STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145295	A. BUILDING _____ B. WING _____	04/08/2016

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RIVERSHORES HLTH & REHAB CTR	**578 WEST COMMERCIAL STREET MARSEILLES, IL 61341**

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F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	Annual Licensure and Certification Survey 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy for four	F 164		

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

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F 164	Continued From page 1	F 164		

of 14 residents (R14, R20, R27 and R43) reviewed for privacy in the sample of 17.

Findings include:

The facility's policy Quality of Life - Dignity, dated 2009, documents "10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures."

The facility document titled "Residents' Rights for People in Long-term Care Facilities" (no date) states, "Your medical and personal care are private."

1. On 4/6/16, at 8:45 am, E7, Registered Nurse/RN, administered medication via R20's gastrostomy tube. R20's door to the hall was open and no privacy curtain was pulled closed.

On 4/6/16, at 9:08 am, E7 RN, stated "I know I forgot to pull the curtain."

2. On 4/6/16, at 2:00 pm, E14, Certified Nurse Assistant/CNA performed incontinent care for R14. The bathroom door was open through to the other side leading to R43's room exposing R14's bare bottom to R43 who was in bed.

On 4/6/16, at 2:02 pm, E15, Housekeeper, reached into R14's room to close the bathroom door.

On 4/6/16, at 2:15 pm, E14 CNA, stated "I should have made sure both bathroom doors were shut."

3. On 4/7/16 at 10:35 AM, R27 was in (R27)'s room. The bed in R27's room that is closest to

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F 164	Continued From page 2 the hallway door extended the length of the wall and blocked the ability to shut the hallway door, leaving the door open approximately six inches. On 4/7/16 at 10:35 AM , R27 stated (R27) told the nursing facility staff about the bed blocking the door at the beginning of the week. R27 states (R27) would like to be able to close the door for privacy.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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F 225	Continued From page 3 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report allegation of mental and verbal abuse for one of 14 residents (R22) reviewed for abuse in the sample of seventeen and one resident (R30) in the supplemental sample. Findings include: R22 and R30's Nurses Notes dated 4/8/2016 at 12:00AM document the following: (R22 and R30) were heard cursing and calling each other vulgar names; and the nurse and Certified Nurses Aid (CNA) responded and provided 1:1 (one to one) interventions. On 4/8/2016 at 9:30AM E2 Director of Nursing (DON) stated the following: E2 had not been notified of any problems between two residents over night. On 4/8/2016 at 10:20AM E1 Administrator stated the following: "We have called in the third shift staff for statements and then we will immediately educate; and this incident should have been reported to me immediately when it happened so I could start the investigation."	F 225		

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F 225	Continued From page 4 On 4/8/2016 at 12:30PM, E19 Licensed Practical Nurse (LPN) stated the following: "At midnight (4/8/16), (E20 CNA) and I heard commotion...calling each other names and swearing mainly over the TV; I took it as an argument between two residents; and at that time I did not think of it as abuse." At this same time E19 defined verbal abuse as "name calling and cursing at another resident;" and defined mental abuse as "hurting someone's feelings or making them feel bad." At that same time E19 stated, " Based on my definitions and what I know now I realize that I should have reported this as abuse."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their Abuse Prevention policy for one of 14 residents (R22) reviewed for abuse in the sample of seventeen and one resident (R30) in the Supplemental sample. Findings include: The facility "Abuse Prevention Program" updated 12/2013, documents the following: "This facility desires to prevent abuse, neglect, mistreatment and misappropriation of resident property by	F 226		

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F 226	Continued From page 5 establishing a resident sensitive and resident secure environment.....Employees are required to report any incident ,allegation or suspicion of potential abuse, neglect, mistreatment or misappropriation of resident property they observe hear about or suspect to the administrator immediately.....Residents who allegedly abuse another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety as well as the safety of either residents and employees of the facility....The nursing staff is additionally responsible for assessing there resident, reviewing the documentation and reporting to the administrator..." On 4/8/2016 at 9:30AM, E2 DON stated there was no report of a problem or incident between R22 and R30 over night (4/8/16.) On 4/8/2016 at 9:50AM, E1 Administrator stated the following: "Yes there were behaviors and concerns last night (4/8/16) between (R22 and R30) that should have been reported as abuse; and they (staff) did not follow our Abuse policy."	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 6 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 update a residents care plan to address total parenteral nutrition (TPN) administration changed from a central venous catheter (CVC) to a peripherally inserted central catheter (PICC) for one of 17 residents (R21) reviewed for revising care plans on a sample of 17. Findings include: The facility Care Plan Process-Guidelines, dated February 2015 documents the following: "Individual care plans are reviewed and modified based on information obtained through continued evaluation of the resident's status; this includes but is not limited to falls, change in condition, when the desired outcomes needs modified, re-admission from hospital stay, and quarterly." 1. R21's Current Care Plan created 2/3/16	F 280		

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F 280	Continued From page 7 documents the following: "Problem: (R21) is at risk for infection r/t (related to) double lumen (CVC) to right chest for TPN administration, hx (history) of pneumonia, and malnutrition." R21's Re-admission Nurse Progress Note, dated 2/23/16, documents R21 was readmitted from the hospital...receiving TPN through a newly inserted PICC line. R21's Physician Order Sheet (POS), dated 4/1/16 through 4/30/16, documents the following: "Treatments: started 2/26/16, Site: PICC line, change dressing weekly and as needed." On 4/6/16 at 3:00 p.m., R21's TPN bag was infusing through an intravenous line that was connected to R21's PICC located in R21's left arm. On 4/6/16 at 10:50 a.m., E3 Care Plan Coordinator stated the following: "(R21's) PICC line should be on (R21's) care plan; it is not on (R21's) care plan; and I didn't receive the orders when (R21's) TPN was changed from being infused in (R21's CVC) to the newly placed PICC."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure monitoring of an AV (arterial-venous) graft site for thrill and bruit for one of one resident (R14) reviewed for dialysis in the sample of 17. Findings include: On 4/6/16 at 8:42 am, R14 was reclined in a chair in the facility's dialysis area and was hooked up for dialysis treatment via R14's right arm port (AV graft site). The Patient Discharge Instruction sheet for R14, dated 2/12/16, documents R14 had a dialysis graft procedure done. R14's Physician Order Statement (POS) and Treatment Administration Record (TAR), both dated 4/1/16 to 4/30/16, do not document any orders for the monitoring of R14's AV shunt and checking the thrill and bruit. On 4/7/16 between 12:20 pm and 12:30 pm, E2 Director of Nursing (DON) and E7 Registered Nurse (RN) stated that R14's thrill and bruit should be checked and documented every shift. E7 stated "I usually am the one who checks the dialysis orders and writes 'to check the thrill and bruit every shift' on the TAR. It is not there." On 4/7/16 at 3:00 pm, Z4 Dialysis Regional Manager stated "We tell the facility to write 'check the thrill and bruit every shift' on the Medication Administration Record (MAR)/TAR.	F 309		

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F 314	Continued From page 9	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow physician orders for treatment of a stage four pressure ulcer for one of four residents (R14) reviewed for pressure ulcers in the sample of 17. Findings include: The facility's policy Skin Treatment Guidelines, dated 10/2014, documents "Purpose: To provide standardized, evidenced-based recommendations for prevention, care and treatment of pressure ulcers and wounds." On 4/16/16 at 1:35 pm, a stage IV wound to R14's sacrum was open, pink, odorless, and without drainage. R14's Pressure Ulcer Assessment and Orders sheet, dated 3/30/16, documents R14 has a stage IV pressure ulcer to R14's coccyx measuring 2.5 cm (centimeters) x 0.9 cm x 0.7 cm. The physician's treatment order on this sheet	F 314		

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F 314	Continued From page 10 is documented as "(Calcium) Alginate, and cover with (transparent adhesive dressing) twice per day." R14's Treatment Administration Record (TAR), dated 3/1/16 to 3/31/16, documents R14's treatment as "Cleanse sacrum with normal saline. Apply calcium alginate, cover with (transparent adhesive dressing) twice per day, and as needed." This treatment is documented as completed once on 3/30/16, and not at all on 3/31/16. R14's TAR, dated 4/1/16 to 4/30/16, documents R14's treatment as "Site: Sacrum: Cleanse with normal saline, apply collagen to wound bed only, cover with foam, change daily, and as needed." This treatment is documented as completed daily on 4/1/16 - 4/3/16, and 4/5/16. No treatment is documented as completed for 4/4/16. On 4/6/16 at 1:50 pm, E12 Registered Nurse (RN) stated that the new physician order for R14's pressure ulcer treatment for calcium alginate did not get transcribed over onto the April 2016 TAR for R14. E12 confirmed that the new orders were not followed through and the wrong treatment was being done for R14.	F 314		
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325		

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F 325	Continued From page 11 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and report weight loss for one resident (R25), and failed to accurately record food intakes for three of eleven residents (R8, R15, R25) reviewed for weight loss in the sample of 17. Findings include: The facility's Resident Nutrition Services (revised 4/2010) documents "Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk of, impaired nutrition," and "Significant variations from usual eating or intake patterns...and report it, as indicated, to the Attending Physician and dietician." 1. R25's Physician Order Sheet dated 4/2016 documents a diagnosis of Alzheimer's Disease, and "Weight weekly X (times) 4 (four), then q (every) month." R25's current Care Plan documents "Monitor weights as ordered. Notify MD (Medical Doctor) if (R25) exceeds parameters of weight gain/loss." R25's Nutrition Assessment dated 3/23/16 documents "Intake reported good. Plan- Monitor weight, intake and follow up as needed." R25's Vital Sign Record documents the following weights: 3/15/16 134 pounds (lbs), 3/16/16 132	F 325		

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F 325	Continued From page 12 lbs, 3/23/16 126.4 lbs, 3/30/16 126 lbs, and 4/5/16 124 lbs. On 4/8/16 at 9:32am, E4 Dietary Manager stated R25's weight loss documented on 3/23/16, 3/30/16 and 4/5/16 is a significant weight loss. E4 stated (E4) had not had time to review resident weights and did not realize R25 had had significant weight loss. E4 stated (E4) did not report R25's weight loss to the dietician until 4/8/16. On 4/7/16 at 12:45pm, R25 was served lunch consisting of corned beef, red potatoes, cabbage, bread and butter, lemon dessert, and water. At 1:15pm R25 left the table having eaten only the cabbage. On 4/7/16 at 1:30pm, E11 Certified Nursing Assistant (CNA) removed R25's lunch tray and documented R25 ate 100 % (per cent) of the lunch meal on the Resident Food Consumption Record. On 4/7/16 at 1:55pm R25 stated (R25) ate only the cabbage at lunch. On 4/7/16 at 2:00pm E11 CNA stated "I must have thought (R25) ate all of (R25's) lunch because the napkin was on top of the plate. I did not look under the napkin." On 4/8/16 at 8:45am R25 was served breakfast consisting of scrambled eggs, sausage patty, toast, oatmeal, milk, and apple juice. R25 ate 100% of the sausage, and 50% of the eggs and milk. R25 ate none of the oatmeal, toast or apple juice. At 9:12am E14 CNA removed R25's breakfast tray. On 4/8/16 at 9:12am E14 stated R25 ate half of	F 325		

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F 325	Continued From page 13 the eggs, half of the milk, and all of the sausage. R25's Resident Food Consumption Record dated 4/8/16 Breakfast documents R25 ate 100% of the breakfast meal. On 4/8/16 at 9:20am E14 stated "I must have looked at another resident's tray when I recorded R25's intake. I was standing at the nurse's desk and I thought R25 ate everything." 2. R8's Nutrition Assessment dated 1/7/16 documents R8 has had a 10% weight loss in the past six months. R8's current care plan documents "Monitor dietary intake for all meals and document." R8's Resident Food Consumption Record documents no food intake for 3/17/16-3/21/16, 3/21/16-3/28/16, 3/31/16, 4/4/16, and 4/6/16. 3. R15's Quarterly Nutrition Progress Note dated 2/5/16 documents R15's weight as 152 lbs. R15's Quarterly Nutrition Progress Note dated 3/21/16 documents R15's weight as 141lbs and "Significant weight loss." R15's current care plan documents "Monitor and record nutritional status and dietary intake." R15's Resident Food Consumption Record documents no food intakes for 3/7/16-4/14/16, 3/16/16-3/31/16, and 4/4/26. On 4/8/16 at 12:08pm E4 Dietary Manager stated (E4) expects staff to accurately record resident's food intake. E4 stated accurate residents' food intakes are needed in order to address weight loss and develop interventions to stabilize weight.	F 325		

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F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete dressing change treatments on a peripheral inserted central catheter (PICC) according to the Physician Order Sheet (POS) for two of three residents (R21 and R22) reviewed for specialty care in a sample of 17. Findings include: The facility policy "Central Venous Catheter Dressing Changes" (dated December 2011) states, "5. Change transparent semi-permeable membrane dressing at least every seven days and prn (when wet, soiled or not intact)." 1.) R21's Admission Nursing Assessment, dated 3/22/16, documents Body Observation number four: new PICC line on R21's left arm. R21's Physician Telephone Orders, dated 3/22/16, documents "Change PICC line dressing	F 328		

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F 328	Continued From page 15 weekly and as needed." R21's Physician Order Sheet (POS), dated 4/1/16 through 4/30/16, documents "Treatments: started 2/26/16, Site: PICC line, change dressing weekly and as needed." On 4/5/16 at 3:25 p.m. and 4/6/15 at 3:00 p.m., R21's left arm PICC dressing was undated, had a very faint yellowish brown hue, and was starting to roll away from the skin around the edges. R21's Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 3/23/16 through 3/31/16, have no nurse initials and/or nurse signatures on any of the dates to document the PICC dressing change was completed. R21's MAR and TAR, dated 4/1/16 through current date of 4/6/16, have no nurse initials and/or nurse signatures on any of the dates to document the PICC dressing change was completed. On 4/5/16 at 3:25 p.m. and 4/6/16 at 3:00 p.m., R21 verified that R21's dressing had not been changed since R21's return from the local area hospital where R21's new PICC line was inserted. On 4/7/16 at 11:50 a.m., E1 (Administrator) and E2 (Director of Nurses) verified that the MAR and TAR were not initialed, and R21's dressing change treatment was missed on 3/30/16 according to the POS. 2.) R22's facility face sheet documents R22 was admitted on 4/4/2016. R22's 3/27/2016 Hospital reports documents a diagnosis of Septic arthritis	F 328		

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F 328	Continued From page 16 of the right ankle. R22's April 2016 POS documents Intravenous (IV) antibiotic therapy of Ceftriaxone 2 grams to be infused daily for 36 days. On 4/5/2016 at 9:00AM, R22 was lying in bed with a PICC line in the upper left arm. R22 stated the PICC line dressing has not been changed since R22 arrived at this facility. The April 2016 POS and Treatment Sheet do not document orders for the PICC line dressing change. On 4/6/2016 at 12:30PM, E7 Registered Nurse (RN) verified the PICC dressing was dated 3/30/3016 and stated, "usually there is an order for those dressings to be changed on third shift but there isn't one.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer the correct physician ordered eye drops, and failed to ensure medications were administered via gastrostomy tube. R17 and R20 are two of eight residents reviewed for medication administration in the sample of 17. There were 27 opportunities with five errors resulting in a 18.5% error rate. Findings include:	F 332		

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The facility's policy Medication Management Administration, dated 03/2016, documents "Medications must be administered in accordance with the orders, including any required time frame."

1. The POS for R20, dated 4/1/16 to 4/30/16, documents "Omeprazole DR 20 milligrams/mg one tablet per G-Tube (Gastrostomy tube) once daily; Thiamine (Vitamin B1) 100 mg one tablet per G-Tube once daily; Klor-Con 20 milliequivalents/mEq packet dissolve one packet in liquid and take per G-Tube once daily; and Carvedilol 25 mg take one tablet per G-Tube twice daily.

On 4/6/16, at 8:45 am, E17 RN, administered R20's Omeprazole DR 20 mg, Thiamine 100 mg, Klor-Con 20 mEq, and Carvedilol 25 mg to R20 by mouth. E17 stated "(R20) tells us if (R20) wants to swallow them. If (R20) doesn't then we put them in the G-Tube."

On 4/8/16 at 8:51 am, E2 Director of Nursing/DON stated, "If the physician orders say to give a medication via G-Tube then that is how I would expect it to be given.

2. "The Physician Order Statement/POS for R17, dated 4/1/16 to 4/30/16, documents "Refresh Tears 0.5% eye drops - instill one drop into both eyes four times daily."

On 4/5/16 at 4:00 pm, E19 Registered Nurse/RN stated, "I don't have any Refresh tears for (R17). I have Artificial tears from our stock," and then administered Artificial tears lubricant eye drops, one in each of R17's eyes.

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F 332	Continued From page 18 On 4/8/16 at 8:51 am, E2 Director of Nursing/DON stated that the nurse should get a telephone order before giving a different eye drop than what is ordered.	F 332		
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 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 observation, interview, and record review the facility failed to serve the correct serving size of food according to the dietary department standardized menus and failed to provide substitutions of similar nutritive value. These failures have the potential to affect all 83 residents who consume food in the facility. Findings include: The facility's "Week at a Glance Menu" (printed 2/25/16) documents the lunch meal on Wednesday to include: Stuffing Crusted Pork Choppette, Buttered Carrots, Fruited Gelatin, Coffee/Tea, Condiments." 1.) On 4/6/16 at 11:50 a.m., E9 (Dietary Cook) served bread stuffing using a #12 (1/3 cup) scoop. No additional carbohydrates macronutrients were served during the lunch	F 363		

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period to account for the smaller scoop of stuffing.

The facility's "Stuffing Crusted Pork Choppette" Standardized Recipe (undated) states, "Top each choppette with half a cup of prepared stuffing using a #8 (1/2) scoop."

On 5/6/15 at 11:40 AM, E4 (Dietary Manager) stated, "We followed the Standardized Recipe to make the stuffing be able to serving 85 residents. E9 used a #12 scoop and the standardized recipe called for a #8 scoop. E9 is new to the dietary department and may have misread the standardized recipe scoop requirement. There has been no dietary staff education regarding scoop sizes in a while."

2.) On 4/6/16 at 12:20 p.m., E9 (Dietary Cook) was low on the main entree selection of buttered carrots. At that time, E9 started substituting whole kernel corn for buttered carrots for residents eating lunch in the south dining room.

On 4/6/16 at 1:50 p.m., E4 (Dietary Manager) verified that E9 prepared the buttered carrots recipe using the standardized recipe to serve 80 residents and corn does not have the same nutritive value as buttered carrots.

On 4/6/16 at 1:50 p.m., E5 (Registered Dietitian) stated, "Our menus and recipes are provided by (Food Service Corporation) and are supposed to be accurate to the number of servings you are preparing for if you follow the standardized recipe. We have found some of the recipes have come out differently, requiring us to contact the (Food Service Corporation) company for review...The vitamins and minerals content between corn and

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F 363	Continued From page 20 carrots are different. A more similar substitution should have been used if the shortage didn't occur when lunch was being served." The facility's South Dining Room seating chart, undated, documents R5, R17, R23 through R25, and R28 through 41 are residents who eat lunch in the south dining room.	F 363		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve food as prescribed according to physician orders for three of 14 residents (R15, R16 and R23) reviewed for prescribed therapeutic diets in a sample of 17. Findings include: On 4/8/16 at 2:30 p.m., E1 (Administrator) and E4 (Dietary Manager) verified that resident meal cards are created from the Physician Order Sheet (POS) diet orders. The facility policy "Resident Nutrition Services" (revised April 2010) states, "Each resident shall receive the correct diet...Nursing personnel will ensure that the residents are served the correct food tray. Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident."	F 367		

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The facility guidelines "Mechanical Soft-Dysphagia Level 3" (undated) states, "Meat items are designated to be ground and served with a sauce, gravy or both...Foods containing fresh vegetables or whole kernel corn are to be avoided."

1. R23's Facesheet, dated 3/3/16, documents an admission date of 6/9/15 and diagnoses which include: Legal Blindness, Cerebral Infraction, and Oropharyngeal Phase Dysphagia.

R23's POS, dated 4/1/16 through 4/30/16, states, "Diet Order, Mechanical Soft"

R23 Lunch Meal Card, dated 4/6/15, stated, "Mechanical Soft" diet order.

R23's Current Care Plan states, "(R23) has a diagnoses of Oral Pharyngeal Dysphagia which requires her to need a modified diet....Speech Therapy to monitor and treat as indicated for diet upgrade as appropriate."

R23's Speech Therapy Progress and Updated Plan of Care note, dated 8/16/15, states, "Patient demonstrated improved swallow function with decreased overt s/s (signs and symptoms) cough and wet voice...Patient participated in diet trial with implementation of compensatory techniques...Patient is independent with safe swallow techniques...Patient continues to demonstrate mild overt s/s dysphagia as indicated...Recommended diet is mechanical soft with nectar thick liquids."

On 4/6/16 at 12:30 p.m., R23's was sitting in a chair in the dining room with (R23's) lunch plate consisting of a regular, whole pork choppette and

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F 367	Continued From page 22 corn. At that time, R23 started eating, until it was brought to E17 (Business Office Manager) attention that R23's diet was served inaccurately, at which point E17 removed R23's food and replaced it with the correct diet. On 4/6/16 at 1:50 p.m., E5 (Registered Dietitian) verified that a whole piece of pork choppette and corn are not allowed on a mechanical soft diet order. 2.)R15's POS, dated 4/1/16 through 4/30/16, states, "Diet orders, (nutrition ice cream supplement) daily." R15's Current Care Plan states, "Problems: (R15) has a diagnosis of oral phase dysphagia and is edentulous, requiring an alteration in diet/liquid consistency placing her a risk for nutrition and hydration deficits. (R15) also has a diagnosis of Diabetes, Hypertension, and a history of significant weight loss...Interventions...Provide diet as ordered by Physician, see POS." R15 Lunch Meal Card, dated 4/6/15, stated, "Lunch Notes (nutrition ice cream supplement)." The Extra Supplements List for (nutrition ice cream supplements) (undated), documents R15 receives nutrition ice cream supplements at "lunch and at supper if still hungry." On 4/6/16 at 12:10 p.m., R15's lunch tray did not have a nutrition ice cream supplement. At this time, no other nutrition supplement substitution was provided. 3.) R16's Lunch Meal Card, dated 4/6/15, states, "Lunch Notes (nutrition ice cream supplement)." R16's Current Care Plan states, "Problems: (R16) is at risk for altered nutrition r/t (related to) (R16's) hx (history) of malnutrition. (R16) has a hx of weight loss. (R16) has had a trending pattern of weight loss not yet significant. Current weight is 115 lbs (pounds). Interventions:...Provide supplements as indicated. Super cereal at	F 367		

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F 367	Continued From page 23 breakfast and (nutrition ice cream supplement cup)." The Extra Supplements List for (nutrition ice cream supplements) (undated), documents R16 receives nutrition ice cream supplements "two times daily" at lunch and dinner. On 4/6/16 at 12:10 p.m., R16's lunch tray did not have a nutrition ice cream supplement. At this time, no other nutrition supplement substitution was provided. On 4/6/16 at 12:10 p.m., E8 (Dietary Aide) state, "We are out of (nutrition ice cream supplement) until tomorrow morning's shipment is received (4/7/16)." On 4/6/16 at 1:50 p.m., E4 (Dietary Manager) verified the facility ran out of the nutritional supplement and R15 and R16 did not receive a nutritional supplements on their lunch trays.	F 367		
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 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to keep the kitchen exhaust hood, griddle, oven range, multiple cooling and freezer units and a fan free from	F 371		

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dust, food debris, and grease buildup. They also failed to follow hand hygiene and glove use in a manner that reduces the potential for food contamination. This failure has the potential to affect all 83 residents currently living in the facility.

Findings include:

1.) On 4/5/16 at 9:15 a.m., during initial tour with E4 (Dietary Manager), the kitchen exhaust hood pipes, kitchen range, griddle backsplash, and a shelf above the kitchen griddle and range had buildup up of dirt, dust, and grease splashes.

On 4/5/16, also during the initial tour, three cooling units and one-three door freezer had crumbs at the bottom of the cooler and freezer units, and the cooling unit located on the far right had red-brown dry spots on the bottom of the cooler.

On 4/6/16 at 11:50 a.m., a fan that is located on the floor between the dishwasher and a cooling unit had excessive dust buildup. The fan was turned on pointing in an upward direction towards the food preparation area and holding tables.

On 4/6/16 at 1:50 p.m. E4 (Dietary Manager) verified that E4 noticed the dusty fan on that day.

The facility policy "Cleaning Schedule" (undated) stated, "The food service department will have a cleaning schedule identifying cleaning tasks, staff to complete the work and day work day work is to be completed...The food service manager will develop, post and enforce a cleaning schedule."

The facility Kitchen Checklist (dated between

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F 371	Continued From page 25 3/14/16 through 4/3/16) documents the back refrigerator/freezer were wiped out last on 3/20/16. On 4/5/16 at 9:15 a.m., E4 stated, "The cleaning list is posted weekly. All tasks should be completed daily. The cooler and freezers should be wiped out daily as stated on the Kitchen Cleaning Checklist and no initials have signed to mark the task complete since 3/20/16. The range shelf, exhaust hood pipes, the griddle backsplash and fan are not on the cleaning checklist. The range shelf, exhaust hood pipes and griddle backsplash should be wiped at least weekly and after each use if soiled. The fan will also need to be added to the cleaning checklist. I used to have a employee designated to cleaning, but that employee has had to help with other kitchen staff due to dietary staff leaving." The Centers for Medicare and Medicaid Services "Resident Census and Conditions of Resident", form 672, completed by E3 (Care Plan Coordinator) and E13 (Restorative Registered Nurse) on 4/5/16 lists 83 residents are living in the facility. The facility policy "Disposable Gloves" (undated) states, "Disposable gloves will be worn when manual contact with food that is ready-to-eat is unavoidable. Food handlers will wash hands before putting on gloves." 2. On 4/6/15 at 12:00 p.m., E10 (Dietary Aide) had gloved hands and was placing parsley garnishes directly on the pork chop, dressing and gravy of resident plates for lunch. After placing the garnish, a cover was placed on the residents plates and the plated trays were placed on a cart	F 371		

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F 371	Continued From page 26 to be wheeled to the appropriate dining area. When the cart was full, E10 removed E10 gloves and pushed the cart to the dining area. Upon reentering the kitchen, E10 applied gloves without washing hands. E10 continued to place parsley leaves on resident lunch foods and place the plates on another cart, until six carts were full. E10 took each of the six carts out to the dining rooms and never washed hands upon returning to the kitchen and reapplying gloves for each cart taken out. On 4/6/16 at 1:50 p.m., E4 (Dietary Manager) stated, "Staff should be washing hands upon entering the kitchen after pushing the carts out to the dining room and should wash hands before putting on gloves and touching food." 3. On 4/5/16, at 1:00 pm, E16, Certified Nurse Assistant/CNA, assisted R14 with a sandwich. E16 touched the bread with E16's bare hands to cut the sandwich and to hand the sandwich to R14. On 4/6/16, at 8:30 am, E16 CNA stated, "That is usually how I assist residents with their meal. Should I have worn gloves when touching (R14's) food?"	F 371		
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.	F 441		

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F 441	Continued From page 27 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Facility noncompliance resulted in two deficient practices: A.) Based on observation, interview and record review, the facility failed to follow their policy regarding Contact Isolation Precautions for a	F 441		

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resident (R21) with Carbapenem Resistant Enterobacteriaceae (CRE). This failure has the potential to affect all 74 residents living in the facility.

Findings include:

1. The facility policy "Isolation-Categories of Transmission-Based Precautions" (revised April 2012) states, "Contact Precautions: In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...Examples of infections requiring Contact Precautions include, but are not limited to: Infections with multi-drug resistant organisms...d.) Gown: 1.) Wear a disposable gown upon entering the Contact Precautions room or cubicle...Droplet Precautions: In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets that can be generated by the individual coughing, sneezing, talking...c.) Mask: 1.) In addition to Standard Precautions, put on a mask when entering the room or cubicle."

R21's Current Care Plan, created 2/10/16, states, "Problem: (R21) requires contact isolation for CRE of respiratory tract...Interventions: Maintain isolation precautions as noted."

On 4/5/16 at 9:00 a.m., during initial tour with E3 (Care Plan Coordinator), R21's room door had a red sign hanging on the door that identified

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Contact Isolation Precautions should be followed when entering R21's room. The sign guided staff and visitors to wear gloves and gown, if soiling is likely.

On 4/5/16 at 9:00 a.m., E3 was unable to say why R21 was on Contact Isolation Precautions.

On 4/6/16 at 8:55 a.m., Z3 (Local Area Agency Phlebotomist) was in R21's room wearing gloves and a face mask. Z3 was not wearing a gown. At that time, Z3 was drawing R21's blood.

On 4/6/16 at 8:55 a.m., Z3 was unaware what infection required R21 to be on Contact Isolation Precautions and confirmed that according to the sign on the door, Z3 should've had on a gown when drawing R21's blood.

On 4/6/16 at 9:30 a.m., E11 (Certified Nursing Assistant/CNA) went into R21's room, applied gloves, pulled up the sides of R21's red biohazard trash bag, removed gloves, tied a knot in the red biohazard trash bag, and carried the red biohazard trash bag and white trash reciprocal out of R21's room. E11 placed the white trash reciprocal holding the red biohazard bag on the floor in the hallway outside R21's room. E11 then stepped into R21's room, grabbed a pair of gloves, walked to the soiled linen room, opened the door and carried the white trash reciprocal containing the red biohazard trash bag into the soiled utility room. Moments later, E11 opened the soiled utility room and was carrying the white trash reciprocal that held an empty, new, red biohazard trash bag with gloves on. E11 then walked into R21's room with the clean biohazard trash reciprocal wearing gloves.

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On 4/6/16 at 9:40 a.m., E11 stated that R21 was in Contact Isolation for "something in (R21's) stool that (R21) will have forever." At that time, E11 stated, "I wore gloves when changing out the biohazard trash, but no gown...I'm not sure if I should've taken the trash into the hallway. The red biohazard trash bag was tied."

On 4/6/16 at 10:35 a.m., E2 (Director of Nurses/DON) stated, "(R21) is on Isolation Precautions for CRE of the stool."

R21's Local Area Hospital Results Report, dated 10/24/16, documenting, "Results: Culture, Respiratory, Lower-Sputum...Moderate Escherichia coli (E. coli): CRE detected, patient requires contact isolation. Few Klebsiella pneumoniae: CRE detected, patient requires contact isolation."

On 4/6/16 at 11:40 a.m., E2 (DON) stated, "(R21) CRE infection is respiratory. (R21) should be on Contact Isolation Precautions. This requires gown and gloves if soiling is likely. If taking out soiled trash, the CNA should be wearing gown and gloves. If the Phlebotomist is drawing blood, gown and gloves should be worn."

On 4/6/16 at 1:15 p.m., E6 (Registered Nurse) stated, "I spoke with (Z2/Infectious Disease Physician Nurse) and (Z2) told me that (R21) needs to be in isolation. When a resident comes in requiring isolation, we need three negative culture results before we can remove a resident from isolation precautions. We haven't completed any additional culture swabs since (R21) has been a resident here to verify if (R21) still has the infection. (Z2) recommended (R21) be in contact isolation precautions. If (R21) is not

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coughing or sneezing, face masks would not be required. If symptomatic of cough, staff should wear a face mask and (R21) would need to wear a face mask when leaving (R21's) room. Currently, (R21) is asymptomatic of cough."

On 4/8/16 at 1:15 p.m., E1 (Administrator) stated, "Our CNA's are assigned to a specific hallway, but in a situation where other areas in the facility need assistance, CNA's could potentially work throughout the building."

The Centers for Medicare and Medicaid Services "Resident Census and Conditions of Resident", form 672, completed by E3 (Care Plan Coordinator) and E13 (Restorative Registered Nurse) on 4/5/16 lists 83 residents are living in the facility.

B.) Based on observation, interview, and record review, the facility failed to practice handwashing and glove changes during cares for two of seven residents (R14 and R20) reviewed for incontinent care and one of three residents (R20) reviewed for wound care, and one of six residents (R20) reviewed for medication administration; and failed to ensure that a glucometer was disinfected prior to use for one of two residents (R5 and R28) reviewed for blood glucose testing in the sample of 17.

Findings include:

The facility policy for "Handwashing/Hand Hygiene" documents the Policy Statement. " This facility considers hand hygiene the primary means to prevent the spread of infection....Employees must wash their hands for at least fifteen second using antimicrobial or

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non-antimicrobial soap and water under the following conditions:...Before and after resident contact. Before and after eating or handling food(handwashing with soap and water).....After contact with a resident's mucous membranes and body fluids or excretions....After handling soiled or used linens, dressings, bedpans, catheters and urinals...After removing gloves..."

The facility's policy Handwashing/Hand Hygiene, dated 2012, documents "This facility considers hand hygiene the primary means to prevent the spread of infections. 5. Employees must wash their hands...c. Before and after direct resident contact; q. After contact with a resident's mucous membranes and body fluids or excretions; 6. f. Before moving from a contaminated body site to a clean body site during resident care."

1. On 4/6/16, at 2:00 pm, E14, Certified Nurse Assistant/CNA, performed incontinent care for R14. With gloved hands E14 CNA cleansed stool from R14's rectal area. With the same soiled gloves, E14 cleansed the perineal area.

On 4/6/16, at 2:15 pm, E14 CNA stated, "I usually change my gloves when I go from dirty to clean."

2. On 4/6/2016 at 11:10AM, E16 Certified Nurse Aide (CNA) removed R20's soiled incontinent brief with gloved hands and placed it in a bag on the bed. E16 provided pericare to R20, rolled him from side to side to finish cares, applied a new incontinent brief and then covered R20 with the bed sheet. R16 then removed his gloves and without washing his hands, touched E16's personal glasses, took the bags of soiled linens and disposable items, walked down the hall and placed them into a receptacle. E16 walked to the

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linen cart, returned to R20's room and laid the clean linens on the foot of the bed and left the room again. At 11:30AM when E16 left the room for the second time E16 stated he washed his hands and applied gloves before he started cares but not since providing cares.

On 4/6/2016 at 11:10AM, E7 Registered Nurse (RN) entered R20's room to provide a treatment to R20's right ischium. E7 set up the clean dressings on an overbed table and washed her hands and applied gloves. E7 picked up the spray wound cleanser, sprayed the open area then wiped it with a clean 4x4 gauze dressing. With the same soiled gloves, E7 reached back to the clean field for another dressing and cleansed the opened area a second time. E7 then removed her gloves and washed her hands and applied clean gloves. E7 applied the dressing to the wounds, removed gloves and washed her hands.

On 4/6/2016 at 11:35AM, E7 stated she washed her hands and applied gloves when she started the treatment to R20's bottom..."I had clean gloves on so I wouldn't think I should change my gloves while cleansing the wound twice."

The facility's policy Medication Management Administration, dated 03/2016, documents "Staff shall follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves..etc.) when these apply to the administration of medications."

On 4/6/16, at 8:50 am during medication administration, E7, Registered Nurse/RN, knocked over the cup of R20's pills. One pill fell

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F 441	Continued From page 34 onto the top of the medication cart. E7 picked it up with her bare hands and placed it back into to cup then administered all of the pills to R20. On 4/6/16, at 9:08 am, E7 RN stated, "I am not suppose to touch resident's pills with my bare hands. I realize I did." 3. On 4/5/16, at 4:00 pm, E19, Licensed Practical Nurse/LPN, dropped R5's and R28's glucometer on the floor. E19, LPN picked it up off of the floor and used it to perform blood glucose testing for R5 and R28. On 4/5/16, at 4:05 pm, E19 LPN stated, "We are supposed to clean the glucometer after every use. I guess I don't know if it was cleaned before I used it." On 4/8/16, at 3:05 pm, E2, Director of Nursing/DON stated, "We do not have a glucometer policy. It is my expectation that the nurses cleanse the glucometer before and after each use."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514		

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preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to update the Physician Order Sheet (POS) with the resident's current wishes regarding advanced directives for one of 17 residents (R16) reviewed for accurate medical documentation in a sample of 17.

Findings include:

The facility Admission Advanced Directives policy, revised 3/2016, states, "Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record."

R16's (State Agency) Uniform Do-Not-Resuscitate Advanced Directive Physician Orders for Life-Sustaining Treatment form, dated 6/24/15, states, "Cardiopulmonary Resuscitation (CPR): Do Not Attempt Resuscitation/DNR. When not in cardiopulmonary arrest...Medical Interventions: Limited Additional Interventions."

R16's Face Sheet, dated 12/31/15, states, "Advanced Directives: Do Not Resuscitate."

R16's POS, dated 3/31/16, states, "Advanced Directives: Full Code."

On 4/7/16 at 1:50 p.m., E2 (Director of Nurses/DON) stated, "Our pharmacy company prints our POS for all our residents. We switched pharmacy companies starting on 12/31/15. The

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F 514	Continued From page 36 (previous pharmacy) sent transcripts of all the current orders to the (new pharmacy company)." On 4/8/16 at 1:15 p.m., E1 (Administrator) stated the following: "After contacting both pharmacies, there were no new orders sent to (the former pharmacy company) when (R16's) code status changed; this order was never updated with the new (pharmacy company); and the code status on R16's POS should've been reviewed by the nurse responsible for changing monthly physician orders."	F 514		