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	145800	A. BUILDING _____ B. WING _____	09/03/2015

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F 000	INITIAL COMMENTS Annual Licensure and Certification Validation Survey for Subpart U: Alzheimer Unit Sunset Home is in substantial compliance with Subpart U, 77 Illinois Administrative Code 300.7000.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures for the inclusion of Advanced Directives in the care	F 155		

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

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planning process and failed to include resident specific life-sustaining instructions in the plan of care for two of 24 residents (R10, R23) reviewed for Advanced Directives, in a sample of 24.

Findings include:

1. A POLST (Practitioner Orders For Life-Sustaining Treatment) Form, dated 1/30/15, documents R10 has requested "Selective Treatment" when not in cardiopulmonary arrest, which include: "Comfort-Focused Treatment, use of medical treatment, IV (intravenous) fluids and IV medications, as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support. Transfer to hospital, if indicated. Generally avoid the intensive care unit." R10's current plan of care (no date) fails to address Advanced Directives or R10's specific "Selective Treatment."

2. A POLST (Practitioner Orders For Life-Sustaining Treatment) Form, dated 6/26/14, documents R23 has requested "Limited Additional Interventions in addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV (intravenous) fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support. Transfer to hospital, if indicated. Generally avoid the intensive care unit." R23's current plan of care (no date) fails to address Advanced Directives or R23's specific "Limited Additional Interventions" as requested.

The facility policy, titled "Do Not Resuscitate/POLST Policy (no date)," documents

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F 155	Continued From page 2 "The Social Service Team will review advanced directives with the resident annually to determine if the resident wishes to make changes in such direction." However, the "Do Not Resuscitate/POLST Policy" fails to address how each residents' preference on life-sustaining measures will be incorporated into the care planning process. On 9/2/15 at 11:35 a.m., E5 (Care Plan Coordinator) stated it was not the facility's practice to include Advanced Directives in the care planning process.	F 155		
F 221 SS=E	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 identify devices, which limit resident movement out of bed, as restraints and failed to assess the continued use of a restraint for five of seven residents (R1, R2, R4, R11, R15) reviewed for restraints in a sample of 24. Findings include: Facility Use of Restraints policy dated 2008 states, "Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the	F 221		

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prevention of falls." The policy also states that restraints, "...are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body....there shall be a pre-restraining assessment and review to determine the need for restraints."

1. On 8/31/15 at 12:55p.m. R11 was in a wheelchair with a seat belt around R11's waist which prevented R11 from rising. E10 (Certified Nurse Aide) asked R11 to remove the seat belt. R11 pulled at the seatbelt but was not able to unbuckle it.

On 9/01/15 at 9:40a.m. E11 (Registered Nurse) stated R11's seat belt had been used since 8/03/14. E11 stated R11 needed the seat belt to prevent sliding, falls, and for positioning.

A physician's order dated 8/03/15 documents, R11's wheelchair seatbelt was ordered on that date.

On 9/02/15 at 1:00p.m. E7 (Unit Coordinator) stated R11's medical record did not include any assessment documenting R11's medical symptoms that warranted the implementation and continued use of restraints.

2. On 9/02/15 at 8:55a.m. R15 was laying in bed with a foam pool noodle tucked under the fitted sheet providing a barrier along R15's left side of the bed . R15's right side of the bed was pushed against the wall. R15 denied requesting the use of the pool noodle. R15 denied being able to remove the pool noodle from under the fitted

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sheet or rise out of the bed stating, "They say it's to keep me from falling out of bed. I can't even sit on the side of the bed

On 9/01/15 at 9:10a.m. E11 (Registered Nurse) stated R15 has a noodle restraint because R15 had, "a couple of falls from the bed."

On 9/02/15 at 9:00a.m. E7 (Unit Coordinator) stated R15's medical record does not include a consent, a physician's order for the use of the pool noodle, or a medical symptom for the use of the pool noodle under R15's fitted bed sheet. E7 stated, "It's just to define the perimeter of the bed so R15 won't fall out. It's just a nursing measure."

3. R1's Minimum Data Set dated 6-23-15, indicates R1 is cognitively intact. R1's Fall Investigation Tool dated 6-27-15 at 4:00 p.m., documents R1 was transferring from the bed per self, and was found lying on the floor next to the bed. A fall intervention dated 6-27-15 documents to add a scoop mattress (concave mattress/mattress with raised sides) to R1's bed. R1's current Fall Care Plan includes the following fall interventions: Scoop mattress added to bed. Pool noodle on edge of mattress for more definition of sides. R1's Physician Order Sheets and Assessments dated 1-1-15 to to 9-2-15, do not include a physician's order or an assessment for the use of a scoop mattress or a pool noodle as fall interventions.

On 8-31-15 at 12:57 p.m., E15 (Certified Nursing Assistant/CNA) and E16 (CNA) transferred R1 from a commode to R1's bed. R1's right side of the bed was pushed against the wall and R1's mattress was concave (raised sides). E16

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positioned R1 to the left side of the bed. E16 then placed a foam pool noodle to the left side of the bed, under the fitted sheet, providing a barrier to the left side of R1. R1 remained in this same position from 12:57 p.m. to 3:00 p.m.

On 8-31-15 at 1:15 p.m., R1 stated, "I cannot get out of bed because of that thing (the foam pool noodle). I cannot get over it. I cannot remove the noodle, either."

On 9-2-15 at 2:45 p.m., E2 (Director of Nursing/DON) verified the facility does not have a physician's order or an assessment for the use of a concave mattress or a foam noodle for R1.

On 9-2-15 at 3:00 p.m., E17 (CNA) stated, "The pool noodle is used so (R1) does not try to get out of bed. (R1) sometimes attempts to get up. (R1) cannot get up with the pool noodle beside (R1) because the pool noodle is too thick. We (facility) staff put the pool noodle beside (R1) when (R1) is in bed."

4. R2's Minimum Data Set dated 7/23/15 indicates R2 is cognitively impaired.

R2's current Fall Care Plan includes the following fall interventions: Scoop mattress (concave mattress/mattress with raised sides) placed on bed due to R2's tendency to get out of bed and attempt to transfer without assist. Foam Noodle applied to bed.

R2's current Physician Order Sheet and Assessments do not include a physician's order or assessment for the use of a scoop mattress or a pool noodle as fall interventions.

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On 9/2/15 at 2:50 PM, E19, CNA (Certified Nursing Assistant) stated R2 was a fall risk and the scoop mattress and pool noodle were used to prevent R2 from getting up and falling. E19 stated R2 was not able to remove either device from R2's bed.

On 9/2/15 at 2:53 PM, E20, CNA stated the scoop mattress and pool noodle are used because (R2) tries to get out of bed and the pool noodle is to keep (R4) from getting out of bed.

On 9/2/15 at 3:00 PM, E18, Unit Coordinator, confirmed (R2) uses a scoop mattress and a pool noodle. E18 stated the scoop mattress and pool noodle were used to help (R2) define the edge of the bed. E18 stated there was no physician's order or assessment for the use of a scoop mattress or pool noodle being used for (R2).

5. R4's Minimum Data Set dated 7/23/15 indicates R4 is severely cognitively impaired.

R4's current Fall Care Plan includes the following interventions: Scoop mattress (concave mattress/mattress with raised sides) on bed and noodle.

R4's current Physician Order Sheet and assessments do not include a physician's order or assessment for the use of a scoop mattress or a pool noodle as fall interventions.

On 9/2/15 at 2:50 PM, E19, CNA, stated (R4) was not able to removed either device (pool noodle or concave mattress).

On 9/2/15 at 2:53 PM, E20, CNA, stated (R4) uses a scoop mattress and pool noodle and the

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F 221	Continued From page 7 pool noodle is used to keep (R4) from getting out of bed. On 9/2/15 at 3:00 PM, E18, Unit Coordinator, stated (R4) has a history of getting out of and rolling out of bed. E18 stated the scoop mattress and noodle help (R4) define the edge of the bed. E18 states there was no physician's order or assessment for the use of the scoop mattress or pool noodle being used for(R4).	F 221		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		

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F 278	Continued From page 8 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess one of 24 residents (R10) reviewed for minimum data set assessments in a sample of 24. Findings include: R10's Minimum Data Set assessment (MDS) dated 4/23/15, section M0300, documents R10 has a stage four pressure ulcer which was present at the time of admission/entry or reentry. R10's MDS dated 7/23/15 section M0300 documents R10 has a stage three pressure ulcer and a stage four pressure ulcer which were present upon admission/entry or reentry. On 9/02/15 at 10:45a.m. E7 (Unit Coordinator) stated E7 documented section M for pressure ulcers on R10's Minimum Data Set assessments. E7 stated R10's pressure ulcers were acquired at the facility. E7 stated R10's pressure ulcers did not worsen or improve during hospital visits. E7 stated R10's MDS dated 4/23/15 and 7/23/15 section M0300 were not accurate and should have been documented to reflect R10's pressure ulcers were not present on admission/entry or reentry.	F 278		
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	F 280		

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incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to revise or update a care plan to reflect the use of a fall prevention measure for one of 24 residents (R15) reviewed for care plans in a sample of 24.

Findings include:

On 9/02/15 at 8:55a.m. R15 was laying in bed with a foam pool noodle tucked under the fitted sheet providing a barrier along R15's left side of the bed . R15's right side of the bed was pushed against the wall. R15 denied requesting the use of the pool noodle, and R15 denied being able to remove the pool noodle from under the fitted sheet. R15 denied being able to rise out of the bed stating, "They say it's to keep me from falling

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F 280	Continued From page 10 out of bed... I can't even sit on the side of the bed." R15's current electronic care plan does not include using a foam pool noodle under R15's fitted bed sheet as a fall prevention measure or as a restraint. On 9/02/15 at 9:25a.m. E7 (Unit Coordinator) verified R15's care plan does not include the intervention of a foam pool noodle under R15's fitted bed sheet as a fall prevention measure or as a restraint.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to monitor and provide adequate fluid intake to ensure sufficient hydration for one of ten residents (R2) reviewed for physicians orders in the sample of 24. Findings include: The facility's undated "Intake and Output" policy documents, "The measurement and recording of all fluid intake and output during a 24 hour period which provides important date about the client's fluids and electrolyte balance."	F 282		

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F 282	Continued From page 11 R2's computer generated list of diagnosis dated 9/1/15 documents R2's diagnoses include Dementia with behavioral disturbances, Chronic Kidney Disease, and History of Urinary Tract Infections. R2's current Physician Order Summary documents an order, dated 9/15/14, for R2 to receive 2000 ml (milliliters) liquids daily. In addition, the order summary documents an order, dated 7/21/15 for R2 to have "increased oral liquids." On 8/31/15 at 11:46, R2 was in the dining room , seated at a table. A full glass of water and a full glass of apple juice were on the table in front of R2. On 8/31/15 at 12:15 PM, R2 remained in the dining room, seated at the table with the full glass of water and and a full glass of apple juice on the table, without any encouragement from the facility staff to ensure R2 drank fluids. R2 was then taken to a recliner in the facility living area, without drinking any of the fluids. E2, Unit Coordinator stated on 9/2/15 at 10:10 AM, R2 did have an order for 2000 ml of fluids a day. E2 stated no intake tracking was being documented by staff. E2 confirmed intake monitoring should have been implemented when the order for 2000 ml of fluids a day was received.	F 282		
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	F 314		

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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 develop pressure ulcer prevention interventions, for two of three residents (R1 and R10) reviewed for pressure ulcers, in a sample of 24, and failed to follow the facility policy on wound management to prevent cross contamination during wound care, for one of three residents (R10) reviewed for pressure ulcers, in a sample 24.

Findings include:

Facility Pressure Ulcer Prevention and Managing Skin Integrity policy (undated) documents, "The care and intervention for any identified skin breakdown or wound will be aimed at Prevention of any further advancement of the wound, or additional skin breakdown...The presence of skin breakdown/abnormal skin appearance ,i.e. abrasion, blister, bruising due to pressure...will be documented on an incident form." The policy also states, "Patients at risk of pressure ulcer development are repositioned to minimize pressure friction and shearing...Evidence to support this action should be in the form of accurate documentation with explicit information regarding: Position...time and date...condition of skin."

Facility Wound Care policy (undated) documents

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that residents' wound assessments and documentation should include, "Stages and phases."

1. On 8-31-15 at 1:10 p.m., E4 (Registered Nurse) applied a new pressure ulcer treatment to R1's left heel. R1's pressure ulcer to the left heel measured approximately 4 cm long by 2 cm wide by 1 cm deep, with a 2 cm round black edge to the outer edge of the wound. The wound had moderate amounts of yellowish/reddish drainage.

R1's Braden Scale for Predicting Pressure Sore Risk dated 9-18-14 indicates R1 is at a moderate risk of developing a pressure ulcer. R1's Braden Scale for Predicting Pressure Sore Risk dated 12-11-14 and 8-16-15, documents R1 is at a high risk for developing a pressure ulcer.

R1's Progress/Wound Notes dated 11-25-14 document R1's left heel was noted to have a stage one pressure area, indicating the pressure area was brown in color and the surrounding skin was red in color. R1's Progress Note dated 11-3-14 and signed by Z1 (R1's Nurse Practitioner) documents R1 had a stage two pressure ulcer of the right heel measuring 1-2 cm (centimeter) with a 0.5 cm area of skin that had peeled of in the center. This same note documents R1 sleeps on the right side and the left foot rests against the right foot at night, which might be creating some pressure.

R1's Progress Note dated 11-10-14 and signed by Z1 documents R1's left heel had increased in redness, had increased in size to 2-3 cm with sloughing around the edges, and had a small black area of skin inside the reddened area.

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R1's at "Risk for Skin Breakdown Current Care Plan" initiated on 9-16-13, does not include any new pressure relieving interventions until 11-10-14, 7 days after the pressure ulcer to R1's heel developed.

R1's Wound Center Wound Assessment dated 9-2-15, documents R1 currently has a stage four left heel pressure ulcer measuring 3.5 cm (centimeters) long by 4.3 cm wide by 0.8 cm deep.

On 9-1-15 at 10:00 a.m., E3 (Registered Nurse/R1's Unit Care Plan Coordinator) stated, "(R1's) left heel wound started as a stage one pressure ulcer here (the facility). (R1) moves pillows around at night. We (the facility) should have a care plan in place to alert staff to ensure pressure relieving devices are in place for (R1), but do not. The pressure ulcer to the left heel developed on 11-3-15, and pressure relieving boots should have been implemented before the wound was developed, or when the wound developed. The pressure relieving boots were not implemented until 11-10-15."

On 9-2-15 at 12:45 p.m., Z1 (R1's Nurse Practitioner) stated, "I have followed and assessed (R1's) pressure ulcer to the left heel since the development of the ulcer. If the facility would have started pressure boots or a different pressure relief measure prior to the development, it would have prevented the initial development of the pressure ulcer and the progression of the pressure ulcer from a stage one to a stage two from 11-3-14 to 11-10-14. The pressure ulcer developed at the facility. (R1's) care plan should include an intervention to make sure a pillow is in

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place to prevent pressure. Pressure relief measures could have prevented the initial development and progression from a stage one pressure ulcer to a stage two pressure ulcer....."

2. On 8/31/15 at 10:10 a.m., E7 (Unit Coordinator) stated R10 had a stage four pressure ulcer to the right buttock (ischial) and a stage three pressure ulcer to the left buttock (ischial).

R10's pressure ulcer log, dated 2/28/14 to 8/27/15, documents R10 has had a chronic pressure ulcer on the right upper, outer aspect of the buttock (right ischial) which initially developed as a stage two pressure ulcer then progressed to a stage four pressure ulcer. R10's weekly right ischial pressure ulcer assessments no longer include documentation of staging after 4/07/15.

R10's Nurse's notes dated 4/28/15, document R10 developed a second pressure ulcer located on R10's left upper, outer aspect of the buttock (left ischial) measuring 3.0cm (centimeters) long x 2.0cm wide x 0.5cm deep.

R10's weekly wound assessments dated 4/07/15 to 4/25/15, do not include an assessment indicating the stage of R10's right ischial pressure ulcer. R10's weekly wound measurements dated 4/29/15 to 8/30/15 do not include an assessment indicating the stages of R10's right or left ischial pressure ulcers.

R10's Minimum Data Set assessment (MDS) dated, 4/23/15, documents, R10 had one stage four pressure ulcer. R10's MDS dated, 7/23/15 documents, R10 had one stage three pressure ulcer and one stage four pressure

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F 314	Continued From page 16 R10's current electronic care plan (includes multiple dates) documents for staff to turn and reposition R10 every two hours. On 9/02/15 at 1:00p.m. E7 (Unit Coordinator) stated E7 was unable to provide documentation that incident reports were completed after the development of R10's right and left ischial pressure ulcers. E7 was also unable to provide documentation that R10 was being turned and repositioned every two hours. E7 stated R10's care plan was not updated with additional interventions to prevent further advancement of R10's wounds following the development of R10's left ischial pressure ulcer on 4/28/15. E7 verified R10's weekly wound assessments do not include the stages of R10's pressure ulcers. On 9/01/15 at 9:25a.m. E11 (Registered Nurse) was applying a clean dressing to R10's right ischial pressure ulcer. E11 removed scissors from E11's uniform pocket, then without disinfecting the scissor's, E11 cut the end of a ribbon dressing which was inserted into R10's stage four pressure ulcer. E11 verified the scissors were not disinfected immediately after pulling them from E11's pocket stating, "I do use bleach wipes between residents." On 9/03/15 at 9:20a.m. E2 (Director of Nurses) stated staff should disinfect scissors after removing from a uniform pocket and before using them to cut dressings for wounds.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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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 cross contamination during indwelling urinary catheter care for one of five residents (R10) reviewed for indwelling urinary catheter care in a sample of 24.

Findings include:

On 8/31/15 at 1:10p.m. E9 (Certified Nurse Aide) was providing indwelling urinary catheter care to R10. E9 used a wet wash cloth to wash R10's vaginal area around the catheter insertion site using a back and forth motion multiple times, using the same area of the washcloth. Without changing wash cloths or without using a clean area of the wash cloth, E7 wiped the catheter tubing around the insertion site.

Facility Catheter Care Procedure policy (undated) instructs staff, "Perform perineal care. Using clean cloth, clean the catheter from the meatus (insertion site) down the catheter...Use one washcloth per stroke..."

On 9/03/15 at 9:20a.m. E2 (Director of Nurses) verified E9 did not use the correct indwelling

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F 315	Continued From page 18 urinary catheter care technique to prevent cross contamination.	F 315		
F 323 SS=D	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 observation, interview and record review the facility failed to follow a physician's order for a motion sensor alarm and follow fall prevention interventions to prevent falls for one of six residents (R15) reviewed for falls in a sample of 24. Findings include: On 8/31/15 at 10:10a.m. E7 (Unit Coordinator) was standing at the doorway to R15's room. R15 was in laying in bed sleeping. There was no motion detection alarm present in R15's room. E7 verified R15 did not have a motion detecting alarm present stating that R10's motion detecting alarm was discontinued. A fall investigation dated 8/14/15 documents R15 fell while sitting on the bedside commode in R15's room. The investigation also documents that no staff were present when R15 fell and that R15's personal body alarm was not in place.	F 323		

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F 323	Continued From page 19 R15's care plan intervention dated 7/16/13 states, "Do not leave unattended when on toilet, motion sensor in bed and in recliner." A physician's order dated 6/25/14 documents R15 requires a motion detecting alarm, "...for safety at all times while resident is in room." On 9/03/15 at 10:55a.m. E7 (Unit Coordinator) stated, "We don't get orders to discontinue," the motion detection alarm, "it's just a nursing order." E7 stated E7 was not aware R15 had a physician's order to have the motion detecting alarm at all times when in room.	F 323		
F 368 SS=B	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced	F 368		

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by:
Based on record review and interview, the facility failed to offer all residents a bedtime snack, for five of 24 residents (R6, R15, R24, R27 and R28) reviewed for for receiving a nourishing snack at bedtime, in the sample of 24, and for seven residents (R32 - R38) in the supplemental sample.

Findings include:

On 9/01/15 at 9:30 a.m., during the Group Interview, R24, R27, R28, R32, R35 and R38 all stated staff do not offer them a snack in the evening before bedtime.

On 9/01/15 at 3:00 p.m., R6 stated staff never come around in the evening and offer her a snack. R6 stated, "It would be nice if they did. I'm a Diabetic."

On 9/02/15 at 2:00 p.m., R15 stated she has never been offered a snack in the evening before bed. R15 stated, "That would be nice. I would like one (snack)."

On 9/03/13 at 9:45 a.m., R33 stated staff do not come around and offer a bedtime snack, "not that I ever remember."

On 9/03/15 at 9:48 a.m., R34 stated staff had not been asking her if she wanted a snack before bed.

On 9/03/15 at 9:50 a.m., R36 stated she was not offered a snack in the evening or before bed.

On 9/03/15 at 9:47 a.m., R37 stated no one comes around to offer her a snack in the evening.

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F 368	Continued From page 21 On 9/02/15 at 2:40 p.m., E13 (Certified Nursing Assistant) stated they keep resident snacks at the nurses station for residents to just help themselves. E13 pointed to a container, which held crackers and cookies, located at the corner of the 200 Hall nurses station. On 9/02/15 at 2:45 p.m., E14 (Certified Nursing Assistant) stated they go around to resident rooms and pass ice water in the evening, but they do not go to the resident's room and offer them a snack. E14 stated certain residents have an order for a snack and that food is sent up by the Dietary Department. E14 indicated the remaining residents could have a snack, but they would have to come up to the nurses station to get it. On 9/03/15 at 11:15 a.m., E6 (Dietary Manager) stated staff are to offer the residents a snack before bedtime, while passing water. E6 stated residents are not expected to come to the nurses station to get the snack on their own, the snack is to be offered to them. The facility policy, titled "Food and Nutrition Policy and Procedure (no date)," documents, "Every effort is made to determine and provide appropriate snacks for each...resident. All residents with Diabetes will be offered an HS (evening) snack." The policy fails to identify that all residents need to be offered an evening snack.	F 368		
F 441 SS=D	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	F 441		

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F 441	Continued From page 22 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent cross contamination following perineal care for one of	F 441		

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F 441	Continued From page 23 14 residents (R10) reviewed for infection control practices during personal care in a sample of 24. Findings include: 1. Facility Handwashing/Hand Hygiene policy (undated) documents, "Employees must wash their hands for at least 15 seconds using antimicrobial or non microbial soap and water under the following conditions:..after contact with a resident's mucous membranes and body fluids or excretion, after handling...catheters." On 8/31/15 at 1:10p.m. E9 (Certified Nurse Aide) was providing indwelling urinary catheter and perineal care to R10. E9 applied gloves, cleansed R10's perineal area and catheter tubing. Without removing the soiled gloves or performing hand hygiene, E9 touched R10 and R10's bed linens while turning R10 to the right side. E9 noticed R10's pressure ulcer dressing was dislodged. E9 removed the soiled gloves and without performing hand hygiene, E9 exited R10's room. E9 returned to R10's room with E10 (Certified Nurse Aide) to complete R10's perineal/catheter care. E9 and E10 assisted R10 to turn to the left side while E10 cleansed R10's buttocks area. Without removing gloves or performing hand hygiene, E10 touched R10 and R10's bed linens.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to obtain laboratory testing for one of five residents (R2) reviewed for laboratory testing in the sample of 24.

Finding include:

The facility's undated "Laboratory Services" policy, documents the facility will provide laboratory services to residents who need the service. The policy also documents, "(an outside medical group) will order and draw all their resident labs. If a stat order is received and no (medical group) technician is available, a licensed (facility) staff member may collect the specimen."

R2's current Physician's Orders documents R2's BMP (Basic Metabolic Panel) is ordered every three months (January, April, July, and October).

R2's current Physician Orders documents R2's CMP (Comprehensive Metabolic Panel) is ordered every six months(April and October).

R2's medical record include CMP results dated 7/21/15 and 8/11/15. No other CMP or BMP results were found in R2's medical record.

On 9/2/15 at 11:45 AM, E18, Unit Coordinator stated (R2) did have an order for BMPs every three months and CMPs every six months. E18 stated an outside medical group draws the labs. E18 stated (R2) had no labs drawn for the scheduled BMP's in January or April. E18 also stated (R2) had no labs drawn for the scheduled CMP in April.

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