30 PM, E2, Director of Nurse's (DON) and E23, Licensed Practical Nurse (LPN), toileted R2. R2's incontinent brief was saturated with urine. When on the toilet, R2 did not urinate or defecate. E2 wiped R2's front perineal area with a wet wash cloth, folding the cloth once between wipes. E2 did not use peri wash. E2 did not cleanse R2's back, buttocks or thighs.

R2's Physician's Order Sheet, POS, dated June

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2016, documented R2 had the following diagnoses, in part as, Alzheimer's disease and Incontinence of both Bowel and Bladder.
On 06/16/16, the POS documented R2 had open areas on her bottom and to apply gel-filled dressing (Duoderm) to the left buttock and right gluteal fold.

The MDS, dated 04/27/16, documented R2 was severely cognitively impaired with both short and long term memory deficits. It documented R2 required total assistance of at least one staff for hygiene. It also documented R2 required total assistance of two staff for toileting. It documented R2 was frequently incontinent of both bowel and bladder.

The Care Plan, dated 04/14/16, documented R2 was dependent on staff for all Activities of Daily Living (ADL's) and was incontinent of both bowel and bladder. It documented R2 required staff to provide perineal care after each incontinent episode.

3. On 6/22/16, at 11:00 A.M., E11 and E17 transferred R6 from the wheelchair to the toilet in the bathroom. E11 undid R6's incontinent brief prior to transferring R6 to the toilet. During the transfer, R6 urinated on the floor. R6's incontinent brief was dry. When staff stood R6 up, she had urinated and had a bowel movement in the stool. E17 put soap on washcloth from dispenser and had faucet running. After wiping R6 with the washcloth, E17 would then rinse the same washcloth under the faucet and hand back to E11to cleanse R6. E11 did not cleanse peri area, inner thighs, lower legs or buttocks.

R6's MDS, dated 4/5/16, documents that R6 is

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F 315	Continued From page 32 frequently incontinent of urine. R6's Care Plan, dated 1/17/16, documents that R6 has bowel and bladder incontinence. R6's Care Plan documents that staff are to clean R6's peri area with each incontinent episode. R6's Care Plan documents that R6 has a history of UTIs and R6 is to be checked at least every 2 hours for incontinence. R6's Care Plan documents staff are to wash, rinse and dry soiled areas. The facility Urinary Incontinence-Clinical Protocol Assessment and Recognition policy, undated, does not address actual incontinent care provided by staff.	F 315		
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to identify, assess and provide treatment for Range of Motion (ROM) deficits for 4 of 6 residents (R1, R2, R3 and R5) reviewed for ROM in a sample of 12 and one resident (R13) in the supplemental sample. This failure resulted in decline of ROM for R5. Findings include:	F 318		

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F 318	Continued From page 33 1. R5's Minimum Data Set, MDS, dated 10/27/15, documents R5 to have no ROM deficits. R5's MDS, dated 2/1/16 documents limitations bilaterally upper and lower extremities with no services provided. The Minimum Data Set (MDS), dated 5/3/16, documents R5 has severe cognitive impairment and is totally dependent on staff for all activities of daily living (ADL's) except eating. The MDS documents R5 has range of motion limitations of upper and lower bilateral extremities. The MDS also documents R5 does not receive any range of motion services to meet these needs. R5's Care Plan, dated 5/10/16, does not address R5's ROM limitations. On 6/21/16 at 11:34 AM , E3 and E4, Certified Nurse's Assistants, CNAs, applied a gait belt around R5's waist and transferred R5 to his wheelchair. During the transfer, R5 remained bent at the knees as he was transferred to the wheelchair. On 6/23/16 at 8:15 AM , E2, Director of Nurses (DON) stated R5 had an overall decline in general condition beginning in February 2016 and noted in May 2016 when asked about the decline in range of motion. E2 stated the decline was attributed to progression of his disease. A Restorative List, provided by E7, Certified Rehab Aide (CRA), on 6/24/16, included residents receiving Passive Range of Motion (PROM), Active Range of Motion (AROM), and restorative programs. R5's name was not included on this list. The list documented a total of 5 residents receiving services.	F 318		

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On 7/1/16 at 9:45 AM, when asked how the facility determines who gets range of motion, E7 stated she "looks at the residents on admission and sees what they can do." E7 stated the facility only does restorative and doesn't do any assessment toward measuring actual limitations by degrees.

The facility's policy entitled "Rehabilitation: Range of Motion (active, active assistance, and Passive)," undated, documents the purpose as "1. to move the residents joints through as full a range of motion as possible, 2. to improve or maintain joint mobility and muscle strength, 3. to prevent contractures, 4. to increase strength and activity tolerance, 5. to reduce pain, 6. to prevent complications of mobility. The policy continues to document the procedure of range of motion exercises but fails to include assessments of limitations for residents at risk for contracture and for those who currently have contractures to ensure services are provided when needed."

2. The MDS, dated 5/5/16, documents R1 as being severely cognitively impaired and admitted to the facility on 4/22/16 with bilateral limitations to upper and lower extremities.

R1's Care Plan, dated 5//10/16, did not address any ROM services or R1's limitations in ROM.

The Restorative List that includes residents receiving PROM/AROM documented R1 was receiving PROMs to her upper and lower extremities.

The Restorative Therapy Record, written by E7, documents on 5/24/16 that she did "PROM with resident and only did 3 repetitions each, resident

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was very stiff, will have to go slow with her." On 5/26/16, E7 documented "worked on arms today to see if I can get more extention to help her with eating." On 5/27/16, E7 documents "did want to eat good today on her own, try to her to use her arms + hand to help herself. She said no." E7's next note was dated 6/6/16 and documents R1 "did all PROM with U (upper) + L (lower) extremities, resident was very resistant, was able to do some stretches." E7's 6/11/16 note documents, "Did PROM resident was not wanting me to do much, worked mostly with U extremities." On 6/14/16, E7 documented "Resident was good with U extremity ex (exercises) today" and on 6/20/16, E7 documented "Resident did better today did U + L ex it is all PROM."

On 6/23/16 at 10:45 AM, E7 was asked to do PROM on R1 who was in bed at the time. E7 replied that she would wait until they got her up in the wheelchair to do ROM. At 11:20 AM, E7 propelled R1 into the therapy room to do PROMs. R1 remained in her wheelchair. E7 did Flexion/extension and horizontal abduction/adduction on R1's shoulder but failed to do abduction/adduction, Internal/external rotation and hyperextension for the shoulder joint. No elbow joint exercises were done. E7 did flexion/extension/hyperextension on R1's wrist joint but failed to do ulnar/radial deviation or circumduction exercises. No finger joint exercises were done but flexion/extension of the thumb joint was done. No abduction/adduction or opposition of the thumb joint was done. E7 did flexion/extension of R1's hip joint but no abduction/adduction, internal/external rotation or hyperextension of the hip joint was done. E7 failed to do inversion/eversion of the ankle joint

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and no toe joint range of motion was provided.

E7 stated on 6/23/16 at 10:45 AM, that R1 receives ROM 5-6 times per week and that she is the only staff member that does the facility's ROM exercises. E7 stated there are no assessments as to the degree of limitations for R1.

On 6/29/16, Z1, Medical Director, stated he would expect staff to complete PROM procedures properly and for the residents that require it.

On 7/7/16 at 11:30 AM, Z3, Nurse Consultant, stated that standard practice of range of motion would be for it to be done twice daily 7 days a week.

3. On 06/29/16 at 2:15 PM, E14, CNA stated that the CNA's do not do PROM's on residents and that E7, Rehab Aide was responsible for doing restoratives for residents. E14 stated she was not sure which residents were on restorative programs. E12, CNA was in the hall at this time and heard the conversation, and conferred with E14 that CNA's do not do the ROM for the residents.

The MDS, dated 04/27/16, documented R2 was severely cognitively impaired with both short and long term memory deficits. It documented R2 required total assistance of at least one staff for bed mobility, transfers, locomotion, dressing, eating, hygiene and bathing. It documented R2 was identified as having ROM limitations in both the upper and lower extremities.

The Restorative list provided on 07/01/16 by E7, Rehab Aide, documented R2 was to receive PROM's on both upper and lower extremities.

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The facility had no documentation R2 had received any PROM.

4. On 06/21/16, during tour of the 200 hall, R13 had contractures of both hands and both feet. There were no splints, braces or anti-contracture devices in use.

The MDS, dated 05/16/16, documented R13 was moderately cognitively impaired and required total assistance of at least one staff for bed mobility, transfer, ambulation, locomotion, bathing and toilet use. It documented R13 had limitations in both the upper and lower extremities and was on a restorative program for PROM's for seven days per week.

The Restorative list of residents presented on 06/24/16 by E7 did not include R13 for receiving any type of restorative services.

The Care Plan, dated 02/11/16, documented R13 had limited physical mobility.

There was no documentation provided by the facility that R13 received PROMs or that a comprehensive assessment had been conducted that assessed R13's ROM limitations or contractures.

5. On 6/24/2016 12:10 PM E11, CNA, went into R3's room and assisted R3 to sit on the left side of the bed. E11 placed gait belt around R3's trunk and began ambulating R3 into bathroom. R3's knees were slightly bent with ambulation. Upon coming out of bathroom, E11 placed R3 into the wheelchair, removed the gait belt and propelled R3 into the dining room.

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F 318	Continued From page 38 On 6/24/2016, at 12:20 PM, E11, CNA was asked if R3 walks to the dining room for lunch. E11 stated, "No." E11 stated R3 would get up too much and would go by self. On 6/24/2016, at 1:50 PM, E3, CNA, was asked if R3 walked to lunch or was in wheelchair. E3 stated R3 went to lunch in a wheelchair. On 6/24/2016, at 11:10 AM, E7 was asked about R3 walking. E7 stated she walks 100 to 120 feet for lunch and supper and R3 receives no range of motion. R3's Care Plan Intervention/Tasks, revised on 2/1/16, documents "NURSING REHAB/RESTORATIVE: Transfer and walk resident to Lunch and Supper to maintain mobility." R3's MDS, dated 10/20/15, documents R3 had no limitation in range of motion for lower and upper extremities. R3's MDS dated 02/01/2016 documents she had limitations on both sides of both lower and upper extremities.	F 318		
F 323 SS=K	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.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide safe transfer techniques, assess and identify causative factors contributing to falls and injuries, implement progressive interventions and monitor and modify those interventions as necessary to prevent falls and injuries for five of 12 residents (R1, R2, R5, R6 and R10) reviewed for falls and injuries in the sample of 12 and 5 residents (R14, R16, R20, R21 and R23) in the supplemental sample. This failure resulted in R16 sustaining a dislocated shoulder during a transfer requiring a post reduction to surgically restore the dislocation and R23 sustaining a fracture rib.

This failure resulted in an Immediate Jeopardy which was identified to have begun on 3/3/16, when the facility failed to in-service employees on proper transfer techniques to prevent future injuries and unsafe transfers after R16 was transferred unsafely and sustained a dislocated shoulder.

While the Immediate Jeopardy was removed on 7/8/16, the facility remains out of compliance at Severity Level 2 as the facility continues to educate new staff and update policies and procedures as needed.

Findings include:

1. R16's Nurse's Note, dated 03/03/16, documented E13 and E14, Certified Nurses Aides (CNAs) were transferring R16 from the shower chair to the wheelchair. The Nurse's Note documented "(E13) stated that the (mechanical lift) would not fit into the bathroom, so one aide

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got on each side to transfer resident. (E13) heard a pop and (R16) was not able to perform Range Of Motion (ROM) on right arm." It further documented, "(R16) sent to emergency department for evaluation."

On 03/04/16, a Cat Scan (CT) report documented, "Anterior displacement of the humeral component of the right reverse shoulder arthroplasty. There does appear to be superior subluxation of the clavicle relative to the acromion." Also, a post reduction to surgically restore the dislocation to the correct alignment was performed on R16 03/04/16.

On 03/04/16 at 5:30 AM, R16's Nurse's Note documented R16 returned from the hospital after a post reduction of the right shoulder prosthesis.

E13's written statement, dated 3/3/16, documented "We were getting the resident (R16) out of the shower chair and there was not no room." E13 documented, "I had her right arm and leg and (E14) had her left arm and leg. It was very up close and personal, but as we sat her bottom down she was just to the chair and I'm sure I heard a crack in her arm or something. She said it didn't hurt but she couldn't move it."

E14's written statement, dated 3/3/16, documented "I wasn't the shower person and she (E13) said 'Hey come help me, I normally use the (mechanical lift).' We couldn't fit the (mechanical lift) in the bathroom. (E13) just said come and help me and we asked (R16) how they were doing her, she said just lifting her. So, I just helped her cause she asked. I didn't know I could use the sit to stand. Didn't remember about the Kardexs."

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R16's Nurse's Note, undated, documented "Aides used a fireman's technique because the 200 shower room was under temporary construction and the (mechanical lift) would not fit in the 100 hall shower room."

R16's Physician's Order Sheet (POS), dated 01/29/16, documented R16 had the following diagnoses, in part as, Cerebrovascular Accident (CVA) with Right Side Hemiplegia and Hemiparesis, Muscle Weakness, Parkinson's Disease, Cerebral Palsy and history of Right Shoulder Rotator Cuff repair.

On 01/29/16, the Admit/Readmit Screener (Initial Nursing Assessment) documented R16 was total dependence for transfers.

R16's Minimum Data Set (MDS), dated 02/01/16, documented R16 was moderately cognitively impaired and required extensive assistance of two staff for transfers and had ROM limitations of bilateral upper and lower extremities.

The Care Plan, dated 02/07/16, documented R16 required mechanical lift with two staff for transfers. Also, documented R16 was a high fall risk related to Parkinson's Disease and Cerebral Palsy. On 02/24/16, Care Plan was updated documenting R16 required a mechanical lift or sit to stand (dependent on resident mobility at time of transfer) with two staff for transfers.

On 06/29/16 at 3:25 PM, E2, Director of Nursing (DON) stated that E18, MDS/Care Plan Coordinator had added the sit to stand transfer as a courtesy to R16 because R16 wanted to go back to an assisted living facility and could not go

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unless she could be transferred via sit to stand. E2 stated that there were no assessments done to determine if a sit to stand transfer was appropriate or safe for R16. E2 also stated that R16 was not in therapy or on restorative for transfers.

On 06/29/16 at 2:15 PM, E14 stated that she was asked to help E13 to transfer R16 from the wheelchair to the shower chair. She stated that there were three CNAs that helped to transfer R16 from the wheelchair to the shower chair. She stated that they used a fireman-like transfer to lift the resident out of the wheelchair. She stated that R16 was only able to minimally bear weight on one leg, and really couldn't bear weight at all that day. E14 also stated that R16 was a larger woman and it took all three to get her into the shower chair. E14 then stated that she was asked again by E13 to transfer R16 from the shower chair to the wheelchair, but it was only the two of them. She said the shower room was very small and difficult to move around in. She stated that when they sat her down in the wheelchair E13 stated she heard a crack from R16's shoulder area. E14 stated the right arm was the more weakened side for R16 and could not move it at all after the cracking sound. E14 stated that she did not know about the Kardex for R16, did not know how R16 was to be transferred and did not use a gait belt. E14 further stated that she was educated after this incident on how R16 was to be transferred and said it was mechanical lift only.

The facility had no documentation that any staff were inserviced on transfer techniques safety or the Kardex system. The Kardex system is a card kept on each resident regarding basic care issues

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such as how each resident should be transferred.

On 6/29/16, at 10:15 AM, E2 stated that she had not done any in-servicing or training with staff of any kind, especially for Kardex system or transfer training. E2 further stated that each CNA should know about the Kardex's on each resident and that the nurses should be updating them as changes occur. E2 also stated that she had not updated any of the Kardexs for any of the residents living in the facility since she was hired in January 2016.

On 7/1/16, E19, CNA at 3:20 PM, E21, CNA at 3:30 PM, E22 at 3:40 PM, all stated they have not been trained on transfers, gait belts or falls. E20, LPN, was interviewed at 3:25 PM and also stated she has had no in-service training on transfers, gait belts or falls.

2. On 06/30/16 at 3:20 PM, R21 was sitting on a couch in the TV room with his wheeled walker by him. At 3:30 PM, R21 was ambulating with his wheeled walker. He passed by E25, Activity Aide, E19, E21 and E22 (CNAs), E23, LPN and E20, Registered Nurse (RN) without being noticed or assisted and continued down the 200 hall unassisted.

On 7/1/16, at 3:20 PM, E19, stated R21 was a one assist for transfers. At 3:25 PM , E20 stated R21 was an assist with one staff for transfers and ambulation. At 3:30 PM, E21 stated R21 required one person physical assistance for transfers and ambulation. At 3:40 PM, E22 stated R21 required one person physical assistance for transfers and ambulation.

The POS, dated 06/01/16, documented R21 had

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the following diagnoses, in part as, Dementia without Behavioral Disturbances, Chronic Deep Vein Thrombosis of right lower leg, Osteoarthritis, Alzheimer's disease and restlessness and agitation.

R21's MDS, dated 05/08/16, documented R21 was severely cognitively impaired, scoring zero on the Brief Interview for Mental Status (BIMS). It also documented R21 required limited assist of one staff for transfers, dressing and bed mobility. It documented R21 required extensive assist of one staff for hygiene and bathing. Also, it documented R21 was frequently incontinent of both bowel and bladder and had ROM limitations on one side for both upper and lower extremities. The MDS documented R21 was not currently receiving any therapy or restorative services.

The Morse Fall Scale, dated 05/02/16, documented R21 was a high risk for falling.

R21's Care Plan, dated 01/09/16, documented R21 was identified as being a fall risk related to confusion and incontinence and under Activities of Daily Living interventions for Transfers "Resident uses walker to maximize independence with transferring." Other interventions were to anticipate residents needs and call light within reach, however identified R21 as having impaired cognitive function related to Dementia and Alzheimer's Disease. It also documented R21 had actual falls on 10/24/15, 12/08/15, 12/12/15, 02/18/16 and 04/03/16. There were no new interventions listed on the Care Plan after each fall.

The Kardex documented R21 was incontinent and required limited assist of one. It also

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documented R21 will void on the floor in the closet and have a bowel movement on the floor. It also documented R21 required supervision with ambulation and was independent with positioning with supervision.

The Post Fall Management Quality Assurance Form, dated 02/18/16 at 2:50 PM, documented R21 was found in the TV room with his pants down around his ankles attempting to toilet himself and lost balance and fell. No injuries documented. The intervention was that R21's dose of Olanzapine had been reduced on 02/17/16 and to monitor R21 over the weekend for any behaviors. No new interventions for the fall or toileting.

The Post Fall Management Quality Assurance Form, dated 02/18/16 at 9:00 PM, documented R21 "Appears to have hit the night stand in his room." It documented R21 had two skin tears on the left elbow measuring 2.2 cm x 0.9 cm and 0.9 cm x 1.5 cm. There was no documentation of any explanation if R21 was walking or in his wheelchair at the time of the incident. No new interventions were listed.

The Post Fall Management Quality Assurance Form, dated 04/03/16 at 5:30 AM, documented R21 was found on the floor in front of his bed with the floor wet with urine. No documentation of the bed alarm sounding. It documented R21 sustained a right elbow skin tear. No measurements recorded. It documented R21 was sent to the emergency department for evaluation and returned later to the facility. The interventions documented for R21 were every two hour checks while in bed related to toileting needs. There was no documentation that every two hour checks

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were completed by staff during or after this intervention was put into place.

The Post Fall Management Quality Assurance Form, dated 05/07/16 at 9:38 PM, documented R21 was found on the floor in the 300 hall lying on the carpeted floor on his right side knees bent with head resting on right arm sleeping. No documentation of the bed alarm sounding. No injuries were listed and unknown how long resident was there, because R21 ambulated without assist and there was no documentation that every two hour bed checks were done. Also, the 300 hall was vacant with no residents or staff attending that hall and was dark with no lights on. It documented R21 was assisted back to bed.

The Post Fall Management Quality Assurance Form, dated 05/20/16 at 10:00 AM, documented R21 was found sitting on the toilet in his room with a discoloration on top of the left shoulder. It was documented as being reddened bruising measuring 8 cm x 3 cm. Slight grimacing when ROM performed. No documentation of how resident got to the bathroom or that the bed alarm was sounding. It documented R21 has poor safety awareness with frequent bumps into things during ambulation. Alarm remains while in bed. The intervention listed was to encourage R21 to allow staff to assist when ambulating as long as he does not become agitated.

The Post Fall Management Quality Assurance Form, dated 06/14/16 at 7:57 PM, documented R21 was found in bed with multiple blue/black bruises to the right and left forearms. It documented the right forearm measured 6 cm x 6 cm and there were three on the left forearm one measured 2.5 cm x 2.5 cm, one measured 2 cm

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x 1 cm and one measured 3 cm x 1 cm. It documented "Resident walks unsupervised and bumps things often." There were no new interventions documented on the form.

The Post Fall Management Quality Assurance Form, dated 06/25/16 at 11:30 PM, documented R21 was found on the floor in his room, bed alarm was sounding. It documented R21 complained of knee pain. It documented the "Because Factor/Conclusion" was "Resident may have got tired and laid down." There were no new interventions documented on the Quality Assurance Form or Care Plan.

The Post Fall Management Quality Assurance Form, dated 06/29/16 a 9:16 PM, documented R21 was witnessed by E23, LPN entering the shower room with his walker. When she got into the shower room she witnessed R21 let go of his walker and turn to come out of the shower room, lost his balance and fell backwards landing on bottom while both upper extremities struck the wall resulting in multiple skin tears. One skin tear on the left second finger, one on the right third finger and one on the right elbow. It documented that R21 claimed he was ready for bed, continued with confused conversation which is his normal baseline. The "Because Factor/Conclusion" was "Resident likely confused due to room change, may try bed alarm until resident put back to old room near nurses station." There were no new interventions documented on the form.

3. On 06/21/16 at 1:30 PM, E2 and E23, LPN transferred R2 from the wheelchair to the toilet. E2 and E23 placed their arms underneath R2's axillas and lifting her by the gait belt while R2's

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feet never touched the floor. R2 became upset, anxious and agitated during the transfer and after. R2 was transferred in the same manner with her pants and incontinent brief at her ankles from the toilet to the wheelchair and again from the wheelchair to the bed. By this time, R2 was very anxious and agitated. At no time did R2's feet touch the floor during the transfers.

The POS, dated 06/01-30/16, documented R2 had the following diagnoses, in part as, muscle weakness, Alzheimer's Disease, Dementia with Behavioral Disturbances, history of Fall, Anxiety Disorder and Pseudobulbar Affect.

The MDS, dated 04/27/16, documented R2 was severely cognitively impaired with short and long term memory deficits. R2's MDS documented R2 required total assistance of at least one staff for bed mobility, transfer, locomotion, dressing, eating, hygiene and bathing. It documented R2 required total assistance of two staff for toileting. It documented R2 had limited ROM in both upper and lower extremities and was frequently incontinent of both bowel and bladder.

The Morse Fall Scale, dated 04/16/16, documented R2 scored 75 points indicating a high risk for falls.

The Care Plan, dated 04/14/16, documented R2 was dependent on staff due to cognitive deficits. It documented R2 was identified as being totally dependent on at least one staff for all Activities of Daily Living (ADL's). It also documented R2 was identified of being high risk for falls.

4. On 06/22/16 at 9:15 AM, R20 was at a table in the dining room and had just finished eating

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with assistance of staff. Staff members were observed to be taking other residents to their rooms or the TV room. R20 was observed to stand up from her wheelchair, personal alarm sounded and staff intervened quickly and assisted R20 to her seat.

The POS, dated 06/01-30/16, documented R20 had the following diagnoses, in part as, Pseudobulbar Affect, Restlessness and Agitation, Anxiety Disorder, Abnormal Gait, Muscle Wasting and Atrophy, Toxic Encephalopathy, Disorientation and Non-traumatic Subdural Hemorrhage.

The MDS, dated 04/18/16, documented R20 was severely cognitively impaired. R20's MDS documents R20 required extensive assistance of one staff for bed mobility, transfers, dressing, eating and toileting. It also documented R20 required total assistance of one staff for hygiene and bathing, was frequently incontinent of bowel and bladder and had limitations in ROM in both the upper and lower extremities. It documented R20 is not participating in any therapy or restorative programs.

The Morse Fall Scale, dated 04/18/16, documented R20 scored 75 points indicating a high risk for falls.

The Care Plan, dated 01/22/16, documented R20 had impaired cognition with short and long term memory loss and required extensive assist of one staff to move between surfaces. It also documented R20 was identified as being high risk for falls related to gait/balance problems. It also documented R20 was identified as being restless, anxious and fidgety related to anxiety. It

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F 323	Continued From page 50 documented R20 was identified as having potential impairment to skin integrity related to fragile skin, decreased mobility and incontinence. On 02/17/16 at 3:15 PM, the Report of Incident Situation Background Assessment Recommendation (SBAR) documented E9, CNA, was giving R20 a shower and noted bruising underneath both of R20's breasts. It documented R20 had fragile skin, poor safety awareness and that this was as a result of accidental or unintentional injury during transfer. The description was documented as a purple/yellow in color measuring 38.1 cm x 3.5 cm. The interventions were listed as " place gait belt appropriately, monitor bruise and transfer carefully." On 02/16/16, E28, CNA, documented on a shower sheet that he observed bruising to bilateral breasts/ribs area and was signed by E16, LPN. On 02/17/16, the Reportable Incident Report, written by E2 documented that upon investigation, the bruise was noted to be consistent with improper gait belt usage. During this investigation, E2 documented that on 02/13/16, E27, CNA stated that she had noticed the bruising at approximately 7:30 PM, but failed to notify the nurse because she thought they already knew about it. The Investigation documented that all nursing staff would be in-services on proper placement of gait belts. The Investigation did not document that transfer technique with a gait belt was discussed during this in-service. On 7/5/16, at E16, LPN 1:15 PM, she confirmed she observed R20 on 2/17/16 with bruising under both her breasts. 5. On 6/23/16 at 11:10 A.M., E11 and E17,	F 323		

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F 323	Continued From page 51 CNAs, brought the sit to stand lift into R6's room. R6 was unable to grasp the sit to stand with her right hand. E17 stated "The last time before she fell, she could not hold on to the lift. I don't think we should use it." R6 was then pushed into the bathroom. E11 placed gait belt around R6's waist. E11 and E17 stood in front of R6 and undid R6's incontinent brief. E11 and E17 placed a gait belt around R6's waist. E11 and E17 lifted R6 by the gait belt and all of R6's weight was suspended on the gait belt since R6 could not bear weight on her feet. R6 was urinating on the floor during the transfer. R6's clinical record documents that R6 has a history of falls. R6's Progress Note, dated 6/10/16, at 1900, documents that "(R6) was found lying on right side, beside bed, knees bent, swelling present upper forehead 4 Centimeters (Cm) x 0.5 CM laceration in center of swelling. 5 CM x 0.5 CM laceration posterior scalp right side. Light pressure applied with dressing. Resident can move all without pain. Order received to send to hospital for evaluation and treatment." The Hospital Emergency Room Discharge, dated 6/11/16, documents R6 received staples due to a head injury. The facility's incident review notes, dated 6/16/16, documents that R6 "appears to have hit head on nightstand when she rolled from bed. Nightstand is no longer next to the bed. It has been moved to the closet." R6's Care Plan, dated 4/7/16, was not updated to address R6's nightstand being moved.	F 323		

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Throughout the survey, from 6/18 through 7/1/16 at 11:15 AM, R6's nightstand remained next to her bed.

R6's MDS, dated 4/5/16, documents that R6 is totally dependant and requires two plus physical assistance with bed mobility. The MDS documents that R6 is totally dependant, and requires one plus physical assistance for transfers. R6's Morse Fall Scale, dated 4/7/16, documents that R6 has a score of 65 (High risk is 45 and higher). R6's MDS documents that R6 has a diagnosis of Alzheimer's Disease, Restlessness and Agitation, Insomnia and Dementia.

R6's Care Plan, dated 4/7/16 , documents that R6 requires mechanical lift sit to stand with 2 staff assistance for transfers. R6's Care Plan documents R6 is at high risk for falls. R6's Care Plan documents under interventions that the facility will review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter, remove any potential causes if possible. Educate Resident/family/caregivers/Interdisciplinary team (IDT) as to cause.

The facility's Assessment of Fall Potential, dated 9/22/15, documents that R6 has a score of 14. (Score above 8 is high risk and should be at risk for potential falls).

The Kardex, a sheet of paper for each resident that provides CNAs basic instructions for care was in a binder on the 200 hall. R6's Kardex is undated and fails to include any specifics towards transfers except that she does use a recliner chair and one assist.

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On 6/29/16 at 1:28 P.M., E9, CNA stated that she started employment at the facility in January. E9 stated that during orientation she was told what type of lift or transfer was needed for each resident. E9 stated that the Director of Nursing (DON) trained her on the use of a gait belt. E9 stated the training consisted of E9 demonstrating the use of a gait belt on the DON.

On 6/29/16 at 1:25 P.M. E12, CNA stated that she had training on gait belts and transfers when she employment at the facility three months ago. E12 stated that the DON walked her around the facility and showed her how to do things.

6. The facility's Resident Incident Report dated 12/3/15, documents that R23 was found on the floor In his room. The facility's Investigation Conclusion dated 12/3/15, documents that R23 had a history of falling at home and from one fall had sustained an orbital fracture.
R23's Care Plan dated 1/7/16, documents that R23 is a high risk for falls. R23's Care Plan documents that staff are to anticipate and meet R23's needs, be sure R23's call light is within reach and encourage R23 to use it for assistance as needed, R23 needs prompt response to all requests for assistance and R23 uses bed and body alarm.
R23's Morse Fall Scale dated, 1/19/16, documents that R23 has a score of 75, which indicates R23 is at a high risk for falls. R23's Morse Fall Scale, dated 4/22/16, also documents a score of 75.
The Facility's Resident Incident Report dated 2/4/16 documented at 4:45 PM, R23 was found lying on his back on the floor in his room. The Report documented there was feces on the floor

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F 323	Continued From page 54 and his pants. The Post Fall Management QA form documents the root cause of the falls as he was incontinent of bowel and attempted to provide self care without assistance. The interventions was to place a floor mat next to his bed. R23's Care Plan was not revised with these new interventions. R23's MDS, dated 4/18/16, documents that R23 has a Brief Interview of Mental Status (BIMS) of 3, which indicates R23 is severely cognitively impaired. R23's MDS documents that R23 has a diagnosis of Non Alzheimer's Dementia and Depression. R23's MDS documents that R23 requires assistance and 2 plus persons physical assistance for transfers and extensive assistance and 2 plus persons physical assistance for ambulation in his room. R23's MDS documented that under balance during transfers when moving from a seated to a standing position R23 is not steady and only able to stabilize with staff assistance. On 7/1/16 at 3:10 P.M., E23, LPN, stated that in the middle of shift report on 6/30/16, E7, Restorative CNA, yelled from R23's room for help. E23 stated that when she entered the room R23 was lying on his back a distance from the bed. E23 stated that R23's lip was bleeding, and there was an area to right elbow skin tear. E23 stated that later R23 was complaining of his right side hurting, and that when she touched R23's right side he would flinch. E23 stated that she notified the physician and he ordered an X-ray. R23's x-ray report dated 6/30/16 at 8:18 P.M. documents that R23 sustained an acute non-displaced right lateral 8th rib fracture. The facility's Management Incident Investigation Form dated 7/1/16, documents that R23 may have tripped on floor mat, and bed alarm sounding.	F 323		

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7. The MDS dated 4/18/16 documents R14 as requiring total assist of two staff for bed and extensive assist of two for transfer. The MDS documents R14 has severe cognitive impairment. The MDS documents R14's balance to have deficits with only able to move from place to place with the assistance of staff to stabilize.

R14's Care Plan, dated 4/18/16 documents R14 to be at high risk for falls due to vision problems, decreased mobility and cognition. The Goal is to be free of injury through next review with interventions being - "anti-tippers on w/c (wheelchair), anticipate and meet needs, call light within reach, bring to nursing station if unable to redirect or not ready for bed, education resident/family/caregivers about safety reminders and what to do if fall occurs, follow policy, lap buddy while up in w/c - release every two hours and PRN (as needed) for toileting, Review information on past falls and attempt to determine cause of fall, record possible root causes, schedule toileting between 3-4 am, bed/chair alarm - ensure in place, verbal reminders to not lean forward too far for items out of reach, wedge cushion."

Report of Incident Situation Background assessment Recommendation (SBAR) - Physical Injury report documents R14 to have multiple falls. On 1/30/16 at 9:10 AM, R14 fell in the dining room. The report documents R14 leaned too far forward in the wheelchair and "toppled out and landed on her lt (left) side." The report fails to identify whether the wedge cushion was in place but did document the alarm was sounding when she fell. The possible interventions checked include anti-tippers to the front of the

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wheelchair but no evidence that they assessed for adequate supervision. Root cause is identified as poor safety awareness.

A Report documented on 3/31/16 at 6:15 AM, R14 was reaching for the ice cart while in the wheelchair and CNA observed her falling to the floor on her left side. The report states the fall was witnessed in the hallway by the CNA who was unable to get to her in time to prevent the fall. Injuries were documented as a 2 centimeter (cm) x 1.5 cm skin tear to her left elbow and a 2 cm hematoma on the top of her head. Intervention added was to give her a magazine or her purse early am to keep her busy. There is no evidence that R14 had the wedge cushion in her chair at the time. The Report documented only "verbal reminders not to lean forward too far" as interventions. Conclusion was "poor safety awareness." There is no documentation or assessment that the facility looked at adequate supervision since the CNA was unable to reach R14 before she fell or her cognitive impairment to process verbal reminders to not lean forward.

Incident Reports document R14 had two falls on 4/22/16. The Incident Report documents the first fall occurred in her room at 4:50 AM when she "was bending over in the chair fell out hitting her left side of her head first then her knee. Alarm was sounding." the Report documents the fall was witnessed by E15, LPN. E15's Progress Note, dated 4/22/16 at 4:50 AM, documented R14 sustained "a bruised lump to left temple with a 3 cm cut, cleansed with wound wash and steri stripped. Left knee with a 5 cm cut cleansed with wound cleanser and steri stripped." The investigation documents R14 is not able to follow directions, has decreased energy, poor

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coordination/unsteady gait, decreased strength and confusion. No new interventions were documented as put in place following this fall.
At 7:10 AM, on 4/22/16, the progress notes document "Resident propelling herself around facility with wander guard & chair alarm on was bending over like she was reaching for something on the floor fell head first hitting her head on left temple & her left shoulder onto the hallway door. CNA called for writer who examined for injuries & initiated a neuro check. Resident lethargic, slow to answer questions & complaint of head & left shoulder pain. CNA placed towel under residents head. Writer left resident in floor not moving her for preventative of further injury until ambulance arrives." R14 was transferred to the emergency room for evaluation and treatment. The report documents R14 removed her lap buddy.
The progress notes documented R14 returned to the facility on 4/22/16 at 1700 (5:00 PM) and had "a large bruise area around left eye orbit, resident can open eye fine. Lacerations/skin tear above left eye is steri stripped - 7 cm (centimeter) x 8 cm, left knee scraped 4 cm x 4 cm."

The Investigation Record for the 4/22/16 identifies interventions as a lap buddy, restraint assessment, restorative assessment as added due to "poor trunk control, leaning over in w/c." The investigation identifies R14 as confused, impaired memory but does identify R14 as being able to maintain sitting balance. There was no documentation in R14's record that R14's Care Plan or Kardex was updated and a restorative assessment was completed as recommended .

Progress notes also documents ob 4/22/17 at 21:41 (9:41 PM) that R14 "continues to remove

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lap buddy after putting lap buddy on." Progress notes dated 4/27/16 at 20:40 (8:40 PM) documents R14 continues to try and stand up from wheelchair, and fidget with lap buddy, reassurance given frequently" and "attempts to reorient not successful." On 4/28/16 at 8:24 PM, R14 continued to remove the lap buddy according to the progress notes. On 5/18/16 at 8:22 PM, E8 LPN documents in the progress notes "very restless this shift, continuously taking off lap buddy and trying to "get out of here."

On 5/21/16, at 1900 (7:00 PM), Progress notes by E15 document "Resident found sitting on floor mat, beside bed in her room. sitting on buttocks, knees drawn up in front of her. lap buddy beside resident. examined for injury, none found. resident can move all extremities without pain. returned to wheelchair with help of two staff members, lap buddy replaced." The investigation report documents no interventions were added to the Care Plan and/or Kardex and conclusion documented as "poor safety awareness/perceives abilities greater than actual."

On 5/30/16 at 6:12 AM, R14 had another fall witnessed by E16, LPN, who documented "resident fall appears to be due to aid turning away while resident was with out her lap buddy staff made aware that resident needs monitored while in chair without lap buddy." E13, LPN document in the progress notes that R14 sustained "0.5 cm x 1 cm skin tear to left elbow." No investigation was done and no interventions were added to R14's Care Plan or Kardex in response to R14's fall.

On 6/28/16, at 8:15 AM, R14 was in the front

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hallway in her wheelchair. She had her purse open and dropped items from her purse onto the floor in front of her. R14 made several attempts at leaning over to pick them up off the floor, then unhooked the right side of her lap buddy leaning forward before staff reached her. She had a chair alarm clipped onto her shirt with a long cord to the unit. She had no wedge in her chair.

On 6/29/16 at 10:15 AM, E2 Director of Nurse (DON) acknowledged that R14 frequently removes her lap buddy and "quite often, which is okay because it gives staff a little more time to get to her." E2 stated after the first fall, they put an alarm on her but haven't put an additional interventions in place since the lap buddy. E2 stated CNAs know how to care for R14 from the Kardex available on the floor and states she has not had time to review those since becoming the DON in January, 2016. E2 also stated R14 doesn't have the front anti-tippers any longer because they were problematic from the start.

On 6/30/16 at 9:45 AM, E11 and E9, CNAs, confirmed R14 does not have a wedge in her wheelchair but does have a lap buddy and a chair alarm. E11 stated R14 will get "fidgety" when having to use the bathroom so you need to watch her for that. Both CNAs stated R14 can remove the lap buddy and does so many times on some days. E11 stated R14 is unable to use her call light due to her confusion and giving verbal reminders would not help or work due to her confusion.

On 6/30/16 at 10:10 AM, E16, LPN stated R14 is not able to use call light due to cognitive impairment but will tell you when she has to toilet, then off comes the lap buddy. E16 stated you

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F 323	Continued From page 60 would not be able to remind her of safety measures either. The Kardex (undated) identifies R14 as "high risk", position changes with one staff but fails to identify her use of the lap buddy or her ability to remove it. The care plan hasn't been revised since 4/18/16 ever though she's had 3 additional falls and still includes the anti-tipper and the wedge cushion which she no longer has on her wheelchair. The falls prevention plan fails to identify that R14 frequently removes her lap buddy and does so at times when she has to use the toilet. The care plan includes ineffective interventions given R14's severe cognitive impairment such as call light in reach, educate resident about safety measures, verbal reminders to not lean forward too far for items that are out of reach. The facility's policy/procedure (undated) documents its policy as "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." The one page policy documents under "Prioritizing approaches to manage falls and fall risks", it documents "the staff, with input of the attending physician, will identify appropriate interventions to reduce the risks of falls, if a systematic evaluation of a residents fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i. e. to try one or a few at a time, rather than many at once." The policy also documents "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicates why the currant approach remains relevant." The	F 323		

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F 323	Continued From page 61 policy also documents if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions to try to minimize serious consequences of fall. Under "Monitoring Subsequent falls and fall risk," it documents staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling." The policy documents the staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. 8. The MDS dated 5/3/16 identifies R5 was admitted on 6/17/14 and has severe cognitive impairment. The MDS documents R5 is totally dependent on 2 staff for transfers and has a restraint as a lap top table on his wheelchair. The Kardex, dated 10/28/15, documents R5 transfers with gait belt and 1-2 assists, and has a seat belt on. The Care Plan, dated 5/10/16, documents R5 includes two transfer directives: 1) requires extensive assistance by 2 staff to move between surfaces depending on residents functional status at the time (may require sit to stand) dated 2/24/16 and 2) The resident requires Mechanical sit to stand with 2 staff assistance for transfers for resident is unable to stand for 2 assists with gait belt. Staff are to "encourage the resident to participate to the fullest extent possible with each interaction." The care plan also documents R5 to use a three point chair due to poor trunk control, poor positioning and poor posture. On 6/21/16 at 11:34 AM, E3 and E4, CNAs, were at R5's bedside and asked if he was ready to get up for lunch. E3 then pulled the covers down and grabbed him by the back of the neck while E4	F 323		

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F 323	Continued From page 62 swung his feet off the bed to side on the edge of the bed. R5 appeared stiff. E3 then applied a gait belt about his waist and then each CNA grabbed the gait belt under his arm and pulled him to a standing position as they swung him toward the reclining chair dropping him in the seat. R5 was not given the opportunity to stand up straight nor was he cued and/or encouraged to participate in the transfer by cueing him to stand up and move his feet. As R5 was turned to sit in his chair, his feet slid with no steps taken to the chair. E4 stated "He's so tired all of the time." On 6/22/16 at 9:45 AM, R5 was in his room at bedside when E11 and E17, CNAs, entered the room with the mechanical sit to stand machine. Staff directed him to place his hands on the lift bars and attached the strap about his wait. R5 was pulled up into a standing position and moved to the bed safely. On 6/29/16 at 1:25 PM, E2 stated residents are assessed for safe transfers during the first few days by E7 Certified Rehab Aide (CRA) taking into account how they transferred at the last place they were. E2 also stated the transfer technique would be listed on the Kardex which she hasn't had a chance to update since she started as DON in January 2016. When asked what staff do if two different types of transfers were listed, E2 stated they assess the resident at the time in terms of how much assistance they needs. On 6/30/16 at 10:50 AM, E7, CRA, was asked if she assessed residents for safe appropriate transfers stated she "looks at each resident when they are admitted to the facility and sees what how they transferred before" but doesn't evaluate them after that. E7 stated she does it verbally	F 323		

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and has no documentation on it.

9. The MDS dated 5/5/16 documents R1 to have been admitted to the facility on 4/22/16. The MDS documents R1 to have severe cognitive impairment and require extensive assist of two staff for transfers. There is no fall risk assessment done. The MDS indicates she is unable to balance for transfers without staff assistance. The Care Plan, dated 4/29/16, documents R1 to be at high risk for falls due to unaware of safety needs and confusion. The Goal is to be free from falls. Interventions include anticipating/meeting needs, be sure residents light is within reach and encourage the resident to use to it for assistance, and educate the resident/family/caregivers about safety reminders and what to do if falls occur. There is nothing in the care plan regarding transfers and there is no Kardex for R1 in the book for CNAs to use as directives when providing care.

On 6/21/16 at 1:25 PM, E8 (LPN) and E9 (CNA) applied a gait belt and pulled R1 in a standing position. R1 had regular socks on and as she remained bent at the waist, E8 and E9 pivoted R1 around to sit on the recliner. Her feet did not move nor did she participate in the transfer. R1 was then lifted up in the recliner by E8 and E9 pulling her up in the chair under her arms and using the gait belt. R1's feet were dangling off the recliner when E9 stated "the chair is broke and won't recline." R1 was left in the recliner without support to her feet.

On 6/22/16 at 3:05 PM, E3 and E9, CNAs, applied a gait belt around R1's waist and stood R1 up from the recliner, pivoted her to sit in the wheelchair. Her feet did not move and she was

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not bearing weight. She was wearing regular socks. E3 and E9 then moved R1's chair to the bedside and they each grabbed the gait belt with one hand and the other placed under R1's arm. They lifted R1 up onto the mattress using the gait belt around her waist. R1 did not bear weight during this transfer.

On 6/30/16 at 10:50 AM, E7 stated she had not done an assessment on R1 but had only looked at her transfer on admission.

On 6/30/16 at 1:30 PM, E2 stated it is the policy of the facility for all pivot transfers be done with a gait belt. E2 stated all staff are provided a gait belt upon hire and are expected to use them accordingly.

The policy entitled "Transfer Activities" (undated) documents the purpose is to "transfer the resident from bed to chair, toilet or tub safely." The general guidelines include knocking and closing door, explain the procedure to the resident, explain safety measures to resident along with effects and/or complications, place call light in reach, screen for privacy in part. Equipment includes appropriate size chair, mechanical lift, pressure reducing devices as necessary, positioning devices as necessary and appropriate seat belts if necessary. The policy does not include procedures for transfer nor does it include the use of the gait belt.

On 6/29/16 at 9:20 AM, Z1, Medical Director (MD) stated he has discussed falls with the Administrator and DON before and suggested using a large spread sheet on the wall where they could all see the information when discussing fall issues. Z1 stated he was aware that falls

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occurred in the facility and has discussed individuals but not policies/procedures or systems for falls prevention since he's been MD. Z1 said if system problems were identified, developing protocols would raise the standard of care.

10. On 6/22/2016 at 9:05 AM R10 was sitting in a reclining chair and E11 Certified Nurse Aide (CNA) and E17 CNA put a gait belt around R10's trunk to transfer R10 to bed. E11 and E17 had a hand hold on gait belt and under R10's upper arm and transferred R10 into bed. R10 had only regular socks on and her feet did not touch the floor suspending her weight with the gait belt. No support was provided to the lower extremities during the transfer.

On 6/22/2016 at 12:23 PM, E11 and E17 entered R10's room to get her up for lunch. A gait belt was applied around R10's trunk and R10 was assisted to sit on side of bed with just sock on R10's feet and feet not on floor. E11 and E17 grabbed gait belt and upper arm and transferred R10 into a reclining chair. R10's feet again was not touching floor during the transfer again suspending all her weight on the gait belt. No support was provided to R10's lower extremities during the transfer.

On 6/22/2016 at 9:15 AM, E11 was asked if R10's feet were on floor and if she was bearing weight. E11 stated R10 is on hospice, doesn't stand and is contracted. E11 continued to state "We just lift her as she is not heavy."

Care Plan Revision dated on 04/01/2016 documents TRANSFER: "The residents requires Mechanical Lift Sit to Stand with 2 staff." The Morse Fall Scale, dated 3/28/2016, documents

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score of 75 with scoring of High Risk documents score of high risk of 45 and higher. R10's Kardex, updated 11/25/2014, documents "sit to stand for transfers."

The Immediate Jeopardy began on 3/3/16 when the facility failed to in-service all staff on safe transfer techniques to prevent future injuries after R16 sustained a dislocated shoulder after an unsafe transfer. E1 and E2 were notified of the Immediate Jeopardy on 7/6/16 at 10:36 AM.

On 7/8/16, surveyors determined through observation, interview and record review, the facility took the following actions to remove the Immediacy:

1. All current nursing staff and facility staff who have direct contact with residents received in-serviced training starting on 7/6/16 by Z6, Facility consultant. This includes the Sit/Stand Mechanical Lift Competency Checklist, The Total Mechanical Lift Competency Checklist and the Transfer/Gait Belt Competency, fall and resident supervision. all New nursing staff hired at (Facility) will be trained on the Proper transfer of a resident using a gait belt or mechanical lift, prior to starting work on the floor. The Kardex will be updated to include the appropriate transfer measures and fall interventions for each residents. Completion on 7/8/16.

2. An audit of resident fall risk assessments is to be completed on each resident currently in the facility on July 7th, 2016 by Z3, Nurse Consultant. Fall risk assessments to be complete upon admission, quarterly and if the resident has a change in condition. Resident falls to be monitored and discussed by the interdisciplinary

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F 323	Continued From page 67 team during the daily QA (Quality Assurance) meeting for the first 4 weeks and then discussed at the weekly care assessment meeting. Compliance audits to be completed by E38, Assistant Director of Nurse's (ADON) and reviewed by the Corporate Director of Clinical Services. Completion on 7/8/16 and ongoing. 3. E38 to perform random monitoring and return demonstrations of residents' transfers on July 6, 7 and 8, 2016, on each shift to help ensure that employees are using safe and proper techniques in compliance with professionally acceptable standards. Any employee who does not meet such standards will be subject to disciplinary action up to and including termination. E38 and her designee to continue random monitoring of staff transfer techniques thereafter to help ensure continued compliance. Completion on 7/8/16 and ongoing.	F 323		
F 327 SS=E	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 sufficient fluids during care and in between meals to maintain proper hydration for 4 of 6 residents (R1, R2, R5, R6) reviewed for hydration in a sample of 12. Findings include:	F 327		

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F 327	Continued From page 68 1. R5's Minimum Data Set, MDS, dated 5/3/16, documents R5 has severe cognitive impairment and is totally dependent on one staff for eating. R5's June 2016 Physician's Order Sheet (POS) documents he receives Colace 100 milligrams (mg) twice daily for constipation. The Dehydration Screen assesses R5 to be high risk. R5's Kardex, dated 10/28/15, did not document any hydration concerns. R5's Care Plan, dated 5/10/16, did not document concerns or any interventions to provide sufficient fluids to meet R5's fluid needs. The Nutritional Risk Assessment dated 4/11/16 documents R5 drinks on average 1500-2000 cubic centimeters (cc) per day. R5's minimum daily fluids requirements based on 30 cc /kilogram (kg) is not included in the assessment. On 6/21/16 at 11:34 AM, E3 and E4, Certified Nurse's Aides, CNAs, transferred R5 from bed to his wheelchair for lunch. No fluids were offered during care. R5 drank 2 glasses of iced tea with no other fluids offered during his lunch meal. R5 was either in bed or at meals from 11:34 AM until the observation ended at 4:30 PM. On 6/22/16 at breakfast, R5 was served a carton of milk, small glass of orange juice and a glass of water. He drank his juice, water and some milk. At 9:45 AM, R5 was transferred back to bed with the assistance of E11 and E17, CNAs, with no fluids offered at time of care. R5 remained in bed napping for the afternoon with his water glass out of reach on his bedside stand. The Monthly Dietary Intake records document food and fluid intake for the three meals per day.	F 327		

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The May 2016 record documents R5 took an average of 450 cc to 720 cc per day with his meal.

June 2016 Dietary Intake records document R5 drank a total of 360 cc for the noon meal on 6/21/16. This was accurate based on observations. For breakfast meal on 6/22/16, R5 was recorded as drinking 220 cc, again, confirmed by observation. The 2016 June Food/Fluid intake records document R5 as taking in as much as 840 cc or as little as 480 cc but never more that 840 cc from dietary.

Calculating R5's minimal daily fluid requirement based on 30 cc/kg of weight (current weight on monthly weight log is 183 pounds or 83 kg), R5 would require 2490 cc/day to meet his minimal needs.

There was no documentation in R5's medical record the facility has assessed R5's fluid intake deficit and developed a plan to meet R5's hydration needs outside of meals as with activities, with care, or with medication pass.

The facility's policy entitled "Hydration Protocol" (undated) documents "As part of the initial assessment the physician and staff will help define the individual's current hydration status." and "The physician and staff will identify individual's with a significant risk for subsequent fluid and electrolyte imbalance; for example, those with prolonged vomiting, diarrhea, or fever, or who are taking diuretics and/or ACE inhibitors and who are not eating/drinking well." The policy also documents "The staff will provide supportive measures such as providing fluids with meals, snacks, med pass, and HS and adjusting

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F 327	Continued From page 70 environmental temperature." 2. R1's MDS, dated 5/5/16, documents R1 as being severely cognitively impaired and requires extensive assist of 1 staff for eating. The Diagnosis list documents R1 to have dementia, Urinary Tract Infections and Parkinson's Disease. The Dehydration Risk Assessment did not identify R1 at risk. R1's Care Plan, dated 4/22/16, documents under "Nutrition" for staff to monitor intake and record meals. The Care plan does not address R1's fluid needs. The Registered Dietician's, RD's, assessment ,dated 5/13/16, documents R1 takes between 1500-2000 cc per day. R1's minimum daily fluids requirements based on 30 cc/kg is not included in the assessment. Calculating R1's minimal daily fluid requirement based on 30 cc/kg of weight (current weight on monthly weight log is 148 pounds or 67 kg), R1 would require 2010 cc/day to meet her minimal needs. On 6/21/16 for the noon meal, R1 was recorded as drinking 220 cc on the Monthly Dietary Intake Sheet. On 6/21/16, at 1:30PM, E4, CNA and E8, LPN, provided care and they transferred R1 to the recliner. they did not offer R1 fluids during care. R1's water pitcher was on the bedside stand out of reach with no straw in it. The water pitcher remained in the same position until 4:30 PM. On 6/21/16 at 3:05 PM, E3 and E9, CNAs ,transferred R1 to her bed from the recliner. No fluids were offered during this care.	F 327		

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On 6/22/16, at 8:10 AM, for breakfast, R1 drank 100% of a carton of milk, and about 3/4 of a small glass of orange juice. The intake record was inaccurate in recording R1's intake as 220 cc.

The 2016 May Monthly Dietary Intake records document meal time intake for meals and fluids. For the month of May, R1's highest intake amount was recorded on 5/6/16 for 720 cc. The least amount recorded for a daily meal fluid intake was 240 cc on 5/12/16. For the month of June 2016, the most fluid recorded as taken by R1 daily was on 6/10/16 and was 820 cc with the least amount recorded being 320 cc on 6/4/16.

3. On 06/21/16 at 11:35 AM to 1:30 PM, during the lunch meal, R2 was fed by staff. At 1:05 PM, R2 had consumed 90% of her meal and approximately 300 cc of fluids of the possible 720 cc given to her at the meal. At 1:30 PM, E2, Director of Nurse's, DON, and E23, LPN, transferred and provided incontinent care for R2. At no time during this observation did E2 or E23 offer fluids to R2. There were no fluids on the night stand in R2's room.

The POS, dated 04/27/16, documented R2 had the following diagnoses, in part as, Alzheimer's Disease.

The MDS, dated 04/27/16, documented R2 was severely cognitively impaired with both short term and long term memory deficits. It documented R2 required total assistance of one staff for eating.

The Care Plan, dated 04/14/16, documented R2 was totally dependent on staff for all Activities of Daily Living (ADL's) including eating.

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4. On 6/23/16 at 11:10 A.M. E11 and E17, Certified Rehab Aide, CRA, were providing care to R6. They did not offer fluids to R6 after providing care in R6's room. No fluids were available in R6's room throughout the day on 6/23/16.

R6's Care Plan dated 5/1/16, documents that R6 has a potential for fluid deficit. R6's Care Plan documents that R6 needs assistance with fluid intake in order to meet daily requirements, and R6 is to have access to nectar thickened liquids whenever possible.

R6's MDS dated 4/5/16, documents that R6 requires extensive assistance and one person physical assistance with eating.

The undated Facility Policy "Thickened Liquids" documents that the nursing department is responsible for thickening all between meal beverages and all fluids administered with medications.

On 7/1/16 at 11:05 A.M., E26, CNA, stated that she provides residents fluids with care most of the time. E26 stated that thickened liquids are kept in the residents rooms at all times.

7/1/16 at 10:15 A.M. E5, Certified Dietary Manager, stated thickened liquids are made and labeled for each resident and sent out on the nourishment cart for am, pm and night snacks.

On 7/1/16 at 11:15 AM, the 10:00 AM snack tray was sitting on the counter at 200 hall nurses station. R6's nectar thickened water was in a container with ice and had not been opened. R6

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F 327	Continued From page 73 did not have any nectar thickened liquids in her room.	F 327		
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 interviews, observations and record review, the facility failed to comprehensively assess behaviors, adequately monitor/track and have adequate justification for use of medications for 2 of 5 residents (R2 and R5) reviewed for	F 329		

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unnecessary drugs/antipsychotic medication in a sample of 12.

Findings include:

1. R5's July 2016 Physician's Order Sheet, POS, documents R5 currently has received Seroquel 25 milligrams (mg), 1/2 tab, twice daily (BID), since 5/11/16 and Medroxyprogesterone (Provera), 2.5 mg daily for male sexual dysfunction since 11/13/15.

R5's OBRA Screen, dated 6/24/14, did not document any serious mental health illness. R5's diagnoses on the Medical Diagnosis Sheet documents major depressive disorder and mental disorder in part.

R5's Care Plan documents R5 to have a behavioral problem of sexual overtones due to dementia, sad/tearful due to depression and fidgety/restless/agitation due to dementia with the goal being to have fewer episodes of sexual overtones, sad/tearful, fidgety/restless/agitation by next review. Interventions include "medications as ordered, monitor/document side effects, anticipate residents needs, attempt interventions such as 1:1 support, explain all tasks given, offer a drink or snack, approach calmly, use soft tone, let him you are here for him, explain all procedures, if reasonable - discuss behavior and explain why it is not acceptable and is inappropriate, intervene as necessary to protect rights of others, divert attentions, remove from situation and take to alternate location if needed." There is no information in the Care Plan as to the type of sexually behavior R5 exhibits and no interventions directly addressing sexual

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behaviors.

E1, Administrator, stated on 6/24/16 at 9:10 AM that R5 did not have a mental illness diagnosis but does have "sexual overtone" that started in June 2014 for which he receives the Medroxyprogesterone for and Seroquel. The EMedicinehealth.com site documents Medroxyprogesterone as Provera or a "female hormone that helps regulate ovulation (the release of an egg from an ovary) and menstrual periods" and is used to treat absent or irregular menstrual periods or abnormal uterine bleeding among other conditions.

R5's Minimum Data Set (MDS), dated 2/1/16, documents an acute onset of mental status change. Under Mood, the MDS documents R5 is moving or speaking so slowly that others have noticed OR the opposite, being so fidgety that moving more than usual and short tempered and easily annoyed. Under Behaviors, the MDS documents R5 has physical/verbal behaviors (kicking, pushing, grabbing, scratching and abusing others sexually) directed toward others with no other behavior symptoms. The MDS also documents that this behavior does not put him at risk for illness or injury and does not interfere with resident care, activities or social interactions. This assessment also documents that R5's behavior has no risk to others and that he has had some improved behaviors.

A Physician's Order (PO) dated 4/7/16 documents a decrease in Seroquel from 50 mg BID to 25 mg BID.

The MDS dated 5/3/16 documents R5 to have inattention, disorganized thinking, altered level of

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consciousness with no mental status changes identified. Under Mood, R5 is documented as have little interest, depression, feeling down, sleep issues, tired - having little energy, and trouble concentrating. Under Behaviors, the MDS documents R5 to have no hallucinations or delusions, no physical or verbal behaviors directed toward others and no over presence of behaviors.

A Physician's Order dated 5/11/16 shows a decrease of Seroquel from 25mg BID to 1/2 tab BID.

On 6/21/16 at 11:34 AM, E3 and E4, Certified Nurse Aides (CNAs), assisted R5 in transferring from his bed to reclining chair. As the transfer was occurring, R5 was touching the CNA's breast and back. The CNA's redirected telling him to stop and he stated "No, I'm not going to stop" with the behavior continuing as they moved him into the chair.

On 6/22/16 at 9:45 AM, R5 was in his room at bedside when E11 and E17, CNAs, transferred R5 with a mechanical lift. E10, a male Registered Nurse, RN was in attendance. R5 did not display any inappropriate sexual behaviors during this time.

Throughout the day on 6/21/16 and 6/22/16, R5 had no agitation/fidgeting or restlessness behaviors noted. R5 was observed to be sleeping in his chair when up for meals except when E7. Certified Rehabilitation Aide (CRA) was sitting right beside him assisting and was in bed asleep in between meals .
The Behavioral Tracking on the MAR documented the staff are to monitor for restless,

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fidgety, sad, tearful, and inappropriate sexual behaviors. The June 2016 documents showed R5 exhibited no behaviors for anything at all between 6/1 and 6/23/16 even though R5 was observed inappropriately touching female CNA's on 6/21/16.

Behavioral tracking completed by the CNA's for June 2016 identify behaviors being tracked include "sad/tearful" with no occurrences documented for the month and "restless/fidgety" with no occurences documented for the month.

On 6/23/16 at 8:15 am, E2 Director of Nurses (DON) stated R5 has had an overall decline after February 2016 which the physician documented as attributed to the progression of his disease.

On 7/5/16 at 10:30 am, E10, Registered Nurse was asked why R5 was taking the Medroxyprogesterone and Seroquel and replied R5 has "sexual overtone" adding that he used to touch female staff but no longer has that behavior.

There is no comprehensive assessment completed initially or following either MDS to justify the use of either the Seroquel or Medroxyprogesterone according to E2, DON. On 6/23/16 at 8:15 AM, E2 stated the facility has not completed an assessment to identify what behaviors R5 actually exhibits and to what extent as E2 thought the old MDS coordinator was keeping track of that and she wasn't. E2 stated even the Pharmacy failed to identify either drug as a concern given the lack of assessment and overall decline in health R5 exhibited from February to May 1016. E2 stated they just started drug reductions on their own when they

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realized they weren't being done and the pharmacy wasn't making the recommendations then the pharmacy was upset because they were doing it on their own. E2 also stated there is no monthly documentation of response or quantitative/qualitative analysis of the medications/behaviors done by the facility.

On 7/5/16 at 1:50 PM, Z2, Pharmacists stated she reviews everyone's medication regime monthly and makes recommendations. Z2 stated she has made several reduction recommendations in the past few months because of R5's decline in condition. Z2 stated she has informed the facility in the past that the program for Anti-psychotics needs work. Z2 was unaware of any comprehensive assessments for R5's Seroquel or Provera but was aware that he had sexual behaviors directed toward others. Z2 stated the last inservice she did for the facility was a year ago and she reviewed the need for assessments, behavioral management/tracking and reductions.

The facility's policy entitled "Reduction Psychotropic/Anti-psychotic Medications Protocol" (undated) documents residents who must receive psychotropic medications are to be maintained at the safest, lowest dosage necessary to control the resident's condition. Procedures include documenting behaviors in the Medication Administration Record (MAR), a specific condition for which the drug is being given is in the residents record, a plan of care will be initiated with appropriate approaches identified to address these behaviors, tracking will be done, each month - anti-psychotic monitoring form and psychotropic monthly note will be completed with individual response and/or progress, and "each

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resident taking anti-psychotropic medications shall have their psychotropic medications reviewed and documented a minimum of 6 months by a physician, monthly by a pharmacist, and quarterly by the Interdisciplinary team."

2. The POS, dated 06/01-30/16, documented R2 had the following diagnoses, in part as, Alzheimer's Disease, Dementia with Behavioral Symptoms, Anxiety Disorder and Pseudobulbar Affect.

It documented R2 had a Physician's Order, dated 4/14/16, for Seroquel 25 mg twice per day for Dementia.

The Care Plan, dated 04/14/16, documented R2 was totally dependent on staff for all Activities of Daily Living (ADL's). It documented R2 was on psychotropic medications with the following interventions, in part as, administer psychotropic medications as ordered by the physician; monitor for side effects and effectiveness; consult with pharmacy, MD to consider every shift and consider dosage reduction when clinically appropriate at least quarterly; discuss with MD, family regarding ongoing need for medication; review behaviors/interventions and alternative therapies attempted and their effectiveness per facility policy.

The facility staff did not provide any information of a gradual dose reduction plan or that an attempt had been made and was not reflected in the care plan.

The Behavior tracking form presented on 06/23/16 for the month of June, 2016 by E2, DON, documented R2 was being tracked for

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F 329	Continued From page 80 behaviors of "restless, yelling and combative." There were only 4 days of this month that R2 had any behaviors and was easily redirected. The Behavior tracking sheet does not document the actual behavior, i.e. restless, yelling or combative. There were seven days as of the June 23 that were left blank, the other days documented zero for no behaviors. On 06/21/16 at 1:30 PM, E2 stated that R2 does become combative with care and that she does not like her pants to be off. She stated that R2 will kick and hit staff during incontinent care. On 06/22/16 at 11:00 AM, E12 and E26, CNAs, stated that R2 will become combative when doing care. E26 stated that she does not like to have her pants removed during care. E12 stated that R2 can be calmed by talking to her and explaining what staff needs to do for her. On 06/21/16 and 06/22/16, R2 was observed during meals, transfer, incontinent care and in activities at varying times throughout the day. The only time R2 was anxious, combative or upset was during care. At other times, R2 was observed wanting hugs and kisses from staff and holding and caring for a baby doll.	F 329		
F 368 SS=B	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the	F 368		

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following day, except as provided below.

The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to offer bedtime snacks for two of 12 residents (R4 and R9) reviewed for snacks in the sample of 12 and two residents (R26 and R27) in the supplemental sample.

Findings Include:

1. On 6/22/16 at 1:30 P.M., during the group meeting, R4, R9, R26 and R27 stated they are not offered bedtime snacks.

7/1/16 at 10:15 A.M., E5, Certified Dietary Manager, stated a nourishment cart for AM, PM and night snacks is sent out to the nurse's stations from the kitchen.

On 7/7/16 at 10:08 A.M. E5, Certified Dietary Manager stated that there is always additional snacks available at the nurses station. E5 stated that when the kitchen is closed, it is locked. E5 stated that the nurses have a key to the kitchen.

The facility's HS (at bedtime)/6:45 P.M. Nourishment Cart documents that every

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F 368	Continued From page 82 Sunday/Saturday, only 15 snacks are passed out. The Resident Census and Conditions of Residents, cMS 672, dated 6/22/16 documents the facility has a census of 46 residents. On 7/7/16 at 12:30 P.M. E1, Administrator, stated the facility does not have a policy on snacks. E1 stated that she would expect staff to provide snacks. On 7/8/16, at 10:00 A.M. E1 provided a Beverage/Snacks Between Meals dated 10/18/15. The policy documents the purpose of snacks is to provide nourishment throughout the day. The policy documents nursing staff will deliver snacks to residents and document intakes.	F 368		
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.	F 425		

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This REQUIREMENT is not met as evidenced by:
Based on interviews, observations and record review, the facility failed to label and dispose of expired insulin according to their policy for 2 residents (R21, R22) reviewed in the supplemental sample.

Findings include:

1. On 6/22/16 at 4:11 PM, E23, Licensed Practical Nurse (LPN) pulled R21's bottle of Novolin 70/30 Insulin from the top drawer of the medication cart. E23 stated it was a new bottle of insulin as if was fairly full, but was not labeled so she was unable to use it at the time.

2. On 6/23/2016, at 12:25 PM, 100 hall medication cart top drawer was inspected with E8, LPN, present. The following expired bottles of insulin were present:
R21's Novolog 100 units (u) / milliliter (ml) insulin bottle opened and dated 5/3/16 and another Novolog 100u/ml insulin bottle opened and dated 5/5/16. R22's Humalog 100 u/ml insulin bottle was opened and dated 5/3/16.

On 6/23/16, at 12:25 PM, when asked what the yellow tag attached to bottles of insulin says, E8 stated, "Throw away 28 days after opened." E8 stated the insulin will have to be disposed.

The Facility's undated Storage of Insulin policy documents, in part, the 7 Important Storage tips for all insulin: "#4. Never use insulin if expired. The expiration date will be stamped on the vial or pen. Remember is not in the fridge the date on

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F 425	Continued From page 84 the vial or pen does not apply. You must throw away after 28 days since outside the fridge. #5. Write the date on the insulin vial on the day you open it or start keeping it outside the fridge. This will help you remember when to stop using it. Throw the insulin away 28 days after opened or since kept out of the fridge."	F 425		
F 441 SS=F	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 (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	F 441		

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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 interviews, observations and record review, the facility failed to develop, implement, and maintain an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility and failed to ensure proper handwashing and cleaning of equipment after resident care. This has the potential to affect all 46 residents living in the facility.

Findings include:

1. On 6/21/16 during initial tour of the building, two rooms designated "isolation" room were identified by E15, Licensed Practical Nurse (LPN), R10 for Methicillin-resistant Staphylococcus aureus (MRSA) and R24 for Clostridium difficile (C. diff) on the 200 hall.

On 6/22/16, at 10:00 AM, the Infection Control Log for the prior 6 months was requested and E2, Director of Nurses (DON), stated she had all but June done and that she would "provide it when I get it done. I'm waiting for my list from the Pharmacy." Later that afternoon, E2 provided a log for June 2016 that had 8 residents identified on it, all with antibiotics listed. Only one of the

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two isolations were identified as R10. R24 was identified for a urinary tract infection but not for the C Diff and isolation. Of the 8 identified, only 4 had organisms listed, and only 3 infection related diagnosis were completed. Four of the 8 listed, were for Urinary Tract infections (UTIs) with 2 identified for Escherichia Coli (E Coli), one questionable with no organism identified and the 4th blank for organism. The June log also recorded 2 were for Upper Respiratory Infections (URI's.)

For May 2016, a total of 9 infections treated with Antibiotics were logged. Of the 9, 4 were documented as UTI's with one of the UTI's listed as E Coli, the others blank. R24 was listed as isolations for MRSA (urine) and C Diff.

There was no log for April 2016 and for March 2016, only three residents were listed, 2 of which were UTI's and one respiratory. One urine cultured E Coli, the others were blank.

The February 2016 Infection Control Log identifies 6 residents on antibiotics for infections, 3 listed as UTI's with two cultures done, neither pathogen listed. The log had 2 upper respiratory infections listed and one skin infection.

The January 2016 log lists 7 residents with infections, 5 UTI's with no organisms identified but one.

In the Infection Control Notebook, there was no evidence of analysis of infections to determine patterns/trends and no evidence the facility identified infection control practices that could contribute to infections.

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The facility's policy entitled "Infection Control Program" (undated) documents it is the "purpose of the Infection control program to provide a safe, sanitary, and comfortable environment for our residents, and to help prevent the development and transition of disease and infection." The functions list 1) to establish protocol to monitor and investigate the cause of infection and the manner of spread. 2) to investigate control and prevent infections in the facility, 3) to establish isolation procedures that should apply to individual residents dependent upon infection status, and 4) to maintain a record of incidence and corrective actions as they relate to infections." The policy continues to document the facility will perform these functions in the following manner: "A) utilizing a specific record for each infection that identified the infection, date of, causative again, origin/site, and the measures taken to prevent the spread of infection, B) surveillance data will be routinely reviewed and recommendations will be made for prevention and control of additional cases based on this data, C) Program will include observable practices such as; hand washing by direct care, aseptic technique, sterile technique, and routine monitoring of other staff infection control practices, and D) Development of an active infection training program that insures individuals receive adequate information to prevent the acquisition and spread of infections. This will include demonstrations of procedures as they relate to infection control and return demonstrations with random monitoring on a day to day basis".

On 6/29/16 at 9:20 AM, Z1, Medical Director was asked about the infection Control Program and the delay in completing the log until the end of the

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month. Z1 stated one month, the facility had several upper respiratory infections with 2 going to the hospital and stated he had to tell them to do the Pneumonia Vaccines. Z1 couldn't remember what month it was but agreed that early detection of communicable infections would help in preventing the spread. Z1 stated he is not involved in policy/procedures but would expect the facility to follow standard practices.

On 7/5/16 at 11:50 am, E2 was asked to provide any information on corrective actions that have been taken from identifying/analyzing concerns on the infection control log. None were provided as of 7/7/16.

2. On 6/22/16 at 9:45 AM, R5 was transferred to bed from his wheelchair by E17 and E11, Certified Nurse's Aides, CNAs. E17 removed R5's wet incontinent paper brief with gloves on and provided incontinent care. E17 then went on to apply a dry brief, handle his sheets, pillow and covers without first removing her soiled gloves and washing her hands.

The facility's policy entitled "Hand Washing Technique" dated 2002, documents the objective as "to prevent the spread of infection" with the procedure of washing hands included.

3. On 6/22/16 at 4:11 PM, E23, Licensed Practical Nurse (LPN) obtained R21's blood sugar with a glucometer. E23 donned gloves to obtain the blood sample on the glucometer then removing her gloves, returned to the medication cart and placed the glucometer directly on the top of the cart. E23 was asked how she was going to clean the glucometer and she stated she uses alcohol swabs and got one out of the drawer.

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E23 wiped the sides of the glucometer off and then placed it in the drawer. E23 stated she had one other blood sugar to get.

On 6/24/16, E1, Administrator, provided documentation from the glucometer supplier that stated "Product support stated on how to clean the (glucometer)" is do not use any cleaning solutions. Use a dry cloth with alcohol and gently wipe it down. Don't make the cloth too damp because it will contaminate the machine if the alcohol gets into it." E1 also stated the med carts have MicroKill sanitizer available in the bottom drawer for staff to use.

On 7/7/16 1:20 PM, Z5, personnel from the Manufacturer of the glucometer, stated the cleaning instructions are in the manual for the unit, however, they do not have guidelines for multiple resident use glucometers for disinfecting for Long Term Care and recommend following the CMS Guidelines (Centers for Medicare and Medicaid Services.)

4. On 06/22/16 at 11:00 AM, E12 and E26, CNAs ,were observed during transfer and incontinent care for R2. E29, LPN, came into the room, but did not participate in the care. When R2 was transferred from the wheelchair to the bed, R2's pants and wheelchair cushion were saturated with urine. E29 wiped the wheelchair cushion with paper towels in a back and forth method, without wearing gloves. E29 stated that the paper towels were dampened so that she could try to get the food debris off the seat of the wheelchair. E29 did not mention anything about the large urine soaked area on the cushion. E12 and E26 completed the incontinent care and redressed R2 and transferred her back onto the urine soaked

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wheelchair cushion and took her to the dining room for the lunch meal service. At no time did E12 and E26 wash their hands.

5. On 6/23/2016 at 11:00 AM,E16, LPN, entered R8's isolation room with gown and gloves on and supplies to do R8's dressing change. E16 removed R8's shoe, sock and tan/gray drainage soaked sockett from right extremity. E16 took bandage scissors and cut up through the tan/gray drainage on the kerlix wrap starting at ankle and upwards to mid leg. E16 cleansed all open areas to R8's right shin lower medial/inferior wounds with wound cleanser and gauze pads. E16 took the soiled scissors from removing prior drainage soaked dressing and cut clean silver alginate pad into smaller pieces to fit open areas to right shin lower medial/inferior areas and secured with kerlix wrap and tape.

On 6/23/2016, at 11:10 AM, E16 was asked what kind of drainage was on R8's soiled dressing. E16 stated R8 has MRSA drainage. E16 was asked about cleaning and disinfecting soiled scissors. E16 stated "We clean and disinfect scissors when isolation is discontinued." E2 stated R8 went to wound clinic 6/16/2016 and we received a call that R8 had a wound culture done there and has MRSA and isolation was started.

The Facility's undated WOUND CARE policy documents under Procedure: "#21 Wipe reusable supplies with alcohol as indicated (i.e. outside of containers that were touch by unclean hands, scissors blades, etc.). Return reusable supplies to resident's drawer in treatment cart."

The facility's policy of Isolation-Categories of Transmission-Based Precautions revised April

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2010, documented for Contact Precautions. Under Resident-Care Equipment During Contact Precautions" f. (1) if use of common items is unavoidable, then adequately clean and disinfect them."

6. On 6/23/2016, at 12:25 PM when checking 100 hall medication cart with E8, LPN, there was no disinfectant on the medication cart. At 12:30 PM E8 was asked what was used to clean and disinfect the glucose monitoring meter. E8 stated they use sterile alcohol pads. When E8 was asked if alcohol kills all organisms, E8 stated she didn't know.

On 6/23/2016, at 12:30 PM, E10, Registered Nurse (RN) was asked what was used to clean/disinfect glucose monitoring meter. E10 stated they use alcohol. E10 stated he didn't know if alcohol kills all organisms.

7. On 6/22/16 at 11:00 A.M., E11 and E17, CNA's, transferred R6 from the wheelchair to the toilet in the bathroom. E11 undid R6's incontinent device prior to transferring to the toilet. When R6 was transferred she began urinating on the floor. E17 put soap on the washcloth from the dispenser and had faucet running. After wiping R6 with the washcloth , E17 would then rinse the same washcloth under the faucet and hand back to E11 to cleanse R6. E17 wet paper towels

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F 441	Continued From page 92 under the faucet and wiped the foot rests on the wheelchair. E17 had on gloves, but at no time did she change her gloves during R6's incontinent care. E11 wiped the urine on the floor with a towel, and threw in a plastic bag. E11 then removed her gloves but did not wash her hands after removing her gloves. E11 then put R6's tray on her wheelchair. The facility Policy Infection Control Program, which is undated, documents the purpose of the infection control program is to "provide a safe, sanitary and comfortable environment for our residents, and to help prevent the development and transition of disease and infection." The policy documents the infection control program will include observable practices such as handwashing procedures utilized by the direct care staff. The facility's undated policy Handwashing technique documents that the objective is to prevent the spread of infection. 8. The Residents Census and Conditions of Residents, CMS 672, dated 6/22/16, documents the facility has 46 residents living in the facility.	F 441		
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents	F 497		

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as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide performance reviews for Certified Nurse's Aides (CNAs) and failed to provide 12 hours annual in-service training hours to ensure competency for 22 of 22 CNAs (E3, E4, E9, E11, E12, E13, E14, E17, E19, E21, E22, E24, E26, E27, E28, E31-E37) employed by the facility. This failure has the potential to affect all 46 residents in the facility.

Findings include:

1. On 6/21/16, the facility provided a Nurse Aide Roster, listing 22 CNAs (E3, E4, E9, E11, E12, E13, E14, E17, E21, E22, E24, E26, E27, E28, and E31-E37) employed by the facility.

On 7/7/16 at 8:55 AM, E1, Administrator was unable to provide documentation of annual performance evaluations for 22 of 22 CNAs employed by the facility. E1 stated she had provided all training documentation available.

The In-Service Training Log provided by the facility documents in-services conducted since 1/9/16 but does not document the amount of time taken for any in-service training. The Log does not document how many hours each CNA spent in training to ensure they receive 12 hours annually. The same log does not document any training for the care of residents with cognitive

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F 497	Continued From page 94 impairment. 2. The Resident Census and Conditions of Residents, CMS 672, dated 6/22/16, documents the facility has 46 residents living in the facility.	F 497		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's Quality Assurance Committee failed to	F 520		

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F 520	Continued From page 95 adequately identify problems and develop and implement effective, corrective action plans to address identified concerns with falls and safety, infection control and pressure ulcers. This has the potential to affect all 46 residents residing in the facility. Findings include: E2, Director of Nurses stated on 6/24/16 at 8:45 AM that the QA meets monthly and identified Antipsychotic medications and drug reductions as an issue. E2 also stated there wasn't an infection control program until she started in January of 2016 so tracking started then. E2 also stated staff retention was discussed along with pressure ulcers. E2 stated these issues were discussed in the Quality Assurance Committee Meetings but confirmed that the QA Committee did not put any specific Action Plan in writing and couldn't identify or provide any training or monitoring that occurred as a result. E2 stated she has done corrective actions on specific incidents for those staff involved. On 6/24/16 at 10:10 AM, E1, Administrator, stated the facility's QA (Quality Assurance) Committee meet quarterly and most department heads attend along with the Medical Director, Z1 were attendance. E1 recalled QA identified hydration along with falls and incidents in the last two meetings. E1 identified falls as a "success" stating falls have declined a lot from last year. E1 stated for hydration, some of the interventions implemented included the "water me" signs posted for individuals at risk and that the facility currently had no one with dehydration as a diagnoses.	F 520		

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F 520	Continued From page 96 On 6/24/16 at 3:30 PM, E30, Activity Director/Social Service Designee stated she was not present at the last meeting but remembers discussing dehydration, infection control and behavioral tracking in January 2016. E30 stated her roll in QA is to add what interventions activities can provide in regards to the identified issues such as offering fluids during activities, and how activities can play a role in pressure ulcer relief. E30 stated she was unaware if anything was put in writing or if any monitoring is done. The facility provided documentation of an in-service entitled "Employee Education Fair" on 4/8/16 which included thickened liquids but no documentation of falls prevention and/or pressure ulcer prevention. On 6/29/16 at 9:20 AM, Z1, Medical Director stated he does participate in the meetings and stated he was not sure if they were every month, weekly or every couple of weeks. Z1 stated they have criteria they use to determine what issues are discussed such as weight loss, behavior changes, abnormal labs for individuals or specifics related to individuals. When asked about his participation in reviewing/revising policies and procedures, Z1 stated he is not involved in that stating it is up to the owners and administration. Z1 stated he would be willing to look at patient care and issues but they would need to let him know. Z1 stated the group has discussed falls and he suggested using a board or a graft to better be able to identify patterns/trends but was told that was not acceptable due to HIPAA laws. Z1 stated if systems were in place, it would improve the quality of care. Z1 also stated when there is less	F 520		

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F 520	Continued From page 97 turnover, quality of care would also improve. On 7/7/16 at 9:00 AM, E2 provided no documentation or evidence that issues identified within the QA were acted on inservices completed from January to June 2016 in response to any concerns identified within the Quality Assurance. 2. The Residents Census and Conditions of Residents, CMS 672, dated 6/22/16, documents the facility has 46 residents living in the facility.	F 520		