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F 000	INITIAL COMMENTS Annual Licensure and Certification Validation for Subpart U Alzheimer's Unit- F314 refers to R14 Complaint Investigation for 1624357/IL87452 - No fndings	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to complete a pre-restraining assessment, complete quarterly restraint re-evaluations, implement a restraint reductions plan and identify a bed rail as a restraint and entrapment risk for one of one resident (R10) reviewed for Restraints in the sample of 24. Findings include: 1. A Policy and Procedure for Safe Use of Bed rails (date unknown), states "Bed rails are considered restraints; this includes full and half side rails. The only time a bed rail can be used in the facility is when the resident requests or approves of a device to be used to increase	F 221		8/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/25/2016

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his/her independence and mobility...1. The use of bed side rails must first be evaluated for their appropriateness at admission in relation to the resident's condition. 2. The request for half or full bed side rails must be made by the resident and clearly documented in the service plan...4. the continued use of bed side rails must be assessed for appropriateness quarterly as part of updating the residents service plan, or more often as necessary."

A Physical Restraint Policy (date unknown), documents prior to placing a restraint on a resident, there shall be a pre-restraining assessment and review to determine the need for the restraint. The assessment shall be used to determine possible causes of the problematic symptom and to determine if there are less restrictive interventions that may improve the symptom...documentation of the reason for the restraint, resident's response to the restraint, and behavior will be documented in the Nurses' notes by licensed staff. Re-evaluation of the resident's need for restraints will be done on a quarterly basis. The care plan will include the measures taken to reduce or eliminate the need for restraint use...The restraint reduction program will be used to eliminate the need for a restraint or to reduce the restraint to the least restrictive restraint.

On 8/1/16-8/4/16 R10 was in a tilt wheelchair tilted at approximately 45 degrees and also had a lap belt fastened around her waist.

R10's care plan dated 7/27/16, documents R10 uses a pelvic positioning device (lap belt restraint) in her wheelchair related to poor posture and is unaware of safety issues due to the diagnosis of Dementia. The care plan does not address a

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restraint reduction plan.

R10's medical record from 10/2015 to 8/3/2016 did not include documentation of a pre-restraining assessment, quarterly re-evaluations of the lap belt, or restraint reduction plan.

On 8/4/16 at 9:18 a.m., E2 (Director of Nursing) verified there is no documentation of R10's lap belt pre-restraint assessment, quarterly re-evaluations,or restraint reduction plans.

2. On 8/1/16 and 8/2/16, R10's bed had bilateral half bed rails.

R10's Minimum Data Set (MDS) assessment dated 7/21/16, documents R10 has severely impaired cognitive skills and requires extensive assistance of two staff members for bed mobility. R10 MDS assessments dated 1/21/16 and 7/21/16, do not document R10 uses bed rails.

R10's current Physician Orders, do not document an order for bed rail use.

R10's Side Rail Assessment dated 4/20/16, documents R10's family requested that R10 use the side rails. R10's Side Rail Assessment dated 7/20/16, does not mark the box that asks if the resident has ever become entrapped in the side rail or between the side rail and mattress. The Side rail assessment also documents that the side rails will assist R10 with avoiding rolling out of bed.

On 8/4/16 at 9:18 a.m., E2 (Director of Nursing) verified that R10 has had severely impaired cognition since admission in 2011. E2 stated R10 is not aware of her safety needs, is unable to

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F 221	Continued From page 3 consent to the use of bed rails, and is unable to use side rails to aid in mobility upon command. E2 verified the facility policy for side rails documents the resident must be able to request the use of side rails. A Resident Incident Report dated 6/21/16, documents R10 was found face down on her bed with her legs hanging off the bed and right arm trapped beneath the side rail causing a 4.5 by 7.5 centimeter bruise on R10's right forearm near the elbow. On 8/3/16 at 2:30 p.m., E2 (Director of Nursing) stated that R10's side rails were not re-evaluated after the 6/21/16 fall when R10's arm became trapped under the side rail. E2 stated, "We did not take the side rails off (R10's) bed." E2 verified that side rails have the potential to cause severe injuries and entrapment of residents.	F 221		
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, record review, and interview the facility failed to identify a resident at	F 314		8/26/16

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an increased risk for pressure ulcer development after a significant change in condition, failed to develop new pressure ulcer prevention interventions, and failed to routinely monitor/assess a pressure ulcer, for one of four residents (R14) reviewed for pressure ulcers in a sample of 24.

Findings include:

The facility policy, titled "Wound Care (no date)", documents "Assessment and documentation of a wound needs to occur daily. Document daily or more often, in the nurses notes. Provide a weekly summarization on the back of the Treatment Sheet (based on what has been charted in the nurses notes)...Remember the nursing care plan needs to address wound prevention and treatment; Be sure to address prevention and treatment as two separate problems." The Wound Care policy instructs staff to document the would size by measuring the "longest and widest areas of a wound in centimeters, measure the depth in millimeters...check for undermining or tunneling."

On 8-2-16 at 10:30 a.m., R14 had a left heel stage three pressure ulcer measuring approximately 3.0 centimeters round.

The Electronic Medical Record documents R14 has the current diagnoses of Senile Dementia and Aphasia. A Minimum Data Set, dated 6/02/16, identifies R14 has significant cognitive impairment, difficulty expressing needs and as a minimum assist of one staff for transfers/ambulation.

A current Plan of Care (no date) identifies R14 is

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at risk for skin breakdown/pressure ulcer development, related to the diagnoses of Intracranial Hemorrhage and Dementia, and choosing to sleep in a recliner over a bed. The pressure ulcer prevention interventions identified in the current Plan of Care are as follows: Apply barrier cream as needed, assist (R14) in peri-care after incontinent episode, encourage to reposition at least every two hours and skin checks weekly by licensed staff. A Minimum Data Set, dated 6/02/16, documents R14 requires only a stand by assistance of one person for ambulation and transferring.

A Resident Incident Report, dated 6/02/16 at 5:00 p.m., documents R14 was found on the floor lying on her left side. A subsequent Nursing Progress Note, dated 6/04/16, documents R14 was admitted to the hospital with a Left Hip Fracture, which was surgically repaired.

Nursing Progress notes, dated 6/07/16, document R14 was readmitted to the facility. A Restorative Note, on 6/07/16, documents R14 "Is supervised with bed mobility...extensive assist with hygiene and bathing. Extensive (assist) 1 or 2 with toilet use...Limitations lower extremities. She participates in formal transfer and walking restorative programs. A Nutrition Note, dated 6/13/16, documents R14 had a 3 pound weight loss and was not eating well, so a nutritional supplement was started." A follow up Nutritional Note, dated 6/14/16 documents R14 had a weight loss of 14 pounds in three months and a 32 pound weight loss in six months, leaving R14's current weight at 123 pounds.

Nursing Progress notes, dated 6/23/16, document R14 developed a large open area to

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back of left heel, measuring 4.5 cm (centimeters) by 1.5 cm, and the physician was notified. On 6/24/16, Nursing Progress Notes indicate the physician ordered R14's left heel wound was to be cleansed with normal saline, apply telfa and wrap daily, and R14 is to wear heel protectors at bedtime.

After R14's initial wound measurement on 6/23/16, Nursing Progress Notes document staff measured/assessed R14's left heel wound on 7/18/16 and 7/26/16. A Weekly Wound Assessment, as instructed in the "Wound Care" policy, was not completed until 7/29/16, in which R14's left heel wound was described as a Stage III measuring 4.4 cm by 3.8 cm by 0.1 cm.

On 8/04/16 at 9:10 a.m., E2 (Director of Nursing) confirmed that the above mentioned wound measurements/assessments were the only ones documented.

On 8/04/16 at 11:00 a.m., E14 (Advanced Nurse Practitioner) stated that R14's left heel wound resulted as a combination of shearing and pressure. E14 stated that a decrease in activity level and a weight loss can contribute to the development of a pressure ulcer, both of which R14 experienced after fracturing her hip. E14 stated it was difficult to determine if R14's wound was avoidable or not however, the facility should always plan for the possibility of a wound developing and should have implemented some pressure ulcer prevention interventions immediately upon R14's return from the hospital.

On 8/03/16 at 2:30 p.m., E3 (Care Plan Coordinator) confirmed that the facility failed to develop new pressure ulcer prevention

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F 314	Continued From page 7 interventions after R14 had a significant change in condition following the 6/04/16 hip fracture. E3 acknowledged that after R14 fractured her hip, the resident was at an increased risk for pressure ulcer development and the pressure ulcer prevention interventions on E14's current Plan of Care were those initiated back in 2011; therefore, no new interventions were developed. E3 confirmed that the facility had no Plan of Care currently in place related to R14's current left heel pressure ulcer.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident 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 prevent an indwelling catheter drainage bag from lying on the floor and failed to cover an indwelling catheter drainage bag with a cloth cover for one of two residents (R9) reviewed for indwelling catheters in the sample of twenty four. Findings include:	F 315		8/26/16

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F 315	Continued From page 8 A Catheter Drainage Bag policy (date unknown), states "When a resident is up in chair, be sure catheter drainage bag is inside a cloth bag and catheter tubing is not touching the floor." On 8/3/16 at 9:20 a.m., R9 was up in a personal recliner with both legs elevated. R9's indwelling catheter drainage bag was hanging from the pocket of the recliner and the drainage bag was touching the floor. R9's drainage bag was not inside a cloth bag. On 8/3/16 at 9:30 a.m., E17 (Licensed Practical Nurse) stated "The drainage bag should be inside of the pocket of the recliner and should never touch the floor." On 8/4/16 at 9:18 a.m., E2 (Director of Nursing) stated R9's catheter drainage bag should not have been touching the floor and the facility policy states catheter drainage bags should be inside of cotton covers.	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: Noncompliance resulted in two deficient practices.	F 323		8/26/16

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A. Based on record review and interview, the facility failed to to follow the Fall Policy and Gait Belt Policy requiring residents to have accessible call lights and safely transfer a resident to bed using a gait belt for one of seven residents (R19) reviewed for falls in the sample of 24. These failures resulted in R19 falling twice and sustaining a right elbow fracture and multiple lumbar spine fractures.

B. Based on observation, interview, and record review, the facility failed to analyze resident falls for root cause, failed to implement effective fall interventions, failed to supervise a resident, failed to follow care plan fall interventions, and failed to identify side rail entrapment for one of seven residents (R10) reviewed for falls, in the sample of 24.

Findings include:

A.

1. A Falls Management Program policy dated 7-8-16, documents, "In order to maintain a successful falls prevention program, all staff members are responsible for seeking out, removing, and reporting potential fall hazards. A fall checklist includes that staff are to keep the call light, water pitcher, glass, and any personal items within arm's length of the resident."

R19's Minimum Data Set (MDS) Assessment Section G Functional Status dated 4-7-16,

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documents R1 requires extensive assistance of one staff physical assist for walking in the room, transferring, and toileting. R19's MDS dated 4-7-16 also documents R19 is cognitively intact.

R1's Transfer Care Plan dated 1-7-16 to 6-24-16, documents R1 requires extensive assistance of one staff and a roller walker to ensure safety with transfers.

R19's Incident Report dated 5-5-16 at 10:45 p.m., documents "Resident was found lying on the floor on her right side after a CNA (Certified Nursing Assistant) called a nurse for help." R19's Fall Care Plan dated 7-5-16, documents a post fall intervention on 5-5-16 of, "Educate staff about leaving a call light with a resident at all times while they (residents) are alone in their room."

R19's Investigation Report dated 5-6-16 and signed by E2 (Director Of Nursing/DON), documents, "On the evening of 5-5-16 at approximately 11:00 p.m., (R19) was being ambulated with a roller walker to the bathroom. The nurse on the unit was called to (R19's) room and found (R19) on the floor between the bed and bathroom with a gait belt on. The staff member (E6/CNA) reported (R19) has slipped off the roller walker she was sitting on. During the assessment, (R19) reported that her right arm hurt around the elbow, and the right elbow had a bruise.... On 5-6-16, (R19) still complained of mild discomfort and (R19) required a right elbow x-ray.....(R19) has a fracture to the radial head of the right elbow and was transferred to the hospital for a splint."

R19's right elbow x-ray report dated 5-6-16, documents R19 has a probable non-displaced

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medial radial head fracture.

R19's written statement dated 5-6-16 and signed by E2 (Director of Nursing), documents R19 reported that on 5-5-16 E6 (CNA) assisted R19 to the bathroom. E6 put the roller walker in front of R19 and assisted R19 up. R19 then stated, "(E6) continued to comment to me that I was ambulating wrong and I was not putting my feet in the right manner. She (E6) really upset me. We were almost to the bathroom and I told (E6) I needed to sit down. I was getting weak. (E6) left me standing there in the doorway and yelled down the hall for another staff. When they (other staff) got to the room I had already fallen down....." This same statement documents R19 reported that E6 did not leave a call light with R19 before (E6) left the room.

E6's (CNA) Termination Report dated 5-9-15, documents, "Type of Warning: Termination. Failure to follow procedures in transferring residents multiple times. You (E6) have been told several times how to transfer residents in a safe manner. You (E6) did not leave a call light with the resident when you left the room. This fall results in a fracture of the elbow to the resident. This is a category two offense with a failure to follow departmental rules."

On 8-2-16 at 10:30 a.m., R19 stated, "I got a fracture not too long ago, because a CNA left me standing without a call light. I could not get help and needed to 'pee' real bad. I don't want that staff to work with me anymore."

On 8-3-16 at 8:45 a.m., E2 (Director Of Nursing/DON) stated, "On 5-5-16 at 8:45 a.m., a staff member (E6) sat (R19) on her wheeled

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walker and went to the hallway to get other staff. When (E6) returned to (R19's) room, (R19) was on the floor. (E6) did not give (R19) her call light when she was sitting on the roller walker. (R19) was left without a communication device to call for help, got up without help, and fell. (R19) is alert and orientated, so it (the call light) would have helped prevent the fall and fracture....(E6) was termed because according to our policy and procedure, residents are to have call lights within reach at all times."

2. The Facility's Gait Belt /Safe Handling Policy (undated) documents, "The policy of this facility is assure the safety of residents and employees during transfer and repositioning tasks. It is mandatory in this facility to use gait belts for the safety of residents and staff, therefore all licensed and certified nursing staff are to use gait belts while transferring residents. Disciplinary action will be taken with anyone not using a gait belt during a resident transfer."

R19's Fall Investigation Report dated 6-22-16 and signed by E2 (DON) documents, "On the evening of 6-21-16 at 10:00 p.m., (R19) was returning from the bathroom to the bed, ambulating with a wheeled walker and staff (E4/CNA). (E4) leaned forward to take (R19's) blankets down when (R19) fell on (R19's) buttocks to the floor. (R19) complained of right lower back pain....(R19) was sent to the hospital for evaluation...CT (Computed Tomography) report received states (R19) has a L 4 burst (Lumbar Back Burst) fracture with further height loss and a L1 vertebral body fracture."

R19's CT of the Lumbar Spine dated 6-22-16, documents R19 has L1 and L4 vertebral fractures

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(Lumbar Back Fractures).

E4's (CNA) Investigation Report dated 6-22-16 and signed by E2 (DON) documents, "On the evening of 6-21-16 at approximately 10:00 p.m., (E4) transferred a resident (R19) without using a gait belt....(E4) has been given a three day suspension..."'

The facility's Gait Belt Agreement dated 12-31-14 and signed by E4 on 6-8-16, documents E4 understands that a gait belt is required to be used for all resident transfers to promote safety.

E4's Employee Warning Report dated 6-22-16 and signed by E2 (DON) and E4, documents E4 received a final warning three day suspension for transferring a resident (R19) without using a gait belt and not following the company fall and transfer policy.

On 8-3-16 at 8:45 a.m., E2 (DON) stated, "Staff (E4/CNA) walked (R19) back from the bathroom to (R19's) bed with a roller walker. (E4) let go of (R19) to pull (R19's) bed covers down. When (E4) let go of (R19), (R19) fell to the floor. (E4) was not using a gait belt. (E4) had to be educated on asking for help by using the call light instead of letting go of the resident. (E4) should have kept hold of (R19) while pulling down the covers on the bed. This fall resulted in fractures to (R19's) back because (E4) let go of the gait belt."

B.

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	145800	A. BUILDING _____ B. WING _____	08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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1. A Falls Management Program dated 7/8/13, documents the Incident Committee Team will discuss the falls on a regular basis and confirm about potential preventative fall measures and measures to minimize injuries from falls...The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls...If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

A Policy and Procedure for Safe Use of Bedrails (date unknown), documents, "The aim of the introduction of this policy is to help prevent death, asphyxiation, entrapment, and serious injuries from the inappropriate use of bed rails."

A Minimum Data Set (MDS) Assessment dated 7/21/16, documents R10 was originally admitted on 11/18/11 with the diagnoses of Dementia, Mental Disorder, and Major Depressive Disorder. The MDS dated 7/21/16 also documents that R10 has severely impaired cognitive skills, requires extensive assistance of two staff for bed mobility, is unable to ambulate, and uses a trunk restraint on a daily basis.

A Side Rail Assessment dated 7/20/16, documents R10 uses bilateral half side rails when in bed.

A Resident Incident Report dated 6/21/16 at 3:30 p.m., documents ("R10's) bed alarm was sounding. (R10) found lying face down on bed with (R10's) legs hanging off and right arm beneath the side rail." A Physician Notification dated 6/21/16, documents "(R10) rolled to prone

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position while in bed. (R10) got her arm pinned beneath a side rail. Large dark purple bruise to right forearm near elbow...Bruise is 4.5 by 7.5 (centimeters)."

R10's medical record does not document a root cause analysis for R10's fall and arm entrapment from 6/21/16. A Care Plan intervention dated 6/21/16, documents adding a sensor pad to be placed while in bed for safety. Staff are to ensure device is properly placed and working and keep bedroom door ajar to monitor (R10). A Care Plan intervention dated 10/7/15, indicates the same intervention for a sensor pad had already been implemented prior to the 6-21-16 fall.

On 8/1/16 at 1:13 p.m., R10 was in the 2nd floor lounge alone without supervision. On 8/3/16 at 9:45 a.m., 12:10 p.m., and 1:28 p.m., R10 in her room with the door partly closed where R10 could not be visualized from the hallway as the 6-21-16 fall intervention indicates. On 8-2-16 at 10:00 a.m., R10's bed had half bilateral siderails.

On 8/3/16 at 9:18 a.m., E2 (Director of Nursing) stated there was no further documentation on R10's 6/21/16 fall. E2 stated the entrapment of R10's arm had not been addressed and the side rails were not removed until the surveyor discussed this issue with E2 on 8/2/16.

2. A Resident Incident Report dated 11/28/15 at 9:00 p.m., documents "(R10) was on floor with blood present around head. (R10) was moaning. Assessed more and noticed a small scrap to right middle knuckle and right knee. 1.5 inch gash to top of right side of (R10's) head." The Incident Report also documents in the "Witnesses Description of Incident", that R10 was being

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showered by one staff member while the second staff member was getting a towel for R10...R10 tried to stand from the shower chair and fell head first onto the floor. A Care Plan intervention dated 11/28/15, documents, "When (R10) is getting a shower, one staff (Certified Nurse Aide) is to have hands on her at all times."

A Minimum Data Set dated 10/22/15, documents R10 requires two assist with bathing. On 8/4/16 at 9:18 a.m., E2 verified there was no further investigation into R10's fall on 11/28/15 to determine how R10 fell while two staff members were to be assisting with R10's shower.

3. A Resident Incident Report dated 10/4/15 at 4:00 p.m., documents "(R10) fell from recliner onto the floor at the nurse's desk." The incident report also documents that the fall was "heard" but not witnessed by any staff members. A Care Plan intervention dated 10/4/15, documents "Staff are to stay with the resident while she is in recliner."

A Resident Incident Report dated 1/9/16 at 7:30 p.m., documents "Not witnessed, (R10) found on floor. Bruise to (right) knee." The incident report also documents that R10 was in the resident dining room with no supervision and that R10's lap belt restraint was in place when last seen by staff." A Care Plan intervention dated 1/9/16, documents "When (R10) is anxious, place (R10) at nurses desk with staff." R10's medical record does not document R10 was anxious on the evening of 1/9/16.

On 8/4/16 at 9:18 a.m., E2 verified R10 fell on 10/4/15 and 1/9/16 while not being supervised.

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident had a medical diagnosis and associated behavioral symptoms to support the use of an anti-psychotic medication, for one of three residents (R3) reviewed for anti-psychotics in a sample of 24. Findings include:	F 329		8/26/16

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F 329	Continued From page 18 The Electronic Medical Record documents R3 was admitted to the facility on 1/19/16 with the diagnosis of Dementia without Behavioral Disturbances. A Minimum Data Set, dated 3/23/16, identifies R3 as having moderate to severe cognitive impairment and no behaviors that would put herself or others at significant risk of physical injury. Admitting Physician's Orders, dated 1/19/16, document R3 is to receive Risperdal 0.5 mg at bedtime for the diagnosis of "sleep." An Informed Consent for Psychiatric Medications form, dated 1/30/16, requested authorization from R3's Power of Attorney to use Risperdal 0.5 mg daily for "Dementia with Anxiety." Behavior Management Program Tracking Forms for R3 from January 2016 to July 2016 document R3's target behaviors are: Anger Due to Placement, Says She is Going Home, Asking/Trying to Leave Facility, Restless. The Behavior Management Program Tracking forms document only two episodes of physical aggression since R3's admission (1/19/16), occurring on 6/01/16 and 6/08/16, in which R3 became combative with staff during cares. On 8/03/16 at 12:23 p.m., E2 (Director of Nursing) stated that "sleep" was not an appropriate diagnosis for the use of Risperdal. E2 explained that R3's Risperdal was prescribed originally at the hospital and carried on over to her admission to the facility. E2 indicated that a resident would need to have repeated attempts to harm themselves or others, to support the use of an anti-psychotic medication.	F 329		
F 367	483.35(e) THERAPEUTIC DIET PRESCRIBED	F 367		8/29/16

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Therapeutic diets must be prescribed by the attending physician.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview the facility failed to provide a diet as prescribed by the physician for one of 11 residents (R19) reviewed for Hydration/Swallowing difficulties, in the sample of 24.

Findings include:

On 8-1-16 at 12:05 p.m., R19 was served ground hamburger with mushroom sauce (mechanical soft), peas, buttered potatoes, gelatin, pineapple, and a tossed salad. R19 ate 50 percent of the ground hamburger and 100 percent of everything else.

R19's 8-1-16 Physician Order Sheet and 6-24-16 Nutritional Progress note document R19 was ordered a heart healthy regular diet on 6-24-16.

On 8-2-16 at 10:30 a.m., R19 stated, "I do not like that I have to eat ground chopped up meat. It is not appealing and it doesn't taste good. I wish I could have normal meat that is not ground up."

On 8-2-16 at 10:50 a.m., E7 (Dietary Manager) stated, "It was our error. We usually get a pink slip when a diet is changed. (R19) received a no added salt (NAS) mechanical soft diet before. (R19) was suppose to be advanced to a regular

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F 367	Continued From page 20 heart healthy diet on 6-24-16, but was not. We have been giving (R19) a mechanical soft diet with no added salt. A no added salt diet is different from a heart healthy diet. According to (R19's) physician, (R19's) swallow study was normal and (R19) should have been on a regular diet, and not mechanical soft."	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 maintain the cleanliness of two can openers, date food stored in the refrigerator, discard outdated food in the refrigerator, and keep boxes of frozen items off of the freezer floor. This has the potential to affect all 138 residents residing in the facility at this time. Findings include: The Policy Cleaning of Dining and Food Service Areas, no date, states ..."The methods and guidelines to be used and agents used for cleaning shall be available for each task or piece	F 371		8/26/16

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of equipment to be cleaned. A cleaning schedule will be posted for all cleaning tasks."

The Policy titled Refrigeration Storage, no date, states "All refrigerated products will be labeled and dated. Food is discarded as determined by the guidelines...All meats...four days (food must be used or discarded in this time frame)."

On 8/01/16 at 11:00 AM the can opener in the food preparation area and the can opener in the cooking area had accumulated brown dried gummy debris and food particles present on the blade and surrounding area on the machine. The reach in cooler had two pans, one with two slices of lunch meat and one three fourths full of ground turkey dated 7/27/16; a pan half full of ground sausage dated 7/22/16; and a pan half full of ground meat that did not have a date. There were three full large boxes sitting on the freezer floor one labeled Zucchini, one labeled Squash, and one labeled Candy Corn.

On 8/04/16 at 10:30 AM E7, Dietary Manager, confirmed that the can openers needed to be cleaned, "They were dirty and needed to be taken apart and cleaned," The outdated food should have been discarded, "Staff are to check the refrigerators every day and discard what is outdated," the undated pan of meat should have have been dated "Staff know that everything is to be dated" and nothing is to be stored on the freezer floor "Food should not be on the floor".

According to the Centers for Medicare and Medicaid (CMS) Resident's Census and Condition of Residents' Report, form 672, dated 08/01/16 and signed by E2, (Director of Nursing), at the time of the survey 138 residents resided in

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