STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145469	A. BUILDING _____ B. WING _____	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARIS HEALTH CARE CENTER	1011 NORTH MAIN STREET PARIS, IL 61944

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Validation Survey for Subpart U: Alzheimer Unit The facility is in substantial compliance with Subpart U: Alzheimer Unit, 77 Illinois Administrative Code Section 300.7000.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

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

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure that the physician was notified in a timely manner, of 44 missed doses of Eliquis (anticoagulant) medication for one (R24) of 10 residents reviewed for medications on the sample of 15. Findings include: R24's Physician Order Sheet (POS) dated July 1 - 31, 2016 documents the following diagnoses and medication order: Atrial Fibrillation (A-Fib), Heart Failure and a history of TIA (Transient Ischemic Attack, brief interruption of blood flow to part of the brain). The same POS documents a medication order for Eliquis 5 milligrams, by mouth, twice daily. R24's Minimum Data Set dated 5/2/16 documents the following: Cognitively Intact and is on anticoagulation therapy. R24's Care Plan dated 5/3/16 documents the following: R24 is on anticoagulation therapy, monitor, document and report to the physician any adverse reactions or complications. R24's Medication Administration Record (MAR) dated June 18-30, 2016, documents 20 missed doses of Eliquis and R24's MAR dated July 1- 14, 2016 documents 24 additional missed doses of Eliquis.	F 157		

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F 157	Continued From page 2 On 7/13/16 at 8:05 am, E5, Registered Nurse administered R24's medications at 8:00 am. E5 circled the MAR 8:00 am dose of Eliquis to indicate this medication was not being given with R24's medications. On 7/13/16 at 3:15 pm, Z2, Physician (covering for Z3, Primary Care Physician) stated "I see nothing in (R24's) records to indicate that the nursing home notified any physician of (R24's) missed Eliquis doses (44). (Z3) should have been notified of these (missed doses)...(R24) should have been on Eliquis the entire time, as she has A-Fib and is over the age of 60. Not having the Eliquis and a history of TIA's puts (R24) at a high risk of a stroke..." The facility policy "Identifying and Managing Medication Errors and Adverse Consequences" dated April 2007, documents the following: "The staff shall report clinically significant adverse medication consequences and medication errors with adverse clinical consequences to the resident's attending Physician immediately."	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		

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F 167	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to make the results of substantiated complaint survey results and the plans of correction associated with the complaints, readily accessible to residents. This failure has the potential to affect all 77 residents residing in the facility. Findings include: On 7/12/15 at 3:30 pm, a posted notice in the facility's south hall documented, "The current federal and state survey results from the Illinois Department of Public Health are located in the holder just outside the front office." The holder and the survey book were not present. On 7/12/16 at 3:40 pm, E3, Corporate Director of Operations, provided the survey book stating, "It was inside the front office." On 7/12/16 at 3:40 pm, E1, Administrator, stated, "We had that office remodeled back in February of 2016 and they took the holder off the wall at that time." E1 further stated, "Residents would not know the book was inside the office." On 7/12/16 at 3:45 pm, the survey book did not contain the results of substantiated complaints, nor the associated plans of correction, from 10/2/15, 11/24/15, and 2/23/16. On 7/12/16 at 3:50 pm, E1 examined the survey book and agreed that the results from the complaints and the plans of correction were not present in the survey book.	F 167		

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F 167	Continued From page 4 The facility's Resident Census and Conditions of Residents report dated 7/12/16 documents 77 residents reside in the facility.	F 167		
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 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide urinary indwelling catheter care in a manner to prevent cross contamination and potential infection for (R1) one of two residents reviewed for indwelling urinary catheter care in a total sample of 14. Findings include: The Physician's Order Sheet dated July 2016 for R1 states the following diagnoses: Displaced Left Femoral Neck Fracture, History of Prostate Cancer, Dementia, Urinary Tract Infection. On 7/12/16 at 2:15 PM E21, Certified Nursing Assistant, (CNA) performed indwelling urinary catheter care for R1. E21 used soap and water for the procedure. E21 cleaned the shaft of the	F 315		

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F 315	Continued From page 5	F 315		

penis area with up and down strokes, went around the top of the penis with circular motion using the same area of the washcloth. E21 rinsed the shaft of the penis and the top of the penis with the same washcloth. E21 obtained a new washcloth, applied soap and water and anchored the catheter at the insertion site, and went down the catheter tube in up and down strokes three times with the same washcloth. E21 rinsed the catheter tubing with another washcloth using up and down strokes. E21 then applied a new brief and pulled the residents pants up and transferred R1 to his wheelchair. E21 did not provide care to R1's buttocks/backside area.

E21 stated on 7/12/16 at 2:20 PM " Yes I know you don't use the same washcloth."

E2, Director of Nurses stated on 7/12/16 at 2:30 PM "Catheter care consists of cleaning the residents buttocks area."

The facility policy titled "Catheter Care, Urinary" Revised October 2010 states "...#15 For the male: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. ... #16 Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward..."

R1's Laboratory Reports dated 1/31/16, 4/1/16, 5/17/16 documents R1 had a urinary tract infection due to Escherichia Coli organism and on 7/12/16 laboratory report documents R1 had a urinary tract infection due to Pseudomonal Aerugenosa organism. E20, Licensed Practical

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F 315	Continued From page 6 Nurse (LPN), on 7/14/16 at 12:30 PM, confirmed R1 did have the above urinary tract infections on the designated dates.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide supervision while toileting a resident. This failure resulted in R2 falling and sustaining a Cervical Fracture and a Vertebral Artery Dissection. R2 is one of six residents reviewed for falls in the sample of 16. Findings include: The Physician Order Sheet for R2 dated July 2016 includes the following diagnoses: Difficulty in Walking, Cognitive Communication Deficit, Lack of Coordination and Muscle Disorder. R2's Minimum Data Set (MDS) dated 4/1/16 documents R2 as moderately cognitively impaired. This same MDS documents that R2 is an extensive assist with staff providing weight bearing support for transfers and toileting. The facility report titled "Incident Log" dated August 2015 through July 12, 2016, documents	F 323		

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that R2 has had the following falls: 1/26/16 - fell while self transferring, 3/26/16 - trying to step on a bug when in the wheelchair, 4/10/16 - self transferring to go to the toilet and 5/7/16 - resident sitting on toilet and decided to self-transfer and fell and hit head.

The Incident Report Investigation dated 5/7/16 at 12:10 am documents the following: "Resident was on bathroom stool and decided to transfer (self) to wheelchair .....(R2) stated 'I stood up and my legs got weak and I fell hitting my head.'" The following documented statement from the Certified Nursing Assistant, E14 is part of the 5/7/16 fall investigation: "I got resident ready for bed and was toileting (R2). (R2) was sitting on the toilet when I heard a PCA (Personal Clip Alarm) going off from another resident's room. I told (R2) not to get up, that I would be right back. After answering the alarm, I returned to (R2's) room where I found (R2) on the floor in front of the toilet. Being the only one on the floor, I ran to the desk, called to South Hall for the nurse to come over. I then returned to (R2) and the nurse came." E15, Registered Nurse documents that R2 was found on the floor in a supine position (on back) and R2 complains of upper neck pain. E15 assessed R2 and left R2 on the floor in "back-lying position. E15 documents that R2 was sent to the ER (emergency room) for evaluation by ambulance.

The hospital report dated 5/7/16 documents that R2 arrived in the emergency room at 1:10 am and a Computerized Topography (CT) was performed. The following documented results are as follows: "The Cervical Spine demonstrates a non-displaced fracture involving the right (first cervical) C1 arch....does extend into the

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F 323	Continued From page 8 foramen.....transfer ordered to (larger trauma hospital)." The trauma hospital does not provide a written report or a copy of R2's CT for review. However, the discharge instructions dated 5/7/16 confirms the diagnosis of "Closed Non-displaced fracture of first cervical vertebra" with the additional diagnoses of "Vertebral artery dissection and Fall, initial encounter." On 7/13/16 at 12:15 pm E2, Director of Nursing stated "(R2 should not have been left on the toilet (alone)." E2 also acknowledged there was only one Certified Nursing Assistant on R2's hall at the time of R2's fall. On 7/13/16 at 2:10 pm Z1, Primary Care Physician of R2, stated that the fall in the bathroom at the facility caused R2's C1 fracture and Vertebral Artery Dissection. Z1 stated "(R2) should never have been left unsupervised on the toilet....(R2) has had previous falls from trying to self-transfer."	F 323		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to repeatedly administer 44 doses of Eliquis (anticoagulant) medication to one of 10 residents (R24) reviewed for medication on the sample of 15.	F 333		

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Findings include:

R24's Physician Order Sheet (POS) dated July 1 - 31, 2016 documents the following diagnoses and medication order: Atrial Fibrillation (A-Fib), Heart Failure and a history of TIA (Transient Ischemic Attack, brief interruption of blood flow to part of the brain). The same POS documents a medication order for Eliquis 5 milligrams, by mouth twice daily.

R24's Minimum Data Set dated 5/2/16 documents the following: Cognitively Intact and is on anticoagulation therapy.

R24's Care Plan dated 5/3/16 documents the following: R24 is on anticoagulation therapy, monitor, document and report to the physician any adverse reactions or complications.

R24's Medication Administration Record (MAR) dated June 18-30, 2016, documents 20 missed doses of Eliquis and R24's MAR dated July 1- 14, 2016 documents 24 additional missed doses of Eliquis.

On 7/13/16 at 8:05 am, E5, Registered Nurse administered R24's 8:00 am medications. E5 circled the MAR 8:00 am dose of Eliquis to indicate this medication was not being given.

On 7/13/16 at 3:15 pm, Z2, Physician (covering for Z3, Primary Care Physician) stated "...(R24) should have been on Eliquis the entire time as she has A-Fib and is over the age of 60. Not having the Eloquist and a history of TIA's puts (R24) at a high risk of a stroke..."

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F 333	Continued From page 10 On 7/13/16 at 1:40 pm, E2, Director of Nursing stated the following: "...Had the nurses notified me there would not have been any missed dose... I was never notified of (R24's) medication supply of Eliquis or missed doses." On 7/13/16 at 1:55 pm, R24 stated the following: " I was never told I missed any dose of Eliquis. I have a history of TIA's. I have not had one (TIA) in almost a year, but I don't want to either. They (TIA) are no fun to have, they make my arm numb and affect my speech..." The "Pharmacy Medication Guide, Eliquis" dated June 2015, documents the following: " What is the most important information I should know about Eliquis? For People taking Eliquis for A-Fib: people with A-Fib are at increased risk of forming a blood clot in the heart, which can travel to the brain, causing a stroke, or to other parts of the body. Do not stop taking Eliquis without talking to your doctor who prescribed it for you. Stopping Eliquis increases your risk of having a stroke." The facility policy "Administering Medication" dated April 2010, documents the following: "... Medication must be administered in accordance with the (Physician) order...If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.."	F 333		
F 363 SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended	F 363		

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dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review the facility dietary staff failed to have approved planned menus and approved menu changes in advance of serving; failed to prepare the meals according to recipes to provide equivalent amount of protein as planned on the menu and failed to follow the menu and resident diet order for serving the therapeutic diets correctly to residents. This has the potential to affect all 77 residents who reside in the facility.

Findings include:

The Week I Tuesday menu noon meal was planned as Mesquite Roasted Turkey (3 ounces), Au Gratin Potatoes, Sliced Beets and Chocolate Chip Bar. On 7-12-16 at 10:15am E11, Cook, identified the food in the steam table for the noon meal as Chicken and Noodles, Green Beans and Mashed Potatoes. At 11:30am during the serving of the noon meal E11 stated she added cheese to the potatoes to make cheesy potatoes, and added onions and bacon to the green beans.

On 7-12-16 at 11:30am E11 was asked to see the menu the staff would be following for the meal service. E11 stated "(E7), Head Cook, came in early this morning and made the menu change and told us to make this meal instead of the planned one." At this time E11 identified they did not have any therapeutic diet extensions for the

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prepared meal. E11 stated she was not told what serving size to use for the Chicken and noodles and did not have a recipe to follow. E11 said she would be using a #6 scoop for the Chicken and noodles.

On 7-14-16 at 10:25am E7, Head Cook, stated the staff used 10 pounds (lbs) of Chicken for the Chicken and Noodles on Tuesday and verified they did not have a recipe to follow.

Ten lbs of chicken prepared will yield only a 2 ounce (oz) serving of protein per resident for the 77 residents. The noon meal had planned a 3 oz. protein serving. No other protein food was served for this meal.

Peaches were served at the Tuesday noon meal instead of the Chocolate Chip Bar.

No entries were made on the planned menu for 7-12-16 noon meal to show the menu substitutions the staff made for a review by E10, the facility Registered Dietitian Consultant on the next visit.

On 7-12-16 at 11:20am E11 prepared the Puree Chicken and Noodles for the noon meal. E11 stated she did not have a recipe but followed a standard guideline for puree preparation by adding the broth and one slice of bread per person to be served. E11 had added 3 cups of broth and 6 slices of bread to the 7 serving (6 oz.each) of the chicken and noodles then added 3 additional slices of bread, stating "it needs to thicken up some more." E11 identified the serving size would be a #6 serving scoop, the same one used to dip up the chicken and noodles prior to puree preparation. E11 counted out 9

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servings from the blender.

During the serving of the noon meal on 7-12-16 E11 used the #6 scoop and served the puree chicken and noodles to R17, R28, R29 and R30. With the amount of puree chicken and noodles left over and the amount of chicken used, it is estimated the residents on pureed diets received 2 oz. or less of chicken per serving instead of the planned 3 oz.

On 7-13-16 the noon meal was observed and compared to the planned menu. Dietary altered the planned menu by changing the dessert from Confetti Cake to German Chocolate Cake.

On 7-13-16 at 4:10pm E1 Administrator stated he received revised menus signed by E10, Registered Dietitian Consultant. The revised 4 week cycle had two changes; one was for Week 1 Wednesday Supper meal (7-13-16).

On 7-14-16 at 10:25am E7, Head Cook, stated they didn't have any menu extensions for the therapeutic diets for the menu changes that (E10) just sent to the facility on 7-13-16 for the supper meal. E7 also verified they did not receive any written directions to follow for the menus for the regular diet, the expected serving sizes or the recipes to use with the meal.

On 7-15-16 at the noon meal residents were observed eating. Residents were served mashed potatoes and gravy, and cooked cauliflower. The posted menu stated Baked Sweet Potatoes and was written on the planned menu as Baked Sweet Potatoes. On 7-15-16 at 10:00am E6 Dietary Manager stated staff made the Sweet Potatoes but forgot they were in the oven so they

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F 363	Continued From page 14 made Mashed Potatoes and Gravy. During the serving of the noon meal on 7-12-16 E11, Cook, served resident trays with the following errors besides the shortage of protein in the serving of Chicken and Noodles. R2's diet card says "high calorie food with lunch" and dietary staff served R2 the regular portion size of the Regular foods (Chicken and Noodles, Cheesy Potatoes, Green Beans, Bread and Butter and Fruit). R8's diet card says "serve with lunch finger foods 1 oz. extra protein". R8 was served a Ham salad sandwich, green beans and chips. No additional protein was given to R8. R16's diet card says "serve with lunch double portions". R16 was sent only a single portion of all food for the meal. R25's diet card says "serve with lunch double protein". R25 was sent only one serving of the Chicken and Noodles and no other protein food was given. Both R26 and R27 did not receive Mashed Potatoes. Neither resident had restrictions on their diet cards or dislikes of potatoes. The Resident Census and Conditions of Residents Report on 7-12-16 reflects a census of 77 residents.	F 363		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364		

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by:
Based on interview, record review and observation the facility failed to provide for meals that are palatable and attractive when served. This failure has the potential to affect all 77 residents who reside in the facility.

Findings include:

On 7-12-16 at 10:15am E11, Cook, identified the food in the steam table for the noon meal as Chicken and Noodles, Green Beans and Mashed Potatoes. At 11:30am during the serving of the noon meal E11 stated she added cheese to the potatoes to make cheesy potatoes, and added onions and bacon to the green beans. On 7-12-16 the noon meal prepared was Chicken and Noodles, Cheesy Mashed Potatoes, Green Beans with Bacon and Onions. The planned menu was Mesquite Roasted Turkey, Au Gratin Potatoes and Sliced Beets.

On 7-12-16 at 11:20am E11 prepared the Puree Chicken and Noodles for the noon meal. E11 stated she did not have a recipe but followed a standard guideline for puree preparation by adding the broth and one slice of bread per person to be served. E11 had added 3 cups of broth and 6 slices of bread to the 7 serving (6 oz.each) of the chicken and noodles then added 3 additional slices of bread. Stating "it needs to thicken up some more." E11 identified the serving size would be a #6 serving scoop the same one used to dip up the chicken and noodles prior to puree preparation. E11 counted out 9 serving from the blender.

On 7-12-16 at 11:30am E11, Cook, stated she did not have a recipe to follow for the Chicken and

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F 364	Continued From page 16 Noodles. On 7-12-16 staff began serving resident trays at 11:40am and completed the last tray at 12:30pm. A sample plate was made to taste all menu items except the mechanical Chicken and Noodles which E11 had incorporated the extra into the regular Chicken and Noodles after the mechanical diets were served. Items from the sample plate were as follows: pureed green beans were very liquid (soupy) needing to be thickened; regular Chicken and Noodles did not have much taste and were very mushy; noodles were very broken up without much chicken; pureed chicken and noodles tasted very "bready" without any other taste to them - it was hard to tell it was an entree item; and the cheesy mashed potatoes were very salty. On 7-13-16 the supper meal menu was changed from Vegetable Quiche, Hash Brown Patty, and Roasted Zucchini. On 7-13-16 at 4:10pm E1, Administrator stated he received a menu change for the supper meal on 7-13-16 from E10 Registered Dietitian Consultant. The new menu was Hamburger Vegetable Soup, Turkey Sandwich and Fruit of the Day. This sandwich made the 6th sandwich meal for the week. On 7-14-16 the planned menu was Crispy Baked Chicken, Baked Sweet Potatoes, and Parslied Cauliflower. Observation of resident trays shows residents received Mashed Potatoes and Gravy instead of the Sweet Potatoes. On 7-15-16 at 10:00am E6 Dietary Manager stated staff made the Sweet Potatoes but forgot they were in the oven so they made Mashed Potatoes and Gravy and served it instead.	F 364		

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F 364	Continued From page 17 Residents comments from group interview on 7-13-16 at 10:30am include those from R15, R31, R39, R40 and R41: Vegetables too watery, no seasoning; Food is cold for Breakfast, Lunch and Supper; Coffee is cold; Hall trays are cold. Late in receiving; Meals generally are late; Food presentation is bad; Chicken and Noodles yesterday were bad and did not eat; Meat can be tough; Same thing over and over each week. R39 stated " Why is there a food committee, when nothing gets done?" Review of the Food Council notes dated 7-11-16 with the identified Concerns from residents includes those listed above plus "Residents feel that suppers have been too light for the past few weeks and would like to see less soup and sandwich offered at this meal." The Food Council notes date back to 1-11-16 document that residents are not pleased with the taste and appearance of the food being served for several months now. Residents repeated concerns includes the supper meals, vegetables being watery, overcooked and unseasoned, being tired of the same foods or repeated foods too often, The Resident Census and Conditions of Residents Report on 7-12-16 reflects a census of 77 residents.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

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F 371	Continued From page 18 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on interview, record review and observations the facility failed to protect food from potential overhead water and debris contamination; failed to correctly process the insulated lids during the drying process; failed to correctly label and date opened foods stored in the refrigerator; failed to clean and maintain food preparation and equipment storage areas and failed to correctly store food to avoid potential contamination. This practice has the potential to affect all 77 residents who reside in the facility. Findings include: 1. On 7-12-16 at 11:20am a large accumulation of dust was hanging from overhead air conditioning vents. One was positioned directly over the uncovered steam table and the other one was directly over the open plate storage and food preparation area. During the serving of the noon meal on 7-12-16 at 12:30pm E13, Dietary Aide stated she had something drip on her, then looked up and noted it came from the vent. E13 had been leaning over the steam table at the time. During the time of the meal service when the air was running, the accumulated dust that was hanging down from the vent fins was moving.	F 371		

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F 371	Continued From page 19 2. On 7-12-16 at 11:40am E12, Dietary Aide, was helping during the serving of the noon meal by placing insulated plate covers over the residents plates identified to be delivered to the resident rooms or non adjacent dining rooms. Many of the lids had a clear liquid still inside the lids so when they were turned over, the liquid could potentially deposit on the food on the resident plates. At 12:10pm E12 began using a towel to dry out the lids prior to placing them over the residents' plated food. 3. On 7-13-16 at 9:30am with E11, Cook, and E7, Head Cook, the 2-door refrigerator was identified to have a variety of beverages that were not labeled as to contents, date opened and use by date. Neither E7 or E11 could identify these beverages and dates. The contents of six beverage pitchers were thrown out by E11. Two opened one quart containers of chocolate milk and one container of pre-thickened orange juice did not have the open dates and the use by dates marked on them. A small container marked with "gravy 6-17" and no use by date. A small pan marked with "jello 7-1" and no use by date. In the 3 door reach in refrigerator was American sliced yellow cheese, not in original container, placed in large clear bin, not labeled with name, date opened or use by date. Also in the 3 door reach in refrigerator was an open container of pre-made purchased potato salad that did not have the use by date marked on it. At this time E11 stated "I know, I put it in there after I used it and opened it. I put the date on it of 7-12. Don't worry it will get used." 4. On 7-13-16 at 9:40am the inside edge of three storage drawers located under a preparation	F 371		

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counter had an accumulation of debris. Two plastic three tiered carts, one used for storage for resident plates, lids and other serving equipment was identified to have a heavy coating of multi colored debris. This included both of the shelves where the items are stored and on the side supports.

5. On 7-13-16 at 9:45am in the dry goods storage room were several cardboard boxes of canned food items and paper goods still on the floor from the delivery on 7-12-16. This included a case of mandarin oranges, sweet potatoes, green beans, sliced apples, styrofoam cups and disposable plates.

6. On 7-12-16 at 10:15am with E11, Cook, the dry storage room floor was identified to be covered and stacked high with newly delivered boxes. E11 stated they were just delivered and they were sorting through them to pull out the refrigerated and freezer items so they could be put away first. On 7-12-16 at 11:20am prior to starting the noon meal service in the dry storage room the dietary staff had placed on top of an empty bread rack a box of frozen English Muffins and a box of frozen Garlic Bread that said on the side of the box "keep frozen". At the end of the noon at 12:30pm both boxes were still located on the bread rack. On 7-13-16 at 9:25am E11 stated "the boxes were put away at 1:30pm because staff had to rearrange things in the freezers."

7. On 7-13-16 at 9:47am the three door reach in freezer had a package of raw sausage patties in a plastic bag sitting on the top wire rack. Stored on the racks directly below this raw meat item were multiple packages of a variety of items including cooked chicken and English muffins.

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F 371	Continued From page 21 8. On 7-13-16 at 9:41am both of the oven cavities were encrusted with a heavy carbon (brown/black) build-up. The Resident Census and Conditions of Residents Report on 7-12-16 reflects a census of 77 residents.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure Eliquis (anticoagulant) medication supply was available for administration for one of	F 425		

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F 425	Continued From page 22 ten residents (R24) reviewed for medication on the sample of 15. Findings include: R24's Physician Order Sheet (POS) dated July 1 - 31, 2016 documents the following medication order: " Eliquis 5 milligrams, by mouth, twice daily." R24's Minimum Data Set dated 5/2/16 documents the following: Cognitively Intact and is on anticoagulation therapy. R24's Medication Administration Record (MAR) dated June 18-30, 2016, documents 20 missed doses of Eliquis and R24's MAR dated July 1- 14, 2016 documents 24 additional missed doses of Eliquis. R24 did not recieve any Eliquis during this time. On 7/3/16 at 1:30 pmE2, Director of Nursing stated the following: "I was not aware that (R24) had missed forty - four doses (of Eliquis) until today. The nurses know to notify me and should have. (R24) is going to receive a back up (pharmacy) delivery of Eliquis today and a supply from our contracted pharmacy this evening. We, the facility, are covering the charges, as we would have all along. Paying for the Eliquis, the son does not want to pay their outside (family choice) pharmacy cost (of Eliquis)...Had the nurses notified me, there would not have been any missed doses... I was never notified of (R24's) medication supply of Eliquis was gone..." On 7/13/16 at 1:55 pm, R24 stated the following: "...I do expect the nurses to give me all the medication my doctor orders. I did not know they	F 425		

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F 425	Continued From page 23 ran out of my Eliquis." On 7/13/16 at 3:15 pm, Z2, Physician (covering for Z3, Primary Care Physician) stated "...(R24) should have been on Eliquis the entire time (6/18/16 - 7/13/16) as she has A-Fib and is over the age of 60. Not having the Eloquist and a history of TIA's puts (R24) at a high risk of a stroke..." The pharmacy contract "Health Care Facility/Pharmaceutical Service Agreement" dated September 7, 2014, documents the following: "The primary business of the Health Care Facility is to provide nursing care to it's patients and that in the course of providing said nursing care, the Health Care Facility needs to contract on behalf of it's patients for certain pharmaceuticals and medical supplies and ancillary services."The same contracted pharmacy "Policy and Procedure" dated 1/17/15 documents the following: "A resident or responsible party may request that medications be obtained from a pharmacy other than the facility's primary/contracted pharmacy. Non-contracted pharmacies will adhere to facility to the facility medication policy and procedures and assure delivery on a timely basis....Timely delivery is required so that medication administration is not delayed."	F 425		
F 468 SS=F	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced	F 468		

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F 468	Continued From page 24 by: Based on observation, interview, and record review, the facility failed to maintain corridor handrails in a firmly secured manner. This failure has the potential to affect all 77 residents residing in the facility. Findings include: On 7/12/16 at 11:00 am, the one and one-half inch round plastic handrails in the facility's North Hall were loose and easily moveable on the west side of room 100, between rooms 103 and 104, and between rooms 83 and 84. The one and one-half inch round plastic handrail was loose and easily moveable in the facility's West Hall between the handicap bathroom and the beauty shop. On 7/14/16 at 10:30 am, the handrails remained loose in the manner described in the previous paragraph. E17, Maintenance Director, stated, "I will get those tightened up." The facility's Resident Census and Conditions of Residents report dated 7/12/16 documents 77 residents reside in the facility.	F 468		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced	F 518		

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by:
Based on record review and interview, the facility failed to train all employees for disaster preparedness, other than fire, by failing to conduct disaster preparedness drills. This failure has the potential to affect all 77 residents residing in the facility.

Findings include:

The facility's undated Disaster Policy (policies) documents potential disasters as medical emergencies, severe storm/tornado, bomb threat, earthquake, floods, hazardous chemical spills, power outages, and missing resident.

On 7/14/16 at 10:15 am, E22, Receptionist/ Front Door Monitor, stated, "If the door alarm is sounding, and I do not see anyone at the door, I just turn off the alarm and announce 'front door clear'. I do the same thing every time."

On 7/14/16 at 11:30 am, E17, Maintenance Director, stated, "We have not done any disaster drills since the last survey (8/14/15), only fire drills. We have one (disaster drill) scheduled for 7/29/16. I thought I had a year to do them."

On 7/14/16 at 1:00 pm, E18, Housekeeper, stated, "I have worked here five months and I have not received any training on what to in case of a tornado." E18 further stated, "I have not been trained how to use a fire extinguisher, I do not know how to use one."

The facility's Resident Census and Conditions of Residents report documents 77 residents reside in the facility.